

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

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

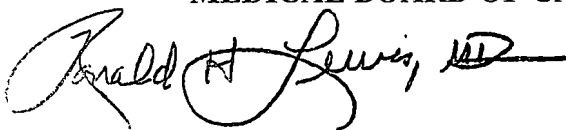
**DECISION**

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**

1 XAVIER BECERRA  
Attorney General of California  
2 MARY CAIN-SIMON  
Supervising Deputy Attorney General  
3 DAVID CARR  
Deputy Attorney General  
4 State Bar No. 131672  
455 Golden Gate Avenue, Suite 11000  
5 San Francisco, CA 94102-7004  
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6 Facsimile: (415) 703-5480  
*Attorneys for Complainant*  
7

8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **RAMNIK KAUR JOSAN, M.D.**

14 5121 Garfield Ave., Apt. 10  
15 Sacramento, CA 95841

16 Physician's and Surgeon's  
17 Certificate No. A 97845

18 Respondent.

Case No. 800-2015-017563

OAH No. 2019090827

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

19  
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical  
24 Board of California (Board). She is a party to this action solely in her official capacity and is  
25 represented in this matter by Xavier Becerra, Attorney General of the State of California, by  
26 David Carr, Deputy Attorney General.  
27  
28



1 **CULPABILITY**

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

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

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

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

17 **RESERVATION**

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

22 **CONTINGENCY**

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

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

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

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

11 **DISCIPLINARY ORDER**

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

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

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

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

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

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

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

24 Respondent shall submit a certification of successful completion to the Board or its  
25 designee not later than 15 calendar days after successfully completing the course, or not later than  
26 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

3 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of  
4 such resignation or unavailability, submit to the Board or its designee, for prior approval, the  
5 name and qualifications of a replacement monitor who will be assuming that responsibility within  
6 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60  
7 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a  
8 notification from the Board or its designee to cease the practice of medicine within three (3)  
9 calendar days after being so notified. Respondent shall then cease the practice of medicine until a  
10 replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

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

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

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

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

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

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

23 11. GENERAL PROBATION REQUIREMENTS.

24 Compliance with Probation Unit

25 Respondent shall comply with the Board's probation unit.

26 Address Changes

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

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

4 Place of Practice

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

8 License Renewal

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

11 Travel or Residence Outside California

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

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

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

21 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or  
22 its designee in writing within 15 calendar days of any periods of non-practice lasting more than  
23 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is  
24 defined as any period of time Respondent is not practicing medicine as defined in Business and  
25 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct  
26 patient care, clinical activity or teaching, or other activity as approved by the Board. If  
27 Respondent resides in California and is considered to be in non-practice, Respondent shall  
28 comply with all terms and conditions of probation. All time spent in an intensive training

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

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

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

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

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

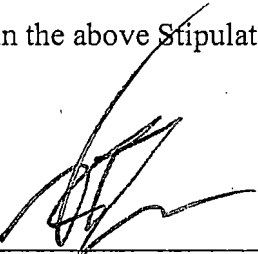
18 14. COMPLETION OF PROBATION. Respondent shall comply with all financial  
19 obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of  
20 probation. Upon successful completion of probation, Respondent's certificate shall be fully  
21 restored.

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



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

4  
5 DATED: 1/31/20

  
6 VIRGIL PRYOR, ESQ.  
7 *Attorney for Respondent*

8 **ENDORSEMENT**

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

11  
12  
13 DATED: 2/4/20

Respectfully submitted,

14 XAVIER BECERRA  
15 Attorney General of California  
16 MARY CAIN-SIMON  
17 Supervising Deputy Attorney General

  
18 DAVID CARR  
19 Deputy Attorney General  
20 *Attorneys for Complainant*

**Exhibit A**

**Accusation No. 800-2015-017563**



1 XAVIER BECERRA  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 DAVID CARR  
Deputy Attorney General  
4 State Bar No. 131672  
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6 Facsimile: (415) 703-5480  
*Attorneys for Complainant*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO Jan 29 20 18  
BY [Signature] ANALYST

7  
8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2015-017563

13 **Ramnik Kaur Josan, M.D.**

OAH Case No.

14 2828 Grasslands Drive, No. 1114  
15 Sacramento, CA 95833

**ACCUSATION**

16 Physician's and Surgeon's  
Certificate No. A 97845,

Respondent.

17  
18 Complainant alleges:

19 **PARTIES**

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

23 2. On or about October 25, 2006, the Board issued Physician's and Surgeon's Certificate  
24 Number A 97845 to Ramnik Kaur Josan, M.D. (Respondent). The Physician's and Surgeon's  
25 Certificate was in full force and effect at all times relevant to the charges brought herein and will  
26 expire on May 31, 2018, unless renewed.

27 ///

28 ///

1 JURISDICTION

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

4 4. Section 2004 of the Code states:

5 "The board shall have the responsibility for the following:

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

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

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

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

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

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

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

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

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

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

22 6. Section 2234 of the Code, states:

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

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

28 "(b) Gross negligence.

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

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

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

11           “(d) Incompetence.

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

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

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

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

22           7.     Section 2266 of the Code states: “The failure of a physician and surgeon to maintain  
23 adequate and accurate records relating to the provision of services to their patients constitutes  
24 unprofessional conduct.”

25           8.     Section 2227 of the Code states:

26           “(a) A licensee whose matter has been heard by an administrative law judge of the Medical  
27 Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default  
28

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

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

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

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

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

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

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

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

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

#### 21 DRUG LIST

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

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

3 12. **Alprazolam** (trade name Xanax) is a psychotropic analogue of the benzodiazepine  
4 class of central nervous system-active compounds. Xanax is used for the management of anxiety  
5 disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as  
6 defined in section 4022 and a Schedule IV controlled substance and narcotic as defined by section  
7 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system  
8 depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol  
9 and other central nervous system depressant drugs during treatment with Xanax.

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

14 14. **Fentanyl** is a potent narcotic analgesic. It is a dangerous drug as defined in section  
15 4022 and a Schedule II controlled substance and narcotic as defined by section 11055,  
16 subdivision (c)(8), of the Health and Safety Code. A dose of .1 mg is approximately equi-  
17 analgesic to 10 mg of morphine. Fentanyl transdermal patches contain a high concentration of  
18 fentanyl. Other central nervous system depressant drugs will have additive or potentiating effects  
19 with fentanyl. Fentanyl can produce drug dependence of the morphine type and therefore has the  
20 potential for being abused.

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

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

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

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

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

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

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

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

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

1 FIRST CAUSE FOR DISCIPLINE

2 (Negligence/Gross Negligence)

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

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

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

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

27 \_\_\_\_\_  
28 <sup>1</sup> To maintain patient confidentiality, the subject patients discussed herein are identified as  
Patients One-Four. The patients' full names will be provided in discovery.



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

5 26. Patient One saw Respondent next on May 9, 2014, and at a final visit on August 8,  
6 2014. On both of these subsequent visits Patient One's primary complaint was of  
7 musculoskeletal pain. In the interval between the first office visit on April 3 and the second  
8 office visit on May 9, Respondent prescribed 360 tablets of Oxycodone in escalating dosage  
9 amounts: from 5 mg initially to 10 mg, then to 20 mg. Respondent's chart notes in the medical  
10 record for these two visits also fail to state that she was prescribing Oxycodone to Patient One.  
11 Although Respondent last saw Patient One on August 8, 2014, she continued to prescribe  
12 Oxycodone to him through March 30, 2015. Over this period of time, Patient One was being  
13 prescribed an amount of Oxycodone that yields a daily average Morphine Equivalent Dose  
14 (MED) of 363 morphine milligram equivalents. Respondent makes no documented reference of  
15 having considered the fact that the patient was a high risk medication user, having acknowledged  
16 to Respondent at the initial visit that he took his son's opiates. It appears that Respondent signed  
17 her medical record pertaining to the April 3, May 9, and August 8, 2014, office visits on March  
18 18, 2016.

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

### 25 SECOND CAUSE FOR DISCIPLINE

#### 26 (Negligence/Gross Negligence)

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

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

5 **THIRD CAUSE FOR DISCIPLINE**

6 **(Negligence/Gross Negligence)**

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

14 **FOURTH CAUSE FOR DISCIPLINE**

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

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

20 **FIFTH CAUSE FOR DISCIPLINE**

21 **(Negligence/Gross Negligence)**

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

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

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

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

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

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

13 35. Respondent has subjected her license to disciplinary action for unprofessional  
14 conduct, in that her prescribing high dose opiate therapy and Adderall to Patient Two without  
15 adequate clinical justification or apparent consideration of his high risk medication status was an  
16 extreme departure from the standard of care, constituting gross negligence in violation of section  
17 2234(b) or was a departure from the standard of care which, in conjunction with the other alleged  
18 departures herein, constitutes repeated acts of negligence in violation of section 2234(c).

#### 19 SIXTH CAUSE FOR DISCIPLINE

#### 20 (Negligence\Gross Negligence)

21 36. The allegations of paragraphs 32-34 above are incorporated by reference as if set out  
22 in full. Respondent is subject to disciplinary action for unprofessional conduct pursuant to section  
23 2234(b) and/or 2234(c) in that her failure to obtain meaningful informed consent from Patient  
24 Two prior to initiating opiate therapy was an extreme departure from the standard of care  
25 constituting gross negligence or was a departure from the standard of care which, in conjunction  
26 with the other alleged departures herein, constitutes repeated acts of negligence.

27 ///

28 ///

1 **SEVENTH CAUSE FOR DISCIPLINE**

2 **(Negligence/Gross Negligence)**

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

9 **EIGHTH CAUSE FOR DISCIPLINE**

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

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

15 **NINTH CAUSE FOR DISCIPLINE**

16 **(Negligence/Gross Negligence)**

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

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

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

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

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

1 anymore and cannot sleep. Gets anxiety bad," Respondent continued to prescribe Alprazolam to  
2 Patient Three until December 2014. On June 2, 2014, Respondent added methadone to Patient  
3 Three's medication regimen. There is no mention in the medical record that Respondent  
4 considered a trial of any adjunctive pain management modalities to address Patient Three's  
5 complaints of pain. Respondent's chart notes for the visits on January 3, 2014, and March 3,  
6 2014, both indicate they were signed by Respondent on April 1, 2016. Chart notes for June 27,  
7 2014, and July 1, 2014 are labeled "Telephone Encounters" but each describes elements of a  
8 physical examination of Patient Three. Respondent stopped prescribing controlled substances to  
9 Patient Three on December 17, 2014.

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

#### 16 TENTH CAUSE FOR DISCIPLINE

##### 17 (Failure to Maintain Adequate and Accurate Records)

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

#### 22 ELEVENTH CAUSE FOR DISCIPLINE

##### 23 (Negligence/Gross Negligence)

24 45. The allegations of paragraphs 40-42 above are incorporated by reference as if set out  
25 in full. Respondent is subject to disciplinary action for unprofessional conduct pursuant to section  
26 2234(b) and/or 2234(c) in that her failure to obtain meaningful informed consent from Patient  
27 Three for both opiate therapy and combined prescribing of opiates and benzodiazepines was an  
28 extreme departure from the standard of care constituting gross negligence or was a departure from

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

3 **TWELFTH CAUSE FOR DISCIPLINE**

4 **(Negligence/Gross Negligence)**

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

11 **THIRTEENTH CAUSE FOR DISCIPLINE**

12 **(Negligence/Gross Negligence)**

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

20 **FOURTEENTH CAUSE FOR DISCIPLINE**

21 **(Negligence/Gross Negligence)**

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

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



1 Patient Four was using fentanyl patches, 400 mcg every 48 hours, and 30 mg oxycodone as  
2 needed to control pain, prescribed by a prior physician. He related a history of alcoholic  
3 pancreatitis but claimed he no longer drank alcohol. He also denied illicit drug use but told  
4 Respondent he had used his mother's boyfriend's pain medications. Physical examination  
5 established a limited range of motion of the lumbar spine. No detailed pain history or evaluation  
6 was obtained at this visit. No diagnostic imaging studies were ordered at this visit. Respondent  
7 diagnosed Patient Four with chronic back pain; she prescribed 30 100 mcg fentanyl patches and  
8 240 tablets of 30 mg oxycodone. Nothing in the medical record suggests Respondent considered  
9 or attempted any pain management alternative to opioid therapy. Respondent apparently made  
10 additional entries to the record of this first visit and signed the record on October 31, 2014.

11 50. Patient Four signed a Pain Management Agreement at his next office visit on January  
12 21, 2014. Objectives for evaluating Patient Four's drug therapy are set out in the Pain  
13 Management Agreement but appear to have been ignored over the course of Respondent's  
14 treatment and prescribing for Patient Four. An undated, pre-printed informed consent document,  
15 entitled "Eight Opioid Safety Principles for Patients and Caregivers" is included in Patient Four's  
16 medical record.

17 51. Respondent's prescribing of fentanyl patches to Patient Four increased in frequency  
18 to the point that he was receiving 30 patches about every 15 days. The prescription amount of  
19 Oxycodone also increased until Patient Four was receiving 240 tablets more frequently than once  
20 per month. Analysis of the total amount of opioids prescribed by Respondent for Patient Four  
21 reveals a daily average in excess of 1000 mg., yet a urine drug screen performed on March 14,  
22 2014, was negative for opioids. Patient Four was also requesting—and receiving—early refills on  
23 his prescriptions, a violation of the Pain Management Agreement. In April of 2014 Patient Four  
24 admitted to Respondent that he was using alcohol, as much as ten beers daily. On May 8, 2014,  
25 Patient Four told Respondent he had lost his fentanyl prescription; Respondent re-issued the  
26 prescription. Examination of the state controlled substance prescribing data base (CURES)  
27 reveals that Patient Four had filled a fentanyl patch prescription on April 30, 2014. CVS  
28 Pharmacy, regularly used by Patient Four to fill Respondent's prescriptions, informed Respondent

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

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

13 **FIFTEENTH CAUSE FOR DISCIPLINE**

14 (Negligence/Gross Negligence)

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

23 **SIXTEENTH CAUSE FOR DISCIPLINE**

24 (Negligence/Gross Negligence)

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

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

3 SEVENTEENTH CAUSE FOR DISCIPLINE

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

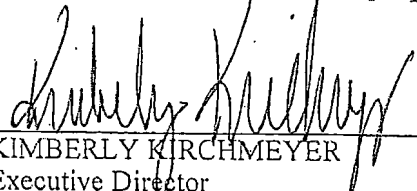
5 55. The allegations of paragraphs 49-51 above are incorporated by reference as if set out  
6 in full. Respondent is subject to disciplinary action for unprofessional conduct for violation of  
7 section 2266 in that she failed to maintain adequate and accurate records relating to her care and  
8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

9 PRAYER

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

- 12 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 97845,  
13 issued to Ramnik Kaur Josan, M.D.;
- 14 2. Revoking, suspending or denying approval of Ramnik Kaur Josan, M.D.'s authority to  
15 supervise physician assistants and advanced practice nurses;
- 16 3. Ordering Ramnik Kaur Josan, M.D., if placed on probation, to pay the Board the  
17 costs of probation monitoring; and
- 18 4. Taking such other and further action as deemed necessary and proper.

19  
20 DATED: January 29, 2018



21 KIMBERLY KIRCHMEYER  
22 Executive Director  
23 Medical Board of California  
24 Department of Consumer Affairs  
25 State of California  
26 Complainant