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

In the Matter of the Second Amended Accusation Against:	)	
Paul Gilbert Johnson, M.D.	)	**Case No. 800-2016-020957**
Physician's and Surgeon's Certificate No. G18771	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License 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 July 1, 2020.

IT IS SO ORDERED March 4, 2020

MEDICAL BOARD OF CALIFORNIA

By: _____
Christine J. Lally
Interim Executive Director

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
LEANNA E. SHIELDS
Deputy Attorney General
State Bar No. 239872
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9401
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **PAUL GILBERT JOHNSON, M.D.** **P. O. Box 3699** **Seal Beach, CA 90740** **Physician's and Surgeon's Certificate No. G 18771,** Respondent.	Case No. 800-2016-020957 OAH No. 2019080583 **STIPULATED SURRENDER OF LICENSE 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). This action was brought by then Complainant Kimberly Kirchmeyer solely in her official capacity as Executive Director of the Board.[1] Complainant is

[1] Kimberly Kirchmeyer became the Director of the Department of Consumer Affairs on October 28, 2019.

represented in this matter by Xavier Becerra, Attorney General of the State of California, by LeAnna E. Shields, Deputy Attorney General.

2. Respondent Paul Gilbert Johnson, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., of Doyle Schafer McMahon, LLP, whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about July 20, 1970, the Board issued Physician's and Surgeon's Certificate No. G 18771 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in the Second Amended Accusation No. 800-2016-020957, and will expire on July 31, 2020, unless renewed.

JURISDICTION

4. On March 8, 2019, Accusation No. 800-2016-020957 was filed before the Board. A true and correct copy of Accusation No. 800-2016-020957 and all other statutorily required documents were properly served on Respondent on March 8, 2019. Respondent timely filed his Notice of Defense contesting the Accusation No. 800-2016-020957.

5. On May 30, 2019, the Second Amended Accusation No. 800-2016-020957 was filed before the Board, and is currently pending against Respondent. A true and correct copy of the Second Amended Accusation No. 800-2016-020957 along with a true and correct copy of a Supplemental Statement to Respondent were properly served on Respondent on May 30, 2019. A true and correct copy of the Second Amended Accusation No. 800-2016-020957 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in the Second Amended Accusation No. 800-2016-020957. Respondent has also carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second 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.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. 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 the Second Amended Accusation No. 800-2016-020957, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 18771 to disciplinary action. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G 18771 for the Board's formal acceptance with an agreed upon effective date of July 1, 2020.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. G 18771 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Order below.

11. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G 18771, all of the charges and allegations contained in the Second Amended Accusation No. 800-2016-020957 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 or elsewhere.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. Respondent understands that by signing this Stipulated Surrender of License and Disciplinary Order he enables the Executive Director of the Board to issue an order, on behalf of

///

the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 18771 without notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

18. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 18771 issued to Respondent Paul Gilbert Johnson, M.D., is hereby surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate No. G 18771 and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order, which shall be on July 1, 2020.

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in the Second Amended Accusation No. 800-2016-020957 shall be deemed to be true,

correct and fully admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Second Amended Accusation No. 800-2016-020957 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G 18771. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 2/14/20

PAUL GILBERT JOHNSON, M.D.
Respondent

I have read and fully discussed with Respondent Paul Gilbert Johnson, M.D. the terms and conditions and other matters contained in the above Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: February 14, 2020

RAYMOND J. McMAHON, ESQ.
Attorney for Respondent

///

///

///

///

///

ENDORSEMENT

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

DATED: Feb. 14, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

SD2019700482
72152348.docx

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
LEANNA E. SHIELDS
Deputy Attorney General
State Bar No. 239872
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9401
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **PAUL GILBERT JOHNSON, M.D.** **P.O. Box 3699** **Seal Beach, CA 90740** **Physician's and Surgeon's Certificate No. G 18771,** Respondent.	Case No. 8002016020957 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 20, 1970, the Medical Board issued Physician's and Surgeon's Certificate No. G 18771 to Paul Gilbert Johnson, 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 July 31, 2020, unless renewed.

JURISDICTION

3. This Second Amended Accusation, which supersedes the First Amended Accusation filed on March 14, 2019, 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, in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

"..."

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."

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent Paul Gilbert Johnson, M.D. has subjected his Physician's and Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, C, D. and E,[1] as more particularly alleged herein:[2]

Patient A

9. On or about July 15, 2011, Patient A, a then 51-year old male, presented for an initial consultation for anxiety and pain management.

10. From on or about July 2011, through on or about April 2013, Respondent provided care and treatment to Patient A for, among other things, neck pain, back pain, and anxiety.

11. From on or about July 2011, through on or about April 2013, Respondent prescribed several controlled substances to Patient A, including, but not limited to, Vicodin ES[3] (7.5/750), Ambien[4] (10 mg), Xanax[5] (1 mg), Xanax (2 mg), and diazepam[6] (10 mg).

///

---

[1] Patient identities have been withheld for patient privacy purposes. Respondent is aware of the identities of the patients referred to herein.

[2] Conduct occurring more than seven (7) years from the filing date of this Second Amended Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] Vicodin ES is a brand name for the drug combination of 7.5 mg of hydrocodone and 750 mg of acetaminophen. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain.

[4] Ambien is a brand name for zolpidem, 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. Ambien is a benzodiazepine analog. When properly prescribed and indicated, it is commonly used to treat insomnia.

[5] Xanax is a brand name for alprazolam, 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. It is an anti-anxiety medication in the benzodiazepine family.

[6] Diazepam 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. Diazepam is a long-acting benzodiazepine. When properly prescribed and indicated, it is used to treat anxiety, seizures and muscle spasms.

12. Between on or about July 2011, and April 2013, Respondent saw Patient A at approximately five (5) office visits, including, but not limited to: July 15, 2011, January 9, 2012, March 23, 2012, October 25, 2012, and April 9, 2013.

13. Between on or about July 2011, and April 2013, Respondent's progress notes for his interactions with Patient A are sparse and often illegible.

14. On or about July 15, 2011, Patient A reported experiencing extreme stress, family history of alcoholism, and prior medications including Xanax (2 mg) three times per day and Ambien. Records for this visit indicate Respondent issued prescriptions to Patient A for Xanax (2 mg) three times per day, and Ambien (10 mg). Respondent's notes for this visit, show no documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects of Ambien and Xanax, and no discussion regarding the high dosage level of Ambien being prescribed or the reasoning for such a high dose.

15. On or about January 9, 2012, Patient A presented for a check up. Records for this visit indicate Respondent issued prescriptions to Patient A for Xanax (2 mg) three times per day, and Ambien (10 mg). Respondent's notes for this visit, show no documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects of Ambien and Xanax, and no discussion regarding the high dosage level of Ambien being prescribed or the reasoning for such a high dose. Respondent's notes for this visit also do not mention whether Patient A's pain, anxiety, or sleep quality was improving or declining.

16. On or about March 23, 2012, Patient A presented with complaints of chronic back pain and a request to refill previous medications for Valium and Vicodin. Records for this visit indicate Respondent issued prescriptions to Patient A for Valium (10 mg) and Vicodin ES (7.5/750). Respondent's notes for this visit, show no documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects of Valium and Vicodin ES, the rationale for switching from Xanax to Valium, or the risks of taking them in combination with Ambien and Xanax. Respondent's notes for this visit also do not mention whether Patient A's pain, anxiety, or sleep quality was improving or declining.

///

17. On or about October 25, 2012, Patient A presented requesting refills of his medications. Records for this visit indicate Respondent issued prescriptions to Patient A for Valium (10 mg), Vicodin ES (7.5/750), and Ambien (10 mg). During this visit, Respondent lowered Patient A's prescription for Ambien in half, from 60 tablets to 30 tablets, without any documentation regarding the reasoning for this change. Respondent's notes for this visit also show no documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects of Ambien, Xanax, Valium or Vicodin ES, or the risks associated with taking them in combination. Respondent's notes for this visit also do not mention whether Patient A's pain, anxiety, or sleep quality was improving or declining.

18. On or about April 9, 2013, Patient A presented for a check up and prescription refills. Records for this visit indicate Respondent issued prescriptions to Patient A for Xanax (2 mg), Ambien (10 mg) and Vicodin ES (7.5/750). Respondent's notes for this visit, show no documentation of Patient A's pain level, no discussion regarding the risks, benefits, or side effects of Ambien, Xanax, Valium or Vicodin ES, or the risks associated with taking them in combination. Respondent's notes for this visit also do not mention whether Patient A's pain, anxiety, or sleep quality was improving or declining.

19. Throughout Respondent's care and treatment of Patient A, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient A's progress toward treatment objectives, refer Patient A to a specialist for additional evaluation and treatment, or consult with a specialist to determine the possibility of alternative treatment modalities.

20. Throughout Respondent's care and treatment of Patient A with chronic opioid therapy, Respondent did not conduct an adequate history and physical examination, perform appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient information to obtain informed consent, establish an opioid management plan, require more frequent office visits, or perform adequate monitoring regarding compliance.

///

21. On or about April 11, 2013, Respondent was notified by the coroner's office that Patient A had passed away.

22. According to Patient A's Controlled Substance Utilization Review and Evaluation System[7] (CURES) report, from on or about November 2011, through on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 900 tablets of Vicodin ES (7.5/750).

23. According to Patient A's CURES report, from on or about November 2011, through on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 900 tablets of diazepam (10 mg).

24. According to Patient A's CURES report, from on or about November 2011, through on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 720 tablets of Xanax (1 mg).

25. According to Patient A's CURES report, from on or about November 2011, through on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 630 tablets of Xanax (2 mg).

26. According to Patient A's CURES report, from on or about November 2011, through on or about April 2013, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 1,080 tablets of Ambien (10 mg).

27. Respondent committed gross negligence in his care and treatment of Patient A, which included, but is not limited to:

A. Paragraphs 9 through 26, above, are hereby incorporated by reference and realleged as if fully set forth herein;

---

[7] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

B. Respondent failed to document and/or develop a treatment plan or document and/or identify objectives for which a treatment plan could be evaluated, including the failure to discuss or document Patient A's reported pain levels, sleep quality, or anxiety improvement;

C. Respondent failed to document or sufficiently inform Patient A of the risks and benefits associated with the use of the prescribed controlled substances, including the failure to discuss the risks associated with the combined use of opioids and benzodiazepines, the failure to discuss the additional risks associated with a family history of alcoholism, and the failure to advise against combining them with alcohol;

D. Respondent failed to perform periodic evaluations regarding Patient A's progress toward treatment objectives, including the failure to document any change in pain level, sleep quality, or anxiety improvement;

E. Respondent failed to discuss with Patient A or refer Patient A for additional consultation, evaluation and treatment, in order to achieve treatment objectives, including the failure to enlist the aid of relevant specialists to determine the underlying cause of Patient A's issues or suggest alternative treatments; and

F. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient A, including the failure to document critical patient-care related discussions.

Patient B

28. On or about December 29, 2009, Patient B, a then 32-year old male, presented for an initial consultation for anxiety and pain management. Respondent's notes for this visit indicate Patient B admitted being a prior alcoholic.

29. From in or around 2009, through in or around 2018, Respondent provided care and treatment to Patient B for, among other things, pain, depression, anxiety, fatigue, and hypertension.

///

30. From in or around 2012, through in or around 2018, Respondent prescribed several controlled substances to Patient B, including, but not limited to, oxycodone[8] (30 mg), Percocet[9] (10/325), Endocet[10] (10/325), Norco[11] (10/325), lorazepam[12] (2 mg), Ambien (10 mg), and Zaleplon[13] (10 mg).

31. In or around 2012, Respondent saw Patient B at approximately five (5) office visits, including, but not limited to: March 8, 2012, April 5, 2012, September 7, 2012, November 9, 2012, and December 27, 2012. Respondent's notes for his interactions with Patient B during these visits are sparse and often illegible.

32. On or about March 8, 2012, Patient B presented with complaints of arthritis and body aches. During this visit, Patient B informed Respondent that he had been receiving Gabapentin[14] (800 mg) from another provider. Respondent issued a prescription to Patient B for Gabapentin (800 mg).

---

[8] Oxycodone is an opioid and is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Percocet is a brand name for the drug combination of oxycodone (2.5 mg, 5 mg, 7.5 mg, or 10 mg) and acetaminophen (325 mg). See Footnote 8, above, regarding oxycodone.

[10] Endocet is a brand name for the drug combination of oxycodone (10 mg) and acetaminophen (325 mg). Oxycodone is an opioid and is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[11] Norco is a brand name for the drug combination of hydrocodone (5 mg, 7.5 mg, or 10 mg) and acetaminophen (325 mg). Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The DEA has identified opioids, such as Hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

[12] Lorazepam, brand name Ativan, 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. It belongs to a group of drugs called benzodiazepines.

[13] Zaleplon, brand name Sonata, 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.

[14] Gabapentin is an anti-epileptic drug commonly used to treat seizures and epilepsy. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

33. On or about March 12, 2012, Patient B presented to an emergency department with complaints of body aches and pain. After a thorough review of systems, Patient B was discharged and provided information regarding osteoarthritis. Records for this encounter are maintained in Respondent's chart for Patient B.

34. On or about April 5, 2012, Patient B was seen by Respondent at an office visit, during which Patient B informed Respondent of his recent visit to the emergency department. Respondent's notes for this visit indicate Patient B informed Respondent he was not satisfied with the care provided at the hospital. Respondent's notes for this visit also indicate a discussion with Patient B's fiancé, however, the topic of discussion is not documented.

35. On or about September 5, 2012, Patient B's mother submitted several records to Respondent regarding psychiatric treatment Patient B was receiving from another provider. The submitted documents included Patient B's records for a visit on July 12, 2007, in which the provider notes Patient B's history of polysubstance abuse, completion of three weeks at an inpatient detoxification facility, and Patient B's admitted recent consumption of alcohol and Norco. The submitted documents also included Patient B's records for a more recent visit on May 15, 2012, with the same provider, in which the physician assessed Patient B with the following diagnoses: bipolar, anxiety, panic, and attention deficit hyperactive disorder. Records for these encounters are maintained in Respondent's medical chart for Patient B.

36. On or about September 7, 2012, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit show no discussion regarding the psychiatric records submitted by Patient B's mother.

37. On or about November 9, 2012, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit again show no discussion regarding the psychiatric records submitted by Patient B's mother.

38. Throughout Respondent's care and treatment of Patient B in 2012, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult

with Patient B's psychiatrist or other treating physicians to confirm reported medications or determine the possibility of alternative treatment modalities.

39. In or around 2013, Respondent saw Patient B at approximately three (3) office visits, including, but not limited to: January 18, 2013, September 12, 2013, and October 21, 2013. Respondent's notes for his interactions with Patient B during these visits are sparse and often illegible.

40. On or about January 18, 2013, Patient B presented for a one-month check up visit. According to Respondent, no medications were prescribed during this visit. However, records show Respondent issued a prescription to Patient B for lorazepam, Gabapentin, and Seroquel[15] on this date. According to Respondent, at the previous visit, on or about December 27, 2012, Respondent believed Patient B obtained his prescription for Seroquel from his psychiatrist. However, Respondent's records show no indication of this discussion.

41. Throughout Respondent's care and treatment of Patient B in 2013, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult with Patient B's psychiatrist or other treating physicians to confirm reported medications or determine the possibility of alternative treatment modalities.

42. In or around 2014, Respondent saw Patient B at approximately five (5) office visits, including, but not limited to: January 2, 2014, March 5, 2014, June 26, 2014, September 23, 2014, and October 23, 2014.

43. On or about March 5, 2014, Patient B presented for a follow up visit with Respondent after a recent surgery on his left elbow. Respondent's notes for this visit indicate Respondent prescribed 30 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level, or the risks, benefits, or side effects of Percocet.

---

[15] Seroquel is the brand name for quetiapine, commonly used to treat schizophrenia, bipolar disorder and depression. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

44. On or about June 26, 2014, Patient B presented for a follow up visit after a recent hospitalization reported on June 22, 2014. Respondent's notes for this visit indicate Patient B informed Respondent that his orthopedic surgeon switched Patient B's prescription from Percocet to Norco, and that Patient B's psychiatrist had prescribed him Suboxone.[16] Respondent's notes for this visit show no discussion regarding whether Suboxone was being prescribed for pain or substance abuse issues.

45. On or about September 23, 2014, Patient B presented for a follow up visit with Respondent. During this visit, Patient B's girlfriend was in attendance. Respondent's notes for this visit indicate Patient B reported having another appointment with his psychiatrist and that he had resumed drinking alcohol again. Notes for this visit indicate Respondent urged Patient B not to drink alcohol.

46. On or about October 23, 2014, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit indicate Patient B reported being prescribed a high dose of Ambien by his psychiatrist, but still experiencing issues with sleep. Notes for this visit indicate Respondent issued a prescription to Patient B for 30 tablets of Ambien (10 mg), with no documented discussion regarding the reason for issuing an additional prescription for Ambien, or a discussion regarding the risks, benefits, or side effects of Ambien.

47. Throughout Respondent's care and treatment of Patient B in 2014, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult with Patient B's psychiatrist or other treating physicians to confirm reported medications or determine the possibility of alternative treatment modalities.

48. Throughout Respondent's care and treatment of Patient B with opioid therapy in 2014, Respondent did not conduct an adequate history and physical examination, perform

---

[16] Suboxone is a brand name for buprenorphine and naloxone, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of pain as well as addiction to narcotic pain relievers.

appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient information to obtain informed consent, establish an opioid management plan, require more frequent office visits, or perform adequate monitoring regarding compliance.

49. In or around 2015, Respondent saw Patient B at approximately five (5) office visits, including, but not limited to: July 23, 2015, October 15, 2015, November 5, 2015, November 30, 2015, and December 22, 2015.

50. On or about July 23, 2015, Patient B presented with complaints of pain and injury to his body, claiming he had been attacked by several law enforcement officers approximately one month earlier. Included in Respondent's chart for Patient B are records of Patient B's hospital visit on June 26, 2015, after Patient B was arrested for being under the influence of a controlled substance. Records for this encounter are maintained in Respondent's chart for Patient B. Respondent's notes for Patient B's July 23, 2015 visit indicate Respondent prescribed 120 tablets of Norco (10/325) and 120 tablets of oxycodone (30 mg) to Patient B, and that Patient B agreed this would be a "one-time prescription" that would not be issued again.

51. On or about October 5, 2015, Patient B presented to an emergency department with complaints of injury after he reportedly fell from a tree. After a thorough review and evaluation, Patient B was determined to be stable with no emergent condition and discharged with a prescription for Norco (10/325). According to the hospital records, Patient B indicated he did not want Norco, and requested a prescription for Percocet (10/325) instead. Records for this encounter are maintained in Respondent's chart for Patient B.

52. On or about October 15, 2015, Patient B presented for a follow up visit with Respondent, claiming total body pain due to the recent fall. Respondent's notes for this visit indicate Respondent prescribed 150 tablets of Percocet (10/325) and 120 tablets of Roxicodone[17] (30 mg) to Patient B, with no documented discussion regarding Patient B's pain level, or any discussion regarding the risks, benefits, or side effects of Percocet and Roxicodone.

---

[17] Roxicodone is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.

53. On or about November 5, 2015, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit indicate Respondent prescribed another 150 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level, or any discussion regarding the risks, benefits, or side effects of Percocet.

54. On or about November 30, 2015, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit indicate Respondent prescribed another 180 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level, or any discussion regarding the risks, benefits, or side effects of Percocet. Notes for this visit indicate Respondent informed Patient B he would no longer prescribe oxycodone (30 mg) to Patient B.

55. On or about December 22, 2015, Patient B presented for a follow up visit with Respondent. Respondent's progress notes for this visit indicate Respondent prescribed another 120 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level, or any discussion regarding the risks, benefits, or side effects of Percocet. Notes for this visit indicate Respondent referred Patient B to a neurologist for evaluation.

56. Throughout Respondent's care and treatment of Patient B in 2015, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult with Patient B's psychiatrist or other treating physicians to confirm reported medications or determine the possibility of alternative treatment modalities.

57. Throughout Respondent's care and treatment of Patient B with opioid therapy in 2015, Respondent did not conduct an adequate history and physical examination, perform appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient information to obtain informed consent, establish an opioid management plan, require more frequent office visits, or perform adequate monitoring regarding compliance.

///

///

58. In or around 2016, Respondent saw Patient B at approximately six (6) office visits, including, but not limited to: January 26, 2016, February 23, 2016, March 31, 2016, June 9, 2016, July 7, 2016, and September 2, 2016.

59. On or about February 23, 2016, Patient B presented requesting a refill of his medications. Respondent's notes for this visit indicate Respondent prescribed 186 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level, or any discussion regarding the risks, benefits, or side effects of Percocet.

60. On or about March 31, 2016, Patient B presented requesting a refill of his medications. Respondent's notes for this visit indicate, Patient B's girlfriend accompanied Patient B during this visit and Patient B indicated he was ready to stop taking oxycodone. Respondent's notes for this visit show no documented discussion regarding a tapering plan to lower Patient B's oxycodone. Patient B's girlfriend informed Respondent that Patient B had been snorting his medications. Respondent's notes for this visit show no documentation of this discussion or information provided by Patient B's girlfriend.

61. On or about April 6, 2016, Patient B underwent a neurological consultation with another provider who submitted his neurological examination and report to Respondent. The neurological report is initialed by Respondent and indicates the following: Patient B has a reported history of multiple concussions, occasional falls and black-out episodes.

62. On or about April 19, 2016, Patient B underwent an electroencephalogram (EEG) at the request of the neurologist. The EEG report indicated a normal EEG for Patient B. The EEG results are maintained in Respondent's chart for Patient B and is initialed by Respondent.

63. On or about June 9, 2016, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit indicate Patient B reported experiencing extreme pain from the fall and admitted taking Percocet that he had saved up. Notes for this visit indicate Respondent prescribed 120 tablets of Percocet (10/325) to Patient B, with no documented discussion regarding Patient B's pain level, and no discussion regarding the risks, benefits, or side effects of Percocet.

///

64. On or about July 7, 2016, Patient B presented with complaints of suffering a broken nose after a recent fall. Respondent's notes for this visit indicate Patient B expressed concern with the amount of acetaminophen in Percocet and requested oxycodone instead. Notes for this visit indicate Respondent prescribed 120 tablets of oxycodone (30 mg) to Patient B, with no discussion regarding Patient B's pain level, no discussion regarding liver function tests, no discussion regarding the risks, benefits, or side effects of oxycodone, and no discussion regarding possible abuse or diversion.

65. On or about September 2, 2016, Patient B presented with complaints of continued chronic pain. Respondent's notes for this visit indicate Respondent prescribed another 180 tablets of oxycodone (30 mg) to Patient B, with two additional refills authorized for October 2, 2016 and November 2, 2016, with no discussion regarding Patient B's pain level, and no discussion regarding the risks, benefits, or side effects of oxycodone.

66. Throughout Respondent's care and treatment of Patient B in 2016, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult with Patient B's psychiatrist or other treating physicians to confirm reported medications or determine the possibility of alternative treatment modalities.

67. Throughout Respondent's care and treatment of Patient B with opioid therapy in 2016, Respondent did not conduct an adequate history and physical examination, perform appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient information to obtain informed consent, establish an opioid management plan, require more frequent office visits, or perform adequate monitoring regarding compliance.

68. In or around 2017, Respondent saw Patient B at approximately three (3) office visits, including, but not limited to: April 28, 2017, August 25, 2017, and December 1, 2017.

69. On or about April 28, 2017, Patient B presented requesting a refill of his medications. Respondent's notes for this visit indicate Patient B informed Respondent that his psychiatrist was prescribing him a high dose of Ativan but was slow in authorizing refills, causing

Patient B to suffer panic attacks. Respondent's notes for this visit indicate Respondent prescribed 90 tablets of Ativan (2 mg) and 180 tablets of oxycodone (10 mg), with no documented discussion regarding the rationale for the change in oxycodone dose, and no discussion regarding the risks, benefits, or side effects of Ativan and oxycodone.

70. On or about December 1, 2017, Patient B presented with a cough and cold, and for follow up on previous visits. Respondent's notes for this visit indicate Patient B's mother called and informed Respondent that Patient B had been acting out and requested reevaluation of Patient B's medications. Respondent's notes for this visit indicate Patient B agreed to see his psychiatrist to discuss medication changes. Notes for this visit indicate Respondent prescribed 180 tablets of oxycodone (10 mg), 120 tablets of lorazepam (1 mg), and 60 tablets of Flexeril (10 mg).[18]

71. Throughout Respondent's care and treatment of Patient B in 2017, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, perform periodic reviews to evaluate Patient B's progress toward treatment objectives, or consult with Patient B's psychiatrist or other treating physicians to confirm reported medications or determine the possibility of alternative treatment modalities.

72. Throughout Respondent's care and treatment of Patient B with opioid therapy in 2017, Respondent did not conduct an adequate history and physical examination, perform appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient information to obtain informed consent, establish an opioid management plan, require more frequent office visits, or perform adequate monitoring regarding compliance.

73. In or around 2018, Respondent saw Patient B at approximately two (2) office visits, including, but not limited to: January 15, 2018 and May 4, 2018.

74. On or about January 15, 2018, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit indicate Patient B's friend was present for this visit and informed Respondent that Patient B did well when taking his medications as directed, but

[18] Flexeril is a brand name for cyclobenzaprine, a muscle relaxant commonly used to treat muscle spasms. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

does not do well when he misses his medications. Notes for this visit indicate Respondent encouraged Patient B to return to his psychiatrist.

75. On or about May 4, 2018, Patient B presented for a follow up visit with Respondent. Respondent's notes for this visit indicate Patient B's mother was present for this visit. Notes for this visit indicate Patient B had seen his psychiatrist and agreed to see a pain management specialist. Notes for this visit indicate Respondent provided Patient B with a list of pain management physicians and prescribed 180 tablets of oxycodone (10 mg) to Patient B.

76. According to Respondent's chart for Patient B, on or about June 14, 2018, Patient B reported scheduling an appointment with a pain specialist.

77. Throughout Respondent's care and treatment of Patient B in 2018, Respondent did not provide sufficient information regarding the risks of the medications prescribed or the use of them in combination with alcohol, consult with Patient B's psychiatrist or other treating physicians to confirm reported medications, conduct an adequate history and physical examination, perform appropriate testing to assess for risk of substance abuse, misuse, or addiction, provide sufficient information to obtain informed consent, establish an opioid management plan, require more frequent office visits, or perform adequate monitoring regarding compliance.

78. Throughout the entirety of Respondent's care and treatment of Patient B, on multiple occasions, Respondent received information from Patient B's friends, family, and other treatment providers, regarding Patient B's potential issues with controlled substances, including opiates.

79. Throughout the entirety of Respondent's care and treatment of Patient B, Respondent did not appropriately or timely respond to red flag indications of abuse or diversion exhibited by Patient B or reported by friends, family, and other treatment providers.

80. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 240 tablets of oxycodone (30 mg).

///

///

81. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 1,275 tablets of Percocet (10/325) and/or Endocet (10/325).

82. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 410 tablets of Norco (10/325).

83. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 120 tablets of lorazepam (2 mg).

84. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 240 tablets of Ambien (10 mg).

85. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 30 tablets of Zaleplon (10 mg).

86. According to Patient B's CURES report, from on or about April 2013, through on or about April 2016, based upon prescriptions and refills issued or authorized by other medical providers, Patient B also regularly obtained controlled substances, including, but not limited to, lorazepam, alprazolam, clonazepam, Norco and Suboxone.

87. Respondent committed gross negligence in his care and treatment of Patient B, which included, but is not limited to:

A. Paragraphs 28 through 86, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to document and/or develop a treatment plan or document and/or identify objectives for which a treatment plan could be evaluated, including the failure to discuss or document Patient B's reported pain levels, anxiety improvement, or sleep quality;

///

C. Respondent failed to document or sufficiently inform Patient B of the risks and benefits associated with the use of the prescribed controlled substances, including the failure to discuss the risks associated with the combined use of opioids and benzodiazepines, and the failure to discuss the additional risks associated with a personal history of polysubstance abuse and reported substance abuse related arrests;

D. Respondent failed to perform periodic evaluations regarding Patient B's progress toward treatment objectives, including the failure to document any change in pain level, sleep quality, or anxiety improvement;

E. Respondent failed to discuss with Patient B or timely refer Patient B for additional consultation, evaluation and treatment, in order to achieve treatment objectives, including the failure to enlist the aid of relevant specialists to determine the underlying cause of Patient B's issues or suggest alternative treatments;

F. Respondent failed to give special attention to Patient B who was at risk for misusing or diverting medications based upon his personal history of reported polysubstance abuse, reported arrest for unlawfully being under the influence of a controlled substance, and reports of abuse from friends, family, and other providers, including the failure to consider a trial chronic opioid therapy, or obtain an opioid management plan; and

G. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient B, including the failure to document critical patient-care related discussions.

///

///

///

///

///

Patient C

88. On or about April 13, 2009, Patient C, a then 39-year old female, presented for an initial consultation with Respondent for chronic back pain.

89. From in or around 2009, through in or around 2018, Respondent provided care and treatment to Patient C for, among other things, pain, attention deficit disorder, anxiety, insomnia and hypertension.

90. From in or around 2009, through in or around 2018, Respondent prescribed several controlled substances to Patient C, including, but not limited to, Percocet, Endocet, alprazolam, Ambien, Phentermine,[19] hydromorphone,[20] and dextroamphetamine.[21]

91. In or around 2009, Respondent saw Patient C at approximately four (4) visits, including, but not limited to: April 13, 2009, May 5, 2009, July 31, 2009, and September 2, 2009. Respondent's notes for his interactions with Patient C during these visits are sparse and often illegible. Respondent's records for Patient C also indicate numerous requests for early refills.

92. In or around 2010, Respondent saw Patient C at approximately four (4) visits, including, but not limited to: January 21, 2010, January 29, 2010, June 22, 2010, and October 22, 2010. Respondent's notes for his interactions with Patient C during these visits are sparse and often illegible. Respondent's records for Patient C also indicate numerous requests for early refills.

---

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

[20] Hydromorphone, brand name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[21] Dextroamphetamine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salt used for attention-deficit hyperactivity disorder and narcolepsy.

93. In or around 2011, Respondent saw Patient C at approximately two (2) visits, including, but not limited to: May 3, 2011 and September 1, 2011. Respondent's notes for his interactions with Patient C during these visits are sparse and often illegible. Respondent's records for Patient C also indicate numerous requests for early refills.

94. In or around 2012, Respondent saw Patient C at approximately two (2) visits, including, but not limited to: April 16, 2012 and June 4, 2012. Respondent's notes for his interactions with Patient C during these visits are sparse and often illegible.

95. In or around 2012, Respondent's records for Patient C indicate Patient C made numerous requests for early refills, on dates including, but not limited to: February 24, 2012, May 7, 2012, May 30, 2012, August 17, 2012, September 18, 2012, and December 4, 2012.

96. On or about February 16, 2012, Patient C sent an email to Respondent requesting a prescription for Xanax and sleeping medication. According to Respondent's records for Patient C, Respondent issued a prescription to Patient C for 60 tablets of Xanax (0.25 mg) and 30 tablets of Ambien (10 mg). Respondent's records for Patient C show no corresponding patient visit or discussion with Patient C regarding these medications.

97. On or about February 24, 2012, Patient C sent an email to Respondent requesting an early refill stating previous issues with a pharmacy refusing to refill her medications.

98. On or about April 16, 2012, Patient C presented for a general check-up and refill of medications. Respondent's notes for this visit indicate Respondent prescribed 180 tablets of Percocet (10/325) and 60 tablets of Adderall (20 mg) to Patient C, with no documented discussion regarding Patient C's pain level, or the risks, benefits, or side effects of Patient C's medications.

99. On or about May 7, 2012, Patient C sent an email to Respondent requesting an early refill. Patient C exchanged emails with Respondent discussing issues in obtaining prescription refills from Patient C's pharmacist.

100. Throughout Respondent's care and treatment of Patient C in 2012, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives.

101. In or around 2013, Respondent saw Patient C at approximately three (3) visits, including, but not limited to: January 17, 2013, July 29, 2013, and August 9, 2013. Respondent's notes for his interactions with Patient C during these visits are sparse and often illegible.

102. In or around 2013, Respondent's records for Patient C indicate Patient C made requests for early refills, on dates including, but not limited to: March 11, 2013.

103. On or about July 29, 2013, Patient C presented for a follow up visit with Respondent for refills of her medications. Respondent's notes for this visit indicate Patient C has been seeing a psychologist. Respondent's notes for this visit indicate Respondent prescribed 60 tablets of Xanax (0.25 mg) to Patient C, with no documented discussion regarding Patient C's anxiety levels, or the risks, benefits, or side effects of Xanax.

104. Throughout Respondent's care and treatment of Patient C in 2013, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives.

105. In or around 2014, Respondent saw Patient C at approximately two (2) visits, including, but not limited to: January 14, 2014 and December 9, 2014. Respondent's notes for his interactions with Patient C during these visits are sparse and his handwritten notes are often illegible.

106. On or about January 14, 2014, Patient C presented for a general check-up visit with Respondent. Respondent's notes for this visit indicate Respondent prescribed 180 tablets of Percocet (10/325) and 60 tablets of Adderall (20 mg) to Patient C, with no documented discussion regarding Patient C's pain levels, or the risks, benefits, or side effects of these medications.

107. Throughout Respondent's care and treatment of Patient C in 2014, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives. Furthermore, Respondent's records make no mention of CURES review, urine toxicology screening, or consideration of alternative treatments.

///

108. In or around 2015, Respondent saw Patient C at approximately one (1) office visit, including, but not limited to: January 20, 2015. Respondent's notes for his interactions with Patient C during this visit are sparse and his handwritten notes are illegible.

109. On January 20, 2015, Patient C presented for a visit to discuss recent weight gain and the desire to begin Phentermine. Respondent's notes for this visit indicate Respondent prescribed 30 tablets of Phentermine (37.5 mg), 30 tablets of Ambien (10 mg), and 180 tablets of Percocet (10/325), to Patient C, with no documented discussion regarding Patient C's pain levels, or the risks, benefits, or side effects of these medications.

110. Throughout Respondent's care and treatment of Patient C in 2015, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives. Furthermore, Respondent's records make no mention of CURES review, urine toxicology screening, or consideration of alternative treatments.

111. In or around 2016, Respondent saw Patient C at approximately one (1) office visit, including, but not limited to: September 30, 2016. Respondent's notes for his interactions with Patient C during this visit are sparse and his handwritten notes are illegible.

112. On or about September 30, 2016, Patient C presented for a routine follow up visit with Respondent. Respondent's notes for this visit do not indicate what medications were reviewed or prescribed.

113. On or about October 3, 2016, Patient C contacted Respondent's office requesting an early refill of Percocet, stating her medications were lost in the ocean.

114. Throughout Respondent's care and treatment of Patient C in 2016, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives. Furthermore, Respondent's records make no mention of CURES review, urine toxicology screening, or consideration of alternative treatments.

115. In or around 2017, Respondent saw Patient C at approximately four (4) visits, including, but not limited to: July 11, 2017, August 10, 2017, November 7, 2017, and November

20, 2017. Respondent's notes for his interactions with Patient C during these visits are sparse and his handwritten notes are illegible.

116. On or about November 20, 2017, Patient C presented for a visit with Respondent to discuss her blood pressure medication. Respondent's notes for this visit indicate Respondent prescribed 60 tablets of Percocet (10/325) to finish Patient C's previous prescription, with no documented discussion regarding Patient C's pain levels, or the risks, benefits, or side effects of these medications.

117. Throughout Respondent's care and treatment of Patient C in 2017, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives. Furthermore, Respondent's records show minimal physical exam and make no mention of CURES review, urine toxicology screening, or consideration of alternative treatments.

118. In or around 2018, Respondent saw Patient C at approximately one (1) office visit, including, but not limited to: June 21, 2018. Respondent's notes for his interactions with Patient C during this visit are sparse and his handwritten notes are illegible.

119. On or about May 22, 2018, Respondent sent correspondence to Patient C indicating he can no longer prescribe narcotics and tranquilizers to the same patient, and that Patient C must decide which medication she would like to continue. Respondent's records for Patient C also indicate Respondent made a referral to a pain management specialist on May 22, 2018.

120. On or about June 21, 2018, Patient C presented for a follow up appointment and refills of her medications. Respondent's notes for this visit indicate Respondent increased Patient C's medication for Xanax from 0.25 mg to 0.5 mg with no documentation of the reason for this increase. Respondent's notes for this visit indicate Respondent's prescription for Ambien was discontinued with no documentation of the reason for this change. Respondent's notes for this visit indicate Respondent prescribed 180 tablets of Percocet (10/325) to Patient C, with no documented discussion regarding Patient C's pain level, or the risks, benefits, or side effects of Percocet.

121. On or about June 21, 2018, Patient C provided a urine sample which tested positive for benzodiazepines and opiates, and negative for oxycodone.

122. Throughout Respondent's care and treatment of Patient C in 2018, Respondent did not discuss an overall treatment plan, identify objectives and goals, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient C's progress toward treatment objectives.

123. Throughout the entirety of Respondent's care and treatment of Patient C, Respondent did not appropriately or timely respond to red flag indications of abuse or diversion exhibited by Patient C.

124. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 4,500 tablets of Percocet (10/325).

125. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 2,340 tablets of Endocet (10/325).

126. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 1,500 tablets of alprazolam (0.25 mg).

127. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 1,140 tablets of Ambien (10 mg).

128. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 540 tablets of phentermine (37.5 mg).

129. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 480 tablets of dextroamphetamine (20 mg).

///

130. According to Patient C's CURES report, from on or about January 2014, through on or about January 2017, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 100 tablets of hydromorphone (8 mg).

131. Respondent committed gross negligence in his care and treatment of Patient C, which included, but is not limited to:

A. Paragraphs 88 through 130, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to document and/or develop a treatment plan or document and/or identify objectives for which a treatment plan could be evaluated, including the failure to discuss or document Patient C's reported pain levels, anxiety improvement, or sleep quality; and

C. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient C, including the failure to document critical patient-care related discussions.

Patient D

132. In or around 2013, Patient D, a then 33-year old male, was being treated by Respondent for, among other things, chronic back pain.

133. From in or around 2013, through in or around 2016, Respondent provided care and treatment to Patient D for, among other things, chronic back pain, anxiety, and adult attention deficit hyperactivity disorder (ADHD).

134. From in or around 2013, through in or around 2016, Respondent prescribed several controlled substances to Patient D, including, but not limited to, oxycodone, Norco, Adderall, and alprazolam.

135. In or around 2013, Respondent saw Patient D at approximately 3 (three) visits, including, but not limited to: June 27, 2013, August 2, 2013, and November 11, 2013. Respondent's notes for his interactions with Patient D during these visits are sparse and often illegible. Respondent's notes for these visits show no documentation of a discussion with Patient D regarding the cause of his back pain, pain level, review of his CURES activity report, side

effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

136. Throughout Respondent's care and treatment of Patient D in 2013, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

137. In or around 2014, Respondent saw Patient D at approximately four (4) visits, including, but not limited to: February 7, 2014, May 19, 2014, September 19, 2014, and December 9, 2014. Respondent's notes for his interactions with Patient D during these visits are sparse. Respondent's notes for these visits show no documentation of a discussion with Patient D regarding the cause of his back pain, pain level, review of his CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

138. On or about September 19, 2014, Patient D presented for a follow up visit with Respondent. According to Respondent's records for this visit, Patient D indicated he wanted to change his medication from Xanax to Adderall. No further discussion is documented for the reason for this change. Respondent's records for this visit indicate Respondent prescribed 60 tablets of Adderall (30 mg) to Patient D, with no documented discussion regarding the risks, benefits, or side effects of Patient D's medications.

139. Throughout Respondent's care and treatment of Patient D in 2014, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

140. In or around 2015, Respondent saw Patient D at approximately one (1) visit, including, but not limited to: August 25, 2015. Respondent's notes for his interactions with Patient D during this visit are sparse. Respondent's notes for this visit shows no documentation of a discussion with Patient D regarding the cause of his back pain, pain level, review of his

///

CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

141. Throughout Respondent's care and treatment of Patient D in 2015, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

142. In or around 2016, Respondent saw Patient D at approximately one (1) visit, including, but not limited to: March 11, 2016. Respondent's notes for his interactions with Patient D during this visit are sparse. Respondent's notes for this visit shows no documentation of a discussion with Patient D regarding the cause of his back pain, pain level, review of his CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

143. On or about March 11, 2016, Patient D presented for a follow up visit with Respondent. According to Respondent's records for this visit, Patient D indicated he was recently involved in a motor vehicle accident wherein all of his upper teeth had been knocked out. Respondent's notes for this visit show no further discussion regarding how Patient D was treated as a result of this incident or any medications Patient D may have received from other physicians.

144. Throughout Respondent's care and treatment of Patient D in 2016, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

145. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent did not appropriately or timely respond to red flag indications of abuse or diversion exhibited by Patient D.

146. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent regularly prescribed to Patient D a combination of opioid and benzodiazepine medications with no documentation of periodic review or discussion with Patient D as to their efficacy or monitoring of these controlled substances.

147. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent never ordered X-rays or imaging studies to evaluate the cause of Patient D's back pain.

148. Throughout the entirety of Respondent's care and treatment of Patient D, Respondent never sent Patient D for a formal evaluation for ADHD or anxiety.

149. According to Patient D's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient D obtained approximately 9,120 tablets of oxycodone (30 mg).

150. According to Patient D's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient D obtained approximately 1,440 tablets of Adderall (30 mg).

151. According to Patient D's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient D obtained approximately 1,170 tablets of Xanax (2 mg).

152. According to Patient D's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient D obtained approximately 1,080 tablets of Norco (10/325).

153. Respondent committed gross negligence in his care and treatment of Patient D, which included, but is not limited to:

A. Paragraphs 132 through 152, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to document and/or develop a treatment plan or document and/or identify objectives for which a treatment plan could be evaluated, including the failure to discuss or document Patient D's reported pain levels or anxiety levels;

C. Respondent failed to document or sufficiently inform Patient D of the risks and benefits associated with the use of the prescribed controlled substances, including the failure to discuss the risks associated with the combined use of opioids and benzodiazepines;

///

D. Respondent failed to perform periodic evaluations regarding Patient D's progress toward treatment objectives, including the failure to document any change in pain level or anxiety level;

E. Respondent failed to discuss with Patient D or timely refer Patient D for additional consultation, evaluation and treatment, in order to achieve treatment objectives, including the failure to enlist the aid of relevant specialists to determine the underlying cause of Patient D's chronic back pain or suggest alternative treatments;

F. Respondent failed to give special attention to Patient D who was at risk for misusing or diverting medications, including the failure to obtain an opioid management plan; and

G. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient D, including the failure to document critical patient-care related discussions.

Patient E

154. In or around 2013, Patient E, a then 36-year old male, was being treated by Respondent for, among other things, chronic back pain.

155. From in or around 2013, through in or around 2016, Respondent provided care and treatment to Patient E for, among other things, chronic back pain, anxiety, and diabetes.

156. From in or around 2013, through in or around 2016, Respondent prescribed several controlled substances to Patient E, including, but not limited to, oxycodone, Norco, methadone,[22] clonazepam[23] and alprazolam.

157. In or around 2013, Respondent saw Patient E at approximately eight (8) visits, including, but not limited to: May 6, 2013, June 7, 2013, July 1, 2013, July 30, 2013, August 30,

[22] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[23] Clonazepam 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. It is an anti-anxiety medication in the benzodiazepine family.

2013, October 11, 2013, November 7, 2013, and December 9, 2013. Respondent's notes for his interactions with Patient E during these visits are sparse and often illegible. Respondent's notes for these visits show no documentation of a discussion with Patient E regarding the cause of his back pain, pain level, review of his CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

158. Throughout Respondent's care and treatment of Patient E in 2013, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

159. In or around 2014, Respondent saw Patient E at approximately eight (8) visits, including, but not limited to: January 6, 2014, April 1, 2014, June 30, 2014, July 17, 2014, August 26, 2014, September 25, 2014, October 23, 2014, and December 18, 2014. Respondent's notes for his interactions with Patient E during these visits are sparse. Respondent's notes for these visits show no documentation of a discussion with Patient E regarding the cause of his back pain, pain level, review of his CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

160. On or about July 17, 2014, Patient E presented for a follow up visit with Respondent. According to Respondent's records for this visit, Patient E requested a letter from Respondent for his employer, indicating Patient E would be tapered off methadone and Xanax. Respondent's notes for this visit indicate a letter was provided to Patient E, however, no tapering doses or instructions are indicated in the records.

161. Throughout Respondent's care and treatment of Patient E in 2014, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

162. In or around 2015, Respondent saw Patient E at approximately ten (10) visits, including, but not limited to: January 16, 2015, February 10, 2015, March 12, 2015, March 31,

2015, May 14, 2015, June 4, 2015, June 30, 2015, August 21, 2015, October 16, 2015, and November 19, 2015. Respondent's notes for his interactions with Patient E during these visits are sparse. Respondent's notes for these visits show no documentation of a discussion with Patient E regarding the cause of his back pain, pain level, review of his CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

163. Throughout Respondent's care and treatment of Patient E in 2015, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

164. In or around 2016, Respondent saw Patient E at approximately three (3) visits, including, but not limited to: January 19, 2016, February 16, 2016, and March 11, 2016. Respondent's notes for his interactions with Patient E during these visits are sparse. Respondent's notes for these visits show no documentation of a discussion with Patient E regarding the cause of his back pain, pain level, review of his CURES activity report, side effects of the medications prescribed, opioid agreement, consideration of urine toxicology screening, or alternative treatments.

165. Throughout Respondent's care and treatment of Patient E in 2016, Respondent did not document any discussion regarding an overall treatment plan, identify objectives and goals of treatment, provide sufficient information regarding the risks of the medications prescribed, or perform periodic reviews to evaluate Patient D's progress.

166. Throughout the entirety of Respondent's care and treatment of Patient E, Respondent regularly prescribed to Patient E a combination of opioid and benzodiazepine medications with no documentation of periodic review or discussion with Patient E as to their efficacy or monitoring of these controlled substances.

167. Throughout the entirety of Respondent's care and treatment of Patient E, Respondent never ordered X-rays or imaging studies to evaluate the cause of Patient E's back pain.

///

168. Throughout the entirety of Respondent's care and treatment of Patient E, Respondent never sent Patient E for a formal evaluation for anxiety.

169. According to Patient E's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient E obtained approximately 8,460 tablets of Methadone (10 mg).

170. According to Patient E's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient E obtained approximately 4,800 tablets of oxycodone (30 mg).

171. According to Patient E's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient E obtained approximately 450 tablets of Norco (10/325).

172. According to Patient E's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient E obtained approximately 4,740 tablets of alprazolam (2 mg).

173. According to Patient E's CURES report, from on or about January 2014, through on or about December 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient E obtained approximately 1,860 tablets of clonazepam (1 mg).

174. Respondent committed gross negligence in his care and treatment of Patient E, which included, but is not limited to:

A. Paragraphs 154 through 173, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to document and/or develop a treatment plan or document and/or identify objectives for which a treatment plan could be evaluated, including the failure to discuss or document Patient E's reported pain levels or anxiety levels;

///

///

///

C. Respondent failed to document or sufficiently inform Patient E of the risks and benefits associated with the use of the prescribed controlled substances, including the failure to discuss the risks associated with the combined use of opioids and benzodiazepines;

D. Respondent failed to perform periodic evaluations regarding Patient E's progress toward treatment objectives, including the failure to document any change in pain level or anxiety level;

E. Respondent failed to discuss with Patient E or timely refer Patient E for additional consultation, evaluation and treatment, in order to achieve treatment objectives, including the failure to enlist the aid of relevant specialists to determine the underlying cause of Patient E's issues or suggest alternative treatments;

F. Respondent failed to give special attention to Patient E who was at risk for misusing or diverting medications, including the failure to consider a trial chronic opioid therapy, or obtain an opioid management plan; and

G. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient E, including the failure to document critical patient-care related discussions.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

175. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged herein.

Patient A

176. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but are not limited to:

A. Paragraphs 9 through 27, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to perform and/or document a complete history and physical examination of Patient A throughout his care;

C. Respondent failed to give special attention to Patient A who was at risk for misusing or diverting medications based upon his family history of alcoholism and reported moderate use of alcohol prior to initiating chronic opioid therapy, including the failure to consider a trial chronic opioid therapy, or obtain an opioid management plan;

D. Respondent failed to make reasonable efforts to monitor for compliance to ensure the controlled substances and medications prescribed to Patient A were not being diverted, were not excessive or inappropriate; and

E. Respondent failed to perform urine toxicology screens, review CURES, recognize and explore red flag behavior, or obtain an appropriate opioid agreement with Patient A.

Patient B

177. Respondent committed repeated negligent acts in his care and treatment of Patient B, which included, but are not limited to:

A. Paragraphs 28 through 87, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

B. Respondent failed to perform and/or document a complete history and physical examination of Patient B throughout his care; and

C. Respondent failed to perform urine toxicology screens, review CURES, recognize and explore red flag behavior, or obtain an appropriate opioid agreement with Patient B.

Patient C

178. Respondent committed repeated negligent acts in his care and treatment of Patient C, which included, but is not limited to:

A. Paragraphs 88 through 131, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

B. Respondent failed to perform and/or document a complete history and physical examination of Patient C throughout his care;

C. Respondent failed to document or sufficiently inform Patient C of the risks and benefits associated with the use of the prescribed controlled substances, including the failure to discuss the risks associated with the combined use of opioids and benzodiazepines;

D. Respondent failed to perform periodic evaluations regarding Patient C's progress toward treatment objectives, including the failure to document any change in pain level, sleep quality, or anxiety improvement;

E. Respondent failed to discuss with Patient C or timely refer Patient C for additional consultation, evaluation and treatment, in order to achieve treatment objectives, including the failure to enlist the aid of relevant specialists to determine the underlying cause of Patient C's issues or suggest alternative treatments;

F. Respondent failed to give special attention to Patient C who was at risk for misusing or diverting medications and made numerous requests for early refills and reported several issues in obtaining medication refills from pharmacies;

G. Respondent failed to make reasonable efforts to monitor for compliance to ensure the controlled substances and medications prescribed to Patient C were not being diverted, were not excessive or inappropriate; and

H. Respondent failed to perform urine toxicology screens, review CURES, recognize and explore red flag behavior, or obtain an appropriate opioid agreement with Patient C.

Patient D

179. Respondent committed repeated negligent acts in his care and treatment of Patient D, which included, but is not limited to:

A. Paragraphs 132 through 153, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

B. Respondent failed to perform and/or document a complete history and physical examination of Patient D throughout his care; and

C. Respondent failed to perform urine toxicology screens, review CURES, recognize and explore red flag behavior, or obtain an appropriate opioid agreement with Patient D.

Patient E

180. Respondent committed repeated negligent acts in his care and treatment of Patient E, which included, but is not limited to:

A. Paragraphs 154 through 174, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

B. Respondent failed to perform and/or document a complete history and physical examination of Patient E throughout his care; and

C. Respondent failed to perform urine toxicology screens, review CURES, recognize and explore red flag behavior, or obtain an appropriate opioid agreement with Patient E.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and/or Accurate Records)

181. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as defined by 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 9 through 180, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Violations of the Medical Practice Act)

182. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (a), of the Code, in that he committed a violation or violations of a

provision or provisions of the Medical Practice Act in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 8 through 181, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

183. Respondent Paul Gilbert Johnson, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 18771 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 8 through 182, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 18771, issued to Respondent Paul Gilbert Johnson, M.D.;

2. Revoking, suspending or denying approval of Respondent Paul Gilbert Johnson, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Paul Gilbert Johnson, 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: May 30, 2019

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

SD2019700482
71780362.docx