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

In the Matter of the Accusation Against:	)	
Ramnik Kaur Josan, M.D.	)	**Case No. 800-2015-017563**
Physician's and Surgeon's Certificate No. A97845	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on May 15, 2020.

IT IS SO ORDERED: April 16, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D.
Panel A

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RAMNIK KAUR JOSAN, M.D.** 5121 Garfield Ave., Apt. 10 Sacramento, CA 95841 Physician's and Surgeon's Certificate No. A 97845 Respondent.	Case No. 800-2015-017563 OAH No. 2019090827 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She is a party to this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by David Carr, Deputy Attorney General.

2. Respondent Ramnik Kaur Josan, M.D. (Respondent) is represented in this proceeding by attorney Virgil Pryor, Esq., of Oium, Reyen & Pryor, whose address is 220 Montgomery St., Suite 910, San Francisco, CA 94104.

3. On October 25, 2006, the Board issued Physician's and Surgeon's Certificate No. A 97845 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. 800-2015-017563, and will expire on May 31, 2020, unless renewed.

JURISDICTION

Accusation No. 800-2015-017563 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 January 29, 2018. Respondent timely filed her Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2015-017563 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-017563. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

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CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2015-017563, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the allegations in the Accusation. Respondent hereby gives up her right to contest those charges.

10. Respondent agrees that if she ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2015-017563 shall be deemed true, correct, and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

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

RESERVATION

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

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails

to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 97845 issued to Respondent RAMNIK KAUR JOSAN, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter during the period of probation, Respondent shall

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

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

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

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

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in

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

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

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

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

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

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

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

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

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

Within 60 days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

6. MONITORING -. Within 30 calendar days of the effective date of this Decision,

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

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

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

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

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

quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

7. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

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

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

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

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

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

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such

addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

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

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

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

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

DATED: 1/31/2020

RAMNIK KAUR JOSAN, M.D.
Respondent

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

DATED: 1/31/20

VIRGIL PRYOR, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 2/4/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

DAVID CARR
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2015-017563

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

In the Matter of the Accusation Against: **Ramnik Kaur Josan, M.D.** 2828 Grasslands Drive, No. 1114 Sacramento, CA 95833 Physician's and Surgeon's Certificate No. A 97845, Respondent.	Case No. 800-2015-017563 OAH Case No. **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 25, 2006, the Board issued Physician's and Surgeon's Certificate Number A 97845 to Ramnik Kaur Josan, 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 May 31, 2018, 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 unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2001.1 of the Code provides that the Board's highest priority shall be public protection.

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

7. 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."

8. 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."

9. Section 4022 of the Code defines "dangerous drug" to include any drug unsafe for self use and includes all drugs which can only lawfully be dispensed by prescription.

10. All events described herein occurred in the State of California.

DRUG LIST

11. **Adderall**, a trade name for mixed salts of a single-entity amphetamine, is a dangerous drug as defined in section 4022 of the Code and a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code. Adderall is indicated for Attention Deficit Disorder with hyperactivity and for Narcolepsy. It is contraindicated for patients with advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity to the sympathomimetic amines, glaucoma, agitated states, or a history of drug abuse. Caution is to be exercised in prescribing amphetamines for

patients with even mild hypertension. Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred.

12. **Alprazolam** (trade name Xanax) is a psychotropic analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with Xanax.

13. **Carisoprodol** (trade name Soma) is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022. The effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be additive; appropriate caution should be exercised with patients who take more than one of these agents concurrently.

14. **Fentanyl** is a potent narcotic analgesic. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c)(8), of the Health and Safety Code. A dose of .1 mg is approximately equi-analgesic to 10 mg of morphine. Fentanyl transdermal patches contain a high concentration of fentanyl. Other central nervous system depressant drugs will have additive or potentiating effects with fentanyl. Fentanyl can produce drug dependence of the morphine type and therefore has the potential for being abused.

15. **Hydromorphone hydrochloride** (trade name Dilaudid) is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code. Dilaudid is a hydrogenated ketone of morphine and is a narcotic analgesic. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include

drowsiness, mental clouding, respiratory depression, and vomiting. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression.

16. **Methadone hydrochloride** is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone; it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics.

17. **Morphine sulfate** is for use in patients who require a potent opioid analgesic for relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Morphine has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with morphine. Tolerance and psychological and physical dependence may develop upon repeated administration. Addiction prone individuals should be under careful surveillance when receiving morphine because of the predisposition of such patients to habituation and dependence.

18. **Oxycodone** is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxycodone has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with morphine. Respiratory depression is the chief hazard from

all opioid agonist preparations. Oxycodone can produce drug dependence of the morphine type and has widely misused.

19. **Oxycontin** is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxycontin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. Interactive effects resulting in dangerous respiratory depression, hypotension, profound sedation or coma may result if these drugs are taken in combination with the usual doses of Oxycontin. Oxycontin has been widely abused.

20. **Oxymorphone hydrochloride** (trade name Opana) is a semi-synthetic opioid analgesic. Oxymorphone hydrochloride a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxymorphone hydrochloride has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with morphine. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxymorphone hydrochloride can produce drug dependence of the morphine type and has widely misused.

21. **Vicodin** is the trade name for a combination of hydrocodone bitartrate and acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022 and a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety Code. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety agents, or other central nervous systems depressants (including alcohol) concomitantly with Vicodin may exhibit an additive effect producing greater central nervous system depression. The dose of one or both agents should therefore be reduced. Repeated administration of Vicodin may result in psychic and physical dependence.

FIRST CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

22. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her care and treatment of Patient One[1] included an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence. The circumstances are as follows:

23. Patient One was 60 years old when he first saw Respondent on April 3, 2014. Patient One complained of long-term joint and lower back pain, with pain from his back radiating into his right leg, and tingling of his right ankle. He told Respondent that the Vicodin he had been taking for pain was no longer effective and that he had taken his son's prescription Oxycodone, which provided greater pain relief.

24. Respondent's chart notes for this initial visit describe few physical abnormalities found in Patient One's examination. Respondent's notes of her examination of the patient's back state merely "no physical deformity" and "no tenderness." The record notes the patient's complaint of right ankle pain but no physical examination of the ankle is mentioned, nor was there documented indication that Respondent performed any neurological examination in response to Patient One's complaint of radiating back pain. The few abnormal musculoskeletal findings Respondent noted refer to swelling of Patient One's hand and thumb, which Respondent attributed to gout based on the patient's related history of same, and swelling of the left big toe with noted nail abnormalities. Respondent charted no detailed history of prior pain treatment and no quantitative pain measurements at this initial visit. Respondent ordered lab tests but no diagnostic imaging studies

25. Respondent prescribed an antibiotic for the presumed cellulitis of Patient One's toe; Review of the California Controlled Substance Utilization Review and Evaluation (CURES) system reveals Respondent also prescribed 30 tablets of 5 mg Oxycodone, though this opiate

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[1] To maintain patient confidentiality, the subject patients discussed herein are identified as Patients One-Four. The patients' full names will be provided in discovery.

prescription is not noted in Patient One's medical record of this visit. Respondent's records also fail to note any discussion with Patient One of the risks of opiate therapy; no informed consent for opiate therapy, pain treatment plan, pain management agreement with Patient One, or consideration of non-narcotic pain treatment are present in the record.

26. Patient One saw Respondent next on May 9, 2014, and at a final visit on August 8, 2014. On both of these subsequent visits Patient One's primary complaint was of musculoskeletal pain. In the interval between the first office visit on April 3 and the second office visit on May 9, Respondent prescribed 360 tablets of Oxycodone in escalating dosage amounts: from 5 mg initially to 10 mg, then to 20 mg. Respondent's chart notes in the medical record for these two visits also fail to state that she was prescribing Oxycodone to Patient One. Although Respondent last saw Patient One on August 8, 2014, she continued to prescribe Oxycodone to him through March 30, 2015. Over this period of time, Patient One was being prescribed an amount of Oxycodone that yields a daily average Morphine Equivalent Dose (MED) of 363 morphine milligram equivalents. Respondent makes no documented reference of having considered the fact that the patient was a high risk medication user, having acknowledged to Respondent at the initial visit that he took his son's opiates. It appears that Respondent signed her medical record pertaining to the April 3, May 9, and August 8, 2014, office visits on March 18, 2016.

27. Respondent has subjected her license to disciplinary action for unprofessional conduct, in that her prescribing Oxycodone to Patient One without an adequate physical examination, pain assessment and history, and consideration of his high risk medication status was an extreme departure from the standard of care, constituting gross negligence, in violation of section 2234(b), or a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated negligent acts in violation of section 2234(c).

SECOND CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

28. The allegations of paragraphs 23-26 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct pursuant to

section 2234(b) and/or 2234(c) in that her failure to obtain meaningful informed consent from Patient One prior to initiating opiate therapy was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

THIRD CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

29. The allegations of paragraphs 23-26 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her failure to establish and periodically assess the objectives of the opiate therapy she provided to Patient One, including during the seven-month period after her last visit with the patient in which she continued to prescribe high doses of oxycodone to him was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

30. The allegations of paragraphs 23-16 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct for violation of section 2266 in that she failed to maintain adequate and accurate records relating to her care and treatment of Patient One.

FIFTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

31. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her care and treatment of Patient Two included extreme departures from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence. The circumstances are as follows:

32. Patient Two was forty-six years old when he first saw Respondent on July 16, 2014. Patient Two related a history of chronic back and neck pain, for which he had undergone surgery

and received spine injections; he was taking 12 medications prescribed by other providers when he sought treatment from Respondent, including Oxycodone, Oxycontin, alprazolam, carisoprodol, and Adderall. Respondent's chart notes indicate she had reviewed prior records which stated Patient Two had been previously denied narcotics prescriptions after violating a pain contract. A urine toxicology screen was discussed with patient but deferred to the next visit. The chart notes state that Patient Two was given a pain contract, but Respondent's records for Patient Two do not include a pain contract nor is the contract referenced in later notes. The records do not include a written informed consent, nor do Respondent's chart notes indicate any detailed discussion with Patient Two of the risks of opiate therapy. While Respondent noted Patient Two's documented violation of a prior pain contract, there is no indication Respondent considered this fact in assessing her course of treatment for this patient. Respondent charted no details regarding Patient Two's physical or psychological functioning, nor is there any mention of any adjunctive, non-opiate therapies attempted in the past. No diagnostic imaging studies were ordered for Patient Two nor were any prior imaging studies referenced in Respondent's notes. Respondent prescribed Oxycodone IR 30 mg. and Oxycontin 30 mg., for Patient Two at this visit. Respondent's notes for this July 16, 2014, visit were signed on December 3, 2014.

33. Prior to the second office visit on September 15, 2014, Respondent provided Patient Two with a prescription for morphine sulfate elixir, 10 mg/5 ml., in addition to the Oxycodone and Oxycontin. There is no clinical justification in Respondent's records for prescribing the morphine sulfate. The records for this second visit do not reflect that the anticipated urine toxicology screening was performed or results considered. Respondent's chart entries do not include any rationale for the use of opiates or the dosages given, nor is there any written plan for assessing the effectiveness of opiate therapy in Patient Two's treatment. No diagnostic imaging studies were ordered for Patient Two at this second visit.

34. Over the next nine months, culminating at the last visit on May 15, 2015, Respondent prescribed Adderall, Oxycodone, Oxycontin, fentanyl patches, and carisoprodol for Patient Two in varying amounts and combinations. The calculated MED Respondent prescribed to Patient Two over this period of time was in excess of 800 mg. per day for the oxycodone alone.

Although Respondent's records indicate that Patient Two later admitted drinking regularly, no detailed alcohol use history was done nor was there any apparent substantive modification in Respondent's prescribing of opiates to Patient Two after she learned he was using alcohol. There is no indication in Respondent's records for Patient Two that she confirmed there was a medical indication for the Adderall she prescribed, apart from a diagnosis of Attention Deficit Hyperactivity Disorder made by a prior treating physician. Respondent ultimately referred Patient Two for physical therapy, on the last office visit with him; her notes for that visit indicate Patient Two informed her that he had scheduled an appointment with a pain management specialist. Respondent's chart notes for the office visits of September 15, 2014; February 24, 2015; April 10, 2015; and May 15, 2015, all bear a signature date of April 4, 2016. Respondent's records for Patient Two contain two different office visit notes for the date January 14, 2015; one bears a signature date of January 14, 2015, and the other was apparently signed on April 4, 2016.

35. Respondent has subjected her license to disciplinary action for unprofessional conduct, in that her prescribing high dose opiate therapy and Adderall to Patient Two without adequate clinical justification or apparent consideration of his high risk medication status was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b) or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence in violation of section 2234(c).

SIXTH CAUSE FOR DISCIPLINE

(Negligence\Gross Negligence)

36. The allegations of paragraphs 32-34 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct pursuant to section 2234(b) and/or 2234(c) in that her failure to obtain meaningful informed consent from Patient Two prior to initiating opiate therapy was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

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SEVENTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

37. The allegations of paragraphs 32-34 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her failure to establish and periodically assess the objectives of the opiate therapy she provided to Patient Two over a ten-month period was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

38. The allegations of paragraphs 32-34 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct for violation of section 2266 in that she failed to maintain adequate and accurate records relating to her care and treatment of Patient Two.

NINTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

39. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her care and treatment of Patient Three included extreme departures from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence. The circumstances are as follows:

40. Patient Three first saw Respondent on October 7, 2013, presenting with complaints of back and arm pain, and ankle swelling and pain. Patient Three told Respondent that he was a construction worker and gave a history of multiple fractures; the prior medical record included X-rays of the orthopedic repair in 2006 of a fracture of his right forearm. Patient Three was being prescribed Oxycodone (30 mg every 3 hours, prn) and a non-steroidal anti-inflammatory by a prior treating physician. The record of this office visit sets out the patient's complaints regarding painful arms and ankles, but Respondent's notes under "System Review" states that Patient Three

denies painful joints or ankle swelling. No detailed pain history or clinical description of Patient Three's psychological functioning appears in the medical record. Respondent prescribed 240 tablets of 30 mg Oxycodone to Patient Three at this initial visit; her chart notes state that Patient Three "will get labs done when he has insurance." There is nothing in the medical record indicating that Respondent provided Patient Three with specific information regarding the risks of opiate therapy. Respondent's chart notes offer no detail about prior pain treatment, objective assessment of Patient Three's pain levels, consideration of non-opiate pain treatment alternatives, or means of periodic assessment of the success of opiate therapy as prescribed.

41. Respondent saw Patient Three again on November 4, 2013. She renewed his Oxycodone prescription and noted that Patient Three would be getting medical insurance "by the end of the month" and would get lab tests performed at that time. On December 4, 2013, Patient Three was seen again at an office visit. During the 57-day interval between his first office visit and this third office visit, Patient Three received prescriptions for Oxycodone from Respondent providing a daily average MED of 799 mg. A December 21, 2013, notation in his chart states that Patient Three called in asking for a new prescription, as he had lost the last given to him. Review of CURES, the state's controlled substance prescribing database, reveals that Patient Three had filled his 240 tablet 30 mg Oxycodone prescription on December 17, 2013. Despite repeated notations of Respondent's intent to obtain laboratory testing of Patient Three, no test results were ever included in the record. There is no pain management agreement included in Respondent's records for Patient Three. Safeway Pharmacy, where Patient Three filled his prescriptions, made multiple requests to Respondent for documentation of the clinical basis for her prescribing to Patient Three. Despite Patient Three's explicit reference to his arm fracture repair site as a source of his pain, Respondent did not refer Patient Three to an Orthopedist for consultation at any time while she was treating him.

42. On January 3, 2014, Respondent added the benzodiazepine Alprazolam to Patient Three's prescriptions. Nothing in Respondent's records indicate that she informed Patient Three of the risks of taking a benzodiazepine with opiates. Despite Respondent's office notes for the February 17, 2014 visit which state that Patient Three "does not need Xanax (Alprazolam)

anymore and cannot sleep. Gets anxiety bad," Respondent continued to prescribe Alprazolam to Patient Three until December 2014. On June 2, 2014, Respondent added methadone to Patient Three's medication regimen. There is no mention in the medical record that Respondent considered a trial of any adjunctive pain management modalities to address Patient Three's complaints of pain. Respondent's chart notes for the visits on January 3, 2014, and March 3, 2014, both indicate they were signed by Respondent on April 1, 2016. Chart notes for June 27, 2014, and July 1, 2014 are labeled "Telephone Encounters" but each describes elements of a physical examination of Patient Three. Respondent stopped prescribing controlled substances to Patient Three on December 17, 2014.

43. Respondent has subjected her license to disciplinary action for unprofessional conduct, in that her prescribing high dose opiate therapy to Patient Three without adequate clinical justification or apparent consideration of adjunct treatment for pain was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b) or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence in violation of section 2234(c).

TENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

44. The allegations of paragraphs 40-42 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct for violation of section 2266 in that she failed to maintain adequate and accurate records relating to her care and treatment of Patient Three.

ELEVENTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

45. The allegations of paragraphs 40-42 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct pursuant to section 2234(b) and/or 2234(c) in that her failure to obtain meaningful informed consent from Patient Three for both opiate therapy and combined prescribing of opiates and benzodiazepines was an extreme departure from the standard of care constituting gross negligence or was a departure from

the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

TWELFTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

46. The allegations of paragraphs 40-42 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her failure to establish and periodically assess the objectives of the opiate therapy she provided to Patient Three over the period she was prescribing to him was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

THIRTEENTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

47. The allegations of paragraphs 40-42 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her failure over the 14 months she was treating him with opiates to refer Patient Three to an Orthopedist for his explicit complaint of pain from a former orthopedic surgery site was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

FOURTEENTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

48. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her care and treatment of Patient Four included an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence. The circumstances are as follows:

49. On December 31, 2013, Respondent first saw Patient Four, who presented with complaints of back pain and leg/foot numbness subsequent to a 2004 motorcycle accident.

Patient Four was using fentanyl patches, 400 mcg every 48 hours, and 30 mg oxycodone as needed to control pain, prescribed by a prior physician. He related a history of alcoholic pancreatitis but claimed he no longer drank alcohol. He also denied illicit drug use but told Respondent he had used his mother's boyfriend's pain medications. Physical examination established a limited range of motion of the lumbar spine. No detailed pain history or evaluation was obtained at this visit. No diagnostic imaging studies were ordered at this visit. Respondent diagnosed Patient Four with chronic back pain; she prescribed 30 100 mcg fentanyl patches and 240 tablets of 30 mg oxycodone. Nothing in the medical record suggests Respondent considered or attempted any pain management alternative to opioid therapy. Respondent apparently made additional entries to the record of this first visit and signed the record on October 31, 2014.

50. Patient Four signed a Pain Management Agreement at his next office visit on January 21, 2014. Objectives for evaluating Patient Four's drug therapy are set out in the Pain Management Agreement but appear to have been ignored over the course of Respondent's treatment and prescribing for Patient Four. An undated, pre-printed informed consent document, entitled "Eight Opioid Safety Principles for Patients and Caregivers" is included in Patient Four's medical record.

51. Respondent's prescribing of fentanyl patches to Patient Four increased in frequency to the point that he was receiving 30 patches about every 15 days. The prescription amount of Oxycodone also increased until Patient Four was receiving 240 tablets more frequently than once per month. Analysis of the total amount of opioids prescribed by Respondent for Patient Four reveals a daily average in excess of 1000 mg., yet a urine drug screen performed on March 14, 2014, was negative for opioids. Patient Four was also requesting—and receiving—early refills on his prescriptions, a violation of the Pain Management Agreement. In April of 2014 Patient Four admitted to Respondent that he was using alcohol, as much as ten beers daily. On May 8, 2014, Patient Four told Respondent he had lost his fentanyl prescription; Respondent re-issued the prescription. Examination of the state controlled substance prescribing data base (CURES) reveals that Patient Four had filled a fentanyl patch prescription on April 30, 2014. CVS Pharmacy, regularly used by Patient Four to fill Respondent's prescriptions, informed Respondent

on February 28, 2015, that it would no longer fill Respondent's prescriptions; Patient Four began frequenting another pharmacy. A second urine drug screen performed on May 8, 2015, for Patient Four was again negative for opioids. Another physician in Respondent's physician group assumed responsibility for Patient Four's care in mid-2015; under that physician's care Patient Four underwent thoracic and lumbar MRI studies and was referred to a pain management specialist physician.

52. Respondent has subjected her license to disciplinary action for unprofessional conduct, in that her prescribing high dose opiate therapy to Patient Three without adequate clinical justification was an extreme departure from the standard of care constituting gross negligence in violation of section 2234(b) or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence in violation of section 2234(c).

FIFTEENTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

53. The allegations of paragraphs 49-51 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her failure to refer Patient Four to a pain management specialist when the patient repeatedly violated the provisions of the pain management agreement over the period in which Respondent continued to prescribe very high doses of opiates and when contemporaneous urine screenings were negative for opiates was an extreme departure from the standard of care constituting gross negligence or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

SIXTEENTH CAUSE FOR DISCIPLINE

(Negligence/Gross Negligence)

54. The allegations of paragraphs 49-51 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that her failure to explicitly inform Patient Four of the risks of opiates prior to prescribing high dose opiate therapy was an extreme departure from the standard of care constituting gross negligence

or was a departure from the standard of care which, in conjunction with the other alleged departures herein, constitutes repeated acts of negligence.

SEVENTEENTH CAUSE FOR DISCIPLINE

((Failure to Maintain Adequate and Accurate Records)

55. The allegations of paragraphs 49-51 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct for violation of section 2266 in that she failed to maintain adequate and accurate records relating to her care and treatment of Patient Four.

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 A 97845, issued to Ramnik Kaur Josan, M.D.;

2. Revoking, suspending or denying approval of Ramnik Kaur Josan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Ramnik Kaur Josan, 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: January 29, 2018

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