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

| | | |
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| **In the Matter of the Accusation Against:** | ) | |
| **Douglas Alan Blose, M.D.** | ) | **Case No. 800-2018-046922** |
| **Physician's and Surgeon's Certificate No. G 50355** | ) | |
| **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** April 29, 2020.

**IT IS SO ORDERED** March 30, 2020

**MEDICAL BOARD OF CALIFORNIA**

**By:** Christine J. Lally
**Christine J. Lally**
**Interim Executive Director**

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**DOUGLAS ALAN BLOSE, M.D.**<br>**21020 Pacific City Circle, #2408**<br>**Huntington Beach, CA 92648-8517**<br><br>**Physician's and Surgeon's Certificate No. G 50355**<br><br>Respondent. | Case No. 8002018046922<br><br>OAH No. 2019110483<br><br>**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). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jason J. Ahn, Deputy Attorney General.

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2. Douglas Alan Blose, M.D. (Respondent) is represented in this proceeding by attorney Courtney E. Pilchman, Esq., whose address is: 2030 Main St., Suite 1300, Irvine, CA 92614.

3. On or about July 1, 1983, the Board issued Physician's and Surgeon's Certificate No. G 50355 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-046922 and will expire on December 31, 2020, unless renewed.

## JURISDICTION

4. On October 4, 2019, Accusation No. 800-2018-046922 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 4, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-046922 is attached as Exhibit A and incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2018-046922. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Order.

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

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

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## CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2018-046922, agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. G 50355 for the Board's formal acceptance.

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

## CONTINGENCY

10. 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."

11. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical 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.

12. 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**

13. 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.

14. 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.

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

**ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 50355, issued to Respondent Douglas Alan Blose, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate 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.

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 Accusation No. 800-2018-046922 shall be deemed to be true, correct and 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 Accusation, No. 800-2018-046922 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 Order and have fully discussed it with my attorney Courtney E. Pilchman. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and fully agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 3-9-20

DOUGLAS ALAN BLOSE, M.D.
*Respondent*

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

DATED: 3/9/20

COURTNEY E. PILCHMAN
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: 3/9/20

Respectfully submitted,

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

JASON J. AHN
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 800-2018-046922**

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*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>**Douglas Alan Blose, M.D.**<br>**21020 Pacific City Circle, #2408**<br>**Huntington Beach, CA 92648-8517**<br><br>**Physician's and Surgeon's Certificate No. G 50355,**<br><br>Respondent. | Case No. 8002018046922<br><br>**ACCUSATION** |

## PARTIES

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

2. On or about July 1, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number G 50355 to Douglas Alan Blose, 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 December 31, 2020, unless renewed.

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## JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states, 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.
>
> ...
>
> (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 Business and Professions Code section 2234 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**

**(Repeated Negligent Acts)**

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G 50355 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, and Patient F,[1] as more particularly alleged herein:

**Patient A**

9. On or about January 27, 2015, Respondent saw Patient A who had severe psoriasis.[2] From 2015 through 2018, Respondent prescribed Xanax[3] to Patient A on multiple occasions.

[1] References are made to Patients A through F in order to protect patient privacy.

[2] Psoriasis refers to a condition in which skin cells build up and form scales and itchy, dry patches.

[3] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

Before prescribing Xanax to Patient A, Respondent failed to conduct an appropriate physical examination of her and/or failed to document having conducted an appropriate physical examination. Respondent failed to identify any medical indications for prescribing and/or refilling prescriptions of Xanax to Patient A and/or failed to document medical indications for prescribing and/or refilling prescriptions of Xanax to Patient A. While prescribing Xanax to Patient A, Respondent failed to conduct periodic reviews and/or failed to document having conducted periodic reviews of Patient A's progress. Respondent's medical records of Patient A do not document a treatment plan or timely periodic reviews of Patient A's progress. The medical records are not clearly legible.

**Patient B**

10. On or about July 8, 2015, Respondent prescribed phentermine[4] 37.5 mg # 30, with six (6) refills to Patient B, a Medical Assistant (MA) at Respondent's medical office. According to Respondent's medical records of Patient B, she was a 27 year-old female in "perfect health" who wants to lose "baby fat." Before prescribing phentermine to Patient B, Respondent failed to conduct and/or failed to document having conducted an appropriate physical examination of her. Respondent failed to identify any medical indications for prescribing phentermine to Patient A and/or failed to document medical indications for prescribing phentermine Patient A. After prescribing phentermine to Patient B, Respondent failed to conduct periodic reviews and/or failed to document having conducted periodic reviews of Patient B's progress. Respondent's medical records of Patient B do not document a treatment plan or periodic reviews of Patient B's progress. The medical records are not clearly legible.

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[4] Phentermine HCL (Lonamin®, Fastin®, Adipex®), an anorectic, 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. When properly prescribed and indicated phentermine HCL is used as a short term adjunct in a regiment of weight reduction based on exercise, behavioral modification, and caloric restriction. According to the DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is frequently encountered on the illicit market.

**Patient C**

11. Patient C began seeing Respondent nearly twenty (20) years ago for "cosmetic type [skin] treatments."[5] From on or about October 7, 2015 through August 2018, Respondent prescribed Xanax to Patient C on multiple occasions, for Patient C's anxiety. Respondent failed to discuss and/or failed to document having discussed with Patient C alternative treatments for anxiety. While prescribing Xanax to Patient C, Respondent failed to conduct ongoing periodic review and/or failed to document having conducted ongoing periodic reviews of Patient C's progress.

12. From 2017 through 2018, Respondent prescribed Butal-Acet-Caff[6] to Patient C on multiple occasions. Before prescribing Butal-Acet-Caff to Patient C, Respondent failed to conduct and/or failed to document having conducted an appropriate physical examination. Respondent failed to identify any medical indications for prescribing Butal-Acet-Caff to Patient C and/or failed to document medical indications for prescribing Butal-Acet-Caff Patient C. While prescribing Butal-Acet-Caff to Patient C, Respondent failed to conduct ongoing periodic reviews of Patient C's progress and/or failed to document having conducted ongoing periodic reviews of Patient C's progress.

13. Respondent's medical records of Patient C are not clearly legible and lack important information such as past history, physical examination, a treatment plan, and periodic reviews of Patient C's progress.

**Patient D**

14. On or about July 15, 2016, Patient D presented to Respondent for weight loss. The medical records for this visit stated that Patient D was a twenty-nine (29) year-old Hispanic male with "excellent health," who wanted to lose weight for a wedding. Respondent prescribed phentermine 37.5 mg # 30 to Patient D, with six (6) refills. Thereafter, between July 15, 2016

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

[6] Butal-Acet-Caff is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(c)(3), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used for the treatment of headaches.

through May 23, 2018, the phentermine Respondent prescribed to Patient D was refilled on multiple occasions.

15. Before prescribing phentermine to Patient D, Respondent failed to conduct and/or failed to document having conducted an appropriate physical examination. Respondent failed to identify any medical indications for prescribing phentermine to Patient D and/or failed to document medical indications for prescribing phentermine to Patient D. After prescribing phentermine to Patient D, Respondent failed to conduct periodic reviews and/or failed to document having conducted periodic reviews of Patient D's progress. Respondent's medical records of Patient D do not document a physical examination, a treatment plan or periodic reviews of Patient D's progress.

**Patient E**

16. On or about January 6, 2016, Patient E, an employee of Respondent, presented to Respondent for "weight loss." Respondent's medical records of Patient E stated, among other things, that Patient E was a twenty-seven (27) year-old female in "perfect health," who wants to lose "baby fat." Respondent prescribed phentermine 37.5 mg # 30 to Patient E, with six (6) refills. Between on or about January 6, 2016 through October 8, 2018, the phentermine Respondent prescribed to Patient E was refilled on multiple occasions.

17. Before prescribing phentermine to Patient E, Respondent failed to conduct and/or failed to document having conducted an appropriate physical examination. After prescribing phentermine to Patient E, Respondent failed to conduct periodic reviews and/or failed to document having conducted periodic reviews of Patient E's progress. Respondent's medical records of Patient E do not document a physical examination, a treatment plan, or periodic reviews of Patient E's progress.

**Patient F**

18. Respondent prescribed Xanax to Patient F on or about October 9, 2015, on or about March 8, 2016, and on or about August 9, 2016. Before prescribing Xanax to Patient F, Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to identify any medical indications for prescribing and/or refilling Xanax to

Patient F and/or failed to document medical indications for prescribing and/or refilling Xanax to Patient F. After prescribing Xanax to Patient F, Respondent failed to conduct periodic reviews of Patient F's progress and/or failed to document having conducted periodic reviews of Patient F's progress. Respondent does not have any medical records of Patient F.

19. Respondent committed repeated negligent acts in his care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E and Patient F, which included, but were not limited to, the following:

(a) Respondent inappropriately prescribed Xanax to Patient A;

(b) Respondent failed to maintain adequate medical records of Patient A;

(c) Respondent inappropriately prescribed phentermine to Patient B;

(d) Respondent failed to maintain adequate medical records of Patient B;

(e) Respondent inappropriately prescribed Xanax and Butal-Acet-Caff to Patient C;

(f) Respondent failed to maintain adequate medical records of Patient C;

(g) Respondent inappropriately prescribed phentermine to Patient D;

(h) Respondent failed to maintain adequate medical records of Patient D;

(i) Respondent inappropriately prescribed phentermine to Patient E;

(j) Respondent failed to maintain adequate medical records of Patient E;

(k) Respondent inappropriately prescribed Xanax to Patient F; and

(d) Respondent failed to maintain adequate medical records of Patient F.

**SECOND CAUSE FOR DISCIPLINE**

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

20. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 50355 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, and Patient F, as more particularly alleged in paragraphs 8 through 19, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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## DISCIPLINARY CONSIDERATIONS

21. To determine the degree of discipline, if any, to be imposed on Respondent Douglas Alan Blose, M.D., Complainant alleges that on or about September 27, 2019, in a prior disciplinary action entitled In the Matter of the Accusation Against Douglas Alan Blose, M.D. before the Medical Board of California, in Case Number 800-2017-032231, Respondent's license was revoked with revocation stayed for five (5) years of probation for self-prescribing of controlled substances and conviction of crimes substantially related to qualifications, functions, or duties of a physician and surgeon. That decision is now final and is incorporated by reference 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 Number G 50355, issued to Douglas Alan Blose, M.D.;

2. Revoking, suspending or denying approval of Douglas Alan Blose, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Douglas Alan Blose, 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: October 4, 2019

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

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