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

In the Matter of the Accusation Against **Stephen Peter Bradley, M.D.** **Physician's and Surgeon's License No. C 41489** **Respondent.**	**Case No. 800-2016-021643**

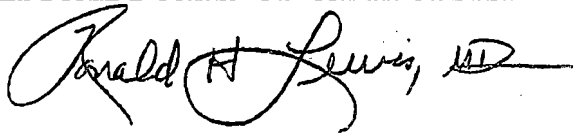
DECISION

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

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

IT IS SO ORDERED: May 6, 2020.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the Accusation Against: **STEPHEN P. BRADLEY, M.D.** **5375 Lakeshore Blvd.** **Lakeport, CA 95453-6123** **Physician's and Surgeon's Certificate No. C 41489** Respondent.	Case No. 800-2016-021643 OAH No. 2019080680 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, via Joshua M. Templet, Deputy Attorney General.

2. Respondent Stephen P. Bradley, M.D. (Respondent) is represented in this proceeding by attorney Adam G. Slote, Slote, Links & Boreman LLP, One Embarcadero Center, Suite 400, San Francisco, CA 94111.

3. On or about July 30, 1984, the Board issued Physician's and Surgeon's Certificate No. C 41489 to Stephen P. Bradley, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-021643, and will expire on October 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-021643 (Accusation) 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 April 12, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of the Accusation is attached as **Exhibit A** and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Accusation. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the Accusation, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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10. 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 charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. 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.

14. 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. C 41489 issued to Respondent Stephen P. Bradley, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

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

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

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

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

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

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

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

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of title 16, California Code of Regulations, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program.

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

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

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

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

shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

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

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

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

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

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

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

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

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Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

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

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

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

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15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Adam G. Slote. 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: 2-3-20

STEPHEN P. BRADLEY, M.D.
Respondent

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I have read and fully discussed with Respondent Stephen P. Bradley, 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: 2-3-20

ADAM G. SLOTE
Attorney for Respondent

ENDORSEMENT

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

DATED: 2/3/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

JOSHUA M. TEMPLET
Deputy Attorney General
Attorneys for Complainant

SF2019200548

Exhibit A

Accusation No. 800-2016-021643

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

In the Matter of the Accusation Against: **STEPHEN PETER BRADLEY, M.D.** **5375 Lakeshore Blvd.** **Lakeport, CA 95453-6123** **Physician's and Surgeon's Certificate No. C41489,** Respondent.	Case No. 800-2016-021643 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about July 30, 1984, the Medical Board issued Physician's and Surgeon's Certificate No. C41489 to Stephen Peter Bradley, M.D. (Respondent). Physician's and Surgeon's Certificate No. C41489 was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2019, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states, in pertinent part:

"(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.

"..."

5. Section 2234 of the Code, states, in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

"..."

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

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."

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. C41489 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A and B[1] as more particularly alleged hereinafter:

[1] To protect patient privacy, patient names have been omitted from this pleading. Respondent is aware of the identities of the patients referred to herein.

Patient A

9. Respondent began treating Patient A, then a 49-year old woman, on or about April 30, 2008.[2] Patient A had a history of chronic back pain, hypertension, migraines, and obesity, among other ailments. Patient A had sustained injuries to her back, left knee, and left foot in or around 1999 after operating a forklift. She had a history of surgeries on her knee and spine, and had been tried on a number of opiates for pain relief, including methadone,[3] hydrocodone/APAP,[4] Oxycontin,[5] morphine,[6] and Suboxone.[7] Prior to 2013, she had also tried diclofenac[8] and Celebrex[9] for pain relief.

10. In his records for Patient A, Respondent noted that Patient A had previously sold some of her hydrocodone/APAP tablets to a neighbor sometime around June 2012. His medical records also document that Patient A had taken excessive amounts of narcotics and diazepam[10] and had become overly sedated following spinal surgery in or around June 2012. At the time, the medications were either discarded or taken away by Patient A's relatives.

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

[3] Methadone is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c).

[4] Hydrocodone/APAP (Vicodin® and Norco®) is a combination of hydrocodone bitartrate and acetaminophen. Hydrocodone/APAP was formerly a Schedule III controlled substance, pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code, section 4022. On August 22, 2014, the Drug Enforcement Agency (DEA) published a final rule rescheduling hydrocodone combination products to Schedule II of the Controlled Substances Act, which became effective October 6, 2014.

[5] Oxycodone HCL (OxyContin®) is a Schedule II controlled substances pursuant to Health and Safety Code, section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code, section 4022.

[6] Morphine sulfate (MS Contin®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code, section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code, section 4022.

[7] Buprenorphine and naloxone (Suboxone®), is used to treat opioid use disorder, and is a dangerous drug pursuant to Business and Professions Code, section 4022. Buprenorphine is an opioid and a Schedule V controlled substance pursuant to Health and Safety Code, section 11058, subdivision (d).

[8] Diclofenac (Voltaren®) is a non-steroidal anti-inflammatory drug (NSAID) and a dangerous drug pursuant to Business and Professions Code, section 4022.

[9] Celecoxib (Celebrex®) is a NSAID and a dangerous drug pursuant to Business and Professions Code, section 4022.

[10] Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code, section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code, section 4022.

11. On or about July 2, 2013, Respondent saw Patient A, then a fifty-four-year-old woman, for an office visit. At this time, Respondent was actively treating Patient A's hypertension and pain, and had been prescribing hydrocodone/APAP, 7.5/750 mg, one tablet to be taken every six hours as needed or four tablets daily, for pain.

12. On or about July 2, 2013 and August 30, 2013, Respondent saw Patient A and refilled her hydrocodone/APAP prescription for 120 tablets.

13. On or about September 30, 2013, Respondent changed Patient A's prescription to hydrocodone/APAP, 7.5/325 mg, to comply with the Food and Drug Administration's regulations on acetaminophen intake. This prescription was refilled after a visit on or about October 30, 2013.

14. On or about December 2, 2013, Patient A saw Respondent and complained of pain in her lower right extremity and numbness in her right hand and forearm. Respondent ordered an MRI and refilled Patient A's hydrocodone/APAP prescription. Respondent also prescribed gabapentin[11] for pain.

15. On or about December 23, 2013, Patient A told Respondent that the gabapentin was not helping, and that because of increased pain, she had been taking more hydrocodone/APAP than prescribed, at eight tablets daily. Respondent reviewed Patient A's MRI, gave her a referral for a spine surgeon, counseled her on her posture and walking, and increased her hydrocodone/APAP prescription to 10/325 mg tablets. He prescribed 150 tablets, one tablet to be taken every four to six hours or four to six tablets daily, as needed for pain.

16. From on or about January 22, 2014 through August 5, 2014, Respondent saw Patient A monthly and continued to prescribe hydrocodone/APAP at the same dose. At an office visit on or about January 22, 2014, Patient A reported that she had fallen on her porch on or about January 19, 2014, had gone to the hospital, and had received oxycodone.

17. On or about August 27, 2014, Patient A reported that she had run out of hydrocodone/APAP, which had been refilled on or about August 5, 2014. Respondent prescribed

[11] Gabapentin (Neurontin®) is a nerve pain medication and anticonvulsant and is a dangerous drug pursuant to Business and Professions Code, section 4022.

her 40 tablets of hydrocodone/APAP at 5/325 mg, to last Patient A until her next scheduled visit on or about September 4, 2014. On or about September 4, 2014, Respondent gave Patient A a 30-day refill for hydrocodone/APAP.

18. On or about September 17, 2014, Patient A told Respondent that she had been taking more narcotics and felt less benefit from them, and was requesting "heavier opiates." Respondent advised Patient A to avoid taking more than five hydrocodone/APAP tablets daily and was "reminded of previous problems with opiate intoxication, diversion and need for family intervention." Patient A rejected Respondent's alternative treatment options of receiving anesthetic patches or nerve stabilizers.

19. On or about September 19, 2014, Patient A went to the emergency room and complained of increased back pain. According to the hospital records, Patient A stated that she had received a refill of her pain medications from her primary care provider, but that insurance would not cover the cost. Patient A was given Tylenol with Codeine and was informed of the hospital's narcotic policy. A copy of the records of this hospital visit were faxed to Respondent on or about September 20, 2014. A review of Patient A's Controlled Substance Utilization Review & Evaluation System (CURES)[12] records shows that Patient A received a 30-day refill of hydrocodone/APAP on or about September 23, 2014, and received another 30-day refill after a visit with Respondent only 23 days later on or about October 16, 2014.

20. On or about November 17, 2014, Patient A requested a muscle relaxant because she was having back spasms at night. Respondent prescribed tizanidine[13] and refilled Patient A's hydrocodone/APAP prescription.

21. On or about December 15, 2014, Patient A reported that she had been to the emergency room multiple times and had tried cyclobenzaprine[14] for her back pain. Respondent

[12] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving regulatory oversight agencies, law enforcement, and public health.

[13] Tizanidine (Zanaflex®) is a muscle relaxant used to treat muscle spasms and is a dangerous drug pursuant to Business and Professions Code, section 4022.

[14] Cyclobenzaprine (Flexeril®) is a muscle relaxant used to treat pain and stiffness caused by muscle spasms and is a dangerous drug pursuant to Business and Professions Code, section 4022.

discontinued tizanidine and prescribed cyclobenzaprine, and refilled Patient A's hydrocodone/APAP prescription.

22. On or about January 3, 2015, Patient A went to the hospital for lower right back pain that radiated down her right leg. She also complained that hydrocodone/APAP was no longer helpful, and that she had finished her 30-day hydrocodone/APAP supply nine days early. Patient A was told that it was inappropriate for her to come to the hospital to get medications, and that her prescriptions should come from one prescriber. Patient A became upset and refused an intramuscular injection of ketorolac for pain. The records for this hospital visit were faxed to Respondent on or about January 3, 2015.

23. On or about January 12, 2015, Respondent saw Patient A and did not document any discussion about her January 3, 2015 hospital visit, other than to note that Patient A went to the emergency room from time to time for additional medications. He refilled Patient A's hydrocodone/APAP prescription, which was filled on or about the same day.

24. From on or about February 5, 2015 through June 4, 2015, Respondent continued to see Patient A monthly and refill Patient A's hydrocodone/APAP prescription.

25. On or about June 24, 2015, Patient A reported that she had fallen on her right scapula on or about June 15, 2015, had experienced severe pain, and was taking up to seven hydrocodone/APAP tablets daily, and had consequently run out of medication. Respondent increased Patient A's 30-day prescription from 150 to 180 hydrocodone/APAP tablets, or six tablets daily.

26. On or about July 21, 2015, Patient A reported that she had increased her pain medications to an average of seven tablets daily. Respondent refilled her hydrocodone/APAP prescription for 180 tablets, but counseled Patient A to reduce her maximum dose from six to five tablets daily.

27. From on or about August 17, 2015 through December 9, 2015, Respondent continued to see Patient A monthly and refill Patient A's hydrocodone/APAP prescription at 180 tablets a month.

28. On or about December 12, 2015, Patient A went to the hospital after hitting her knee against a metal box. An x-ray showed no evidence of acute fracture or dislocation. Patient A told the practitioners at the hospital that she was on a pain contract. She was prescribed oxycodone, 5 mg, one tablet to be taken every four to six hours for pain. The records for this hospital visit were faxed to Respondent on or about December 13, 2015.

29. From on or about January 4, 2016 through March 2, 2016, Respondent continued to see Patient A monthly and continued to refill Patient A's hydrocodone/APAP prescription at 180 tablets a month.

30. On or about April 18, 2016, Patient A contacted Respondent and reported that her medication had been stolen. On or about the same date, Respondent gave Patient A a prescription for 24 tablets of hydrocodone/APAP. Patient A received a refill of her 30-day supply of hydrocodone/APAP on or about April 22, 2016 at the following office visit.

31. On or about May 18, 2016, Patient A complained of sudden onset left hip pain that started on or about May 8, 2016. Respondent increased Patient A's hydrocodone/APAP prescription to 240 tablets, one or two tablets to be taken every six hours as needed for pain or up to eight tablets daily.

32. On or about June 10, 2016, Patient A went to the hospital and reported that hydrocodone/APAP was not helping her knee pain. She requested additional pain medication. Patient A received oxycodone tablets and was told that she needed to get refills from her primary care physician. The records for this hospital visit were faxed to Respondent on or about June 11, 2016.

33. Respondent saw Patient A on or about June 20, 2016 for a follow up visit and refilled her hydrocodone/APAP prescription for 240 tablets.

34. On or about July 14, 2016, Patient A requested stronger pain medications for severe pain in her knees and low back. Respondent noted, "[t]aking hydrocodone/APAP 20/325 [sic] mg in large numbers does not help her nor does diclofenac 100 mg bid plus cyclobenzaprine 10 mg tid but she continues to take them." Respondent's record appears to document that he refilled Patient A's hydrocodone/APAP prescription, although no hydrocodone/APAP prescription was

refilled on this date. Respondent also prescribed extended release morphine, 60 mg, one tablet to be taken twice a day, and immediate release morphine, 15 mg, one tablet to be taken every six hours as needed for breakthrough pain. He also prescribed ibuprofen, 800 mg, to be taken either three or four times daily.

35. On or about August 12, 2016, Patient A complained of nausea and vomiting from the morphine, which she eventually stopped. She requested to resume hydrocodone/APAP, but Respondent noted that she had taken it excessively and she "may do better on a more potent opiate." He prescribed Patient A oxycodone/APAP,[15] 10/325 mg, quantity 240, one or two tablets to be taken four times daily. On or about the same day, Patient A filled the oxycodone/APAP prescription and received a 30-day refill after a visit on or about September 12, 2016.

36. On or about October 4, 2016, Patient A saw Respondent because she had run out of her pain medication. Patient A reported that she had increased her oxycodone/APAP dosage to 10 to 12 tablets a day, even though she was not to exceed eight tablets daily. Respondent issued a prescription for 120 tablets of oxycodone, 30 mg, one tablet to be taken every six hours as needed for pain.

37. On or about October 19, 2016, Patient A went to the hospital for left hip pain. She said that while getting out of the shower, she heard a pop in her hip. She was given Dilaudid[16] in the emergency room, but left against medical advice. She was also given oxycodone. Records of this hospital visit were faxed to Respondent on or about October 20, 2016.

38. On or about October 31, 2016, Patient A told Respondent that she had gone to the hospital and that she had taken more than four oxycodone daily because of her left hip pain. Respondent noted that Patient A was three days early in receiving her pain medication refill, but

[15] Oxycodone/APAP (Percocet®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code, section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code, section 4022.

[16] Hydromorphone (Dilaudid®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code, section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code, section 4022.

gave her a prescription for 120 tablets of oxycodone, 30 mg, with the instruction that she never take over four tablets in 24 hours.

39. On or about November 18, 2016, Patient A reported that she was taking 60 mg of oxycodone four times daily, which was double the prescribed dose. Patient A was to have surgery on her left hip. Respondent prescribed her oxymorphone ER,[17] 30 mg, quantity 90, one tablet three times daily, and Nucynta,[18] 50 mg, quantity 180, one to two tablets every six hours as needed for breakthrough pain. Respondent noted that Patient A "was counseled on the need to use some restraint in taking her analgesics."

40. On or about December 22, 2016, Patient A was recovering from a left hip arthroplasty, and asked Respondent to switch her pain medication back to hydrocodone/APAP. Respondent prescribed hydrocodone/APAP, 10/325 mg, quantity 150, half to one tablet every four to six hours as needed for pain.

41. In or around January 2017, Patient A experienced post-surgical complications, and went back to the hospital for a clogged PICC line. On or about January 24, 2017, Respondent increased Patient A's hydrocodone/APAP to 180 tablets, or six tablets daily.

42. From on or about February 23, 2017 through April 19, 2017, Respondent continued to see Patient A and continued to refill Patient A's hydrocodone/APAP prescription at 180 tablets a month.

43. On or about May 16, 2017, Patient A reported that her right knee pain was severe. Respondent documented that Patient A had increased her oxycodone/APAP to two tablets four times a day, despite the fact that Patient A had been prescribed hydrocodone/APAP. Patient A was scheduled for a total right knee replacement in June. Respondent prescribed 240 tablets of hydrocodone/APAP, or eight tablets daily. This prescription was refilled after another visit on or about June 15, 2017.

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[17] Oxymorphone ER (Opana®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code, section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code, section 4022.

[18] Tapentadol (Nucynta®), an opioid analgesic, is a schedule II controlled substance pursuant to the Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code, section 4022.

44. On or about July 6, 2017, Patient A was recovering from the total knee replacement, and was given another refill of 240 tablets of hydrocodone/APAP, which was filled on or about July 12, 2017. Another 30-day refill was given after a visit on or about August 7, 2017.

45. On or about September 6, 2017, Respondent noted that he told Patient A to start tapering down her hydrocodone/APAP use, but documented no further instructions on how to do so. Respondent prescribed her 240 tablets of hydrocodone/APAP.

46. On or about October 9, 2017, Respondent told Patient A that she had to lower her pain pills "by 10% every week." Respondent also prescribed her 240 tablets of hydrocodone/APAP.

47. On or about November 6, 2017 and December 6, 2017, Respondent continued to prescribe Patient A 240 tablets of hydrocodone/APAP while advising Patient A that she needed to taper her pain medications. Respondent's documentation did not include a schedule or any other directions on how Patient A could lower her hydrocodone/APAP dose.

48. On or about January 9, 2018, Patient A reported that she had lowered her hydrocodone/APAP dose from eight to six tablets daily. Respondent gave her a prescription for 180 hydrocodone/APAP tablets.

49. From on or about February 2, 2018 through October 11, 2018, Respondent reduced Patient A's hydrocodone/APAP prescription from six tablets to 2.5 to three tablets daily.

50. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to prescribing escalating doses of opioids for chronic pain without paying sufficient attention to the risks of intoxication, abuse, overdose and diversion in light of the examples of abuse demonstrated by Patient A.

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Patient B

51. On or about January 26, 2016, Patient B, then a 32-year old man, saw Respondent for opiate and benzodiazepine addiction. Patient B had a history of taking lorazepam[19] and alprazolam,[20] and was then currently taking both medications. He also had a history of taking oxycodone/APAP and heroin, which he was also currently using. Respondent prescribed Patient B Suboxone and gave him instructions on how to take the medication. Respondent also prescribed alprazolam, 2 mg, quantity 120, 16 mg daily, and diazepam,[21] 10 mg, quantity 120, 40 mg daily. Respondent also prescribed carbamazepine[22] for withdrawal seizures and clonidine[23] for anxiety.

52. On or about February 17, 2016, Patient B told Respondent he had been taking 7 mg of alprazolam, less than the prescribed dose, and 40 mg of diazepam daily. Despite taking less than or the prescribed dose, Patient B inexplicably reported that he had run out of his benzodiazepines 11 days early and had borrowed some of his mother's lorazepam. Respondent refilled Patient B's Suboxone prescription and instructed Patient B to gradually taper his daily alprazolam dose in four weeks from 6.5 mg to 5 mg. Respondent advised Patient B to continue to take 40 mg of diazepam daily. Respondent gave Patient B prescriptions for 81 tablets of alprazolam, 2 mg, and 112 tablets of diazepam, 10 mg.

53. On or about March 18, 2016, Patient B told Respondent he had reduced his daily alprazolam dose to 4 mg but increased his daily diazepam dose to 76 mg. Despite this, Respondent wrote in his notes that "[h]e reports significant reduction his benzodiazepine use." Respondent once again gave Patient B instructions on how to taper his daily alprazolam dose in

[19] Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code, section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code, section 4022.

[20] Alprazolam (Xanax®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code, section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code, section 4022.

[21] Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code, section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code, section 4022.

[22] Carbamazepine is an anticonvulsant used to treat seizures and nerve pain, and is a dangerous drug pursuant to Business and Professions Code, section 4022.

[23] Clonidine is a sedative and antihypertensive drug, and is a dangerous drug pursuant to Business and Professions Code, section 4022.

four weeks from 2.0 mg to 0.5 mg, while increasing his daily diazepam dose from 60 mg to 90 mg. At this visit, Respondent documented that Patient B left before submitting a sample for a urine drug screen and also left the written instructions to taper his medications in the office. Respondent noted that Patient B's prescriptions were held until he submitted to a urine drug screen on or about March 23, 2016.

54. On or about March 22, 2016, pharmacy records show that Patient B filled a prescription for 120 tablets of diazepam 10 mg, written by Respondent.

55. On or about March 23, 2016, pharmacy records show Patient B filled prescriptions for 70 tablets of alprazolam, 0.5 mg, and Suboxone, written by Respondent. On or about the same day, Patient B's urine drug screen was positive for buprenorphine, benzodiazepines, amphetamine, opiates, and methamphetamine.

56. On or about April 2, 2016, pharmacy records show that Patient B filled a prescription for 36 tablets of diazepam, 10 mg, written by Respondent. On or about April 5, 2016, pharmacy records show that Patient B filled another prescription for diazepam, 10 mg, quantity 54, written by Respondent.

57. On or about April 14, 2016, Patient B took a urine drug screen, which was positive for buprenorphine, benzodiazepines, amphetamine, and methamphetamine. Respondent noted the irregular drug screen results and Patient B admitted to taking stimulants which he bought online. Patient B reported he was taking 1.5 mg of alprazolam and 70 mg of diazepam daily. Respondent discontinued alprazolam, and prescribed diazepam with a tapering schedule in which Patient B was to gradually reduce from 80 mg to 60 mg daily in four weeks.

58. On or about April 14, 2016, Patient B filled a prescription for diazepam, 5 mg, quantity 117, written by Respondent. On or about April 18, 2016, Patient B filled a prescription for diazepam, 10 mg, quantity 148, written by Respondent.

59. On or about May 12, 2016, Patient B reported that he was going to jail on or about May 28, 2016 for driving while his license was suspended and late child support. He also told Respondent that he had stopped taking alprazolam four weeks prior, was taking 75 mg of diazepam daily, and was still taking Suboxone. Respondent noted that Patient B was to be taking

60 mg of diazepam and was counseled to follow the tapering schedule he provided. Patient B was given another tapering schedule to reduce his diazepam use from 70 mg to 55 mg daily in four weeks. On or about the same day, Patient B filled prescriptions for 60 tablets of diazepam, 5 mg, 105 tablets of diazepam, 10 mg, and Suboxone.

60. On or about July 1, 2016, Patient B reported that he had a seizure on or about June 20, 2016, after running out of diazepam and was treated at a hospital. Patient B also bought more Suboxone and alprazolam, taking approximately 4 mg daily. Patient B took a urine drug screen which was positive for buprenorphine, tricyclic antidepressants, benzodiazepines, amphetamines, opiates, and methamphetamine. When questioned by Respondent, Patient B denied knowledge of taking opiates or methamphetamine, but said he bought some pills. Respondent counseled Patient B on following the prescribed treatment. Respondent gave Patient B another schedule to reduce his diazepam from 55 mg to 42.5 mg daily in four weeks, and was given another prescription for Suboxone. On or about the same day, Patient B filled prescriptions for diazepam, 5 mg, quantity 60, diazepam 10 mg, quantity 105, and Suboxone.

61. On or about August 9, 2016, Patient B told Respondent he went to the hospital for another seizure after he stopped taking diazepam in jail. Patient B reported that since the seizure, he had been taking 30 mg of diazepam daily, and that he last took Suboxone on or about the day prior. A urine drug screen taken that day was negative for all substances. Respondent gave Patient B a 30-day prescription for diazepam, 15 mg, two tablets daily, and refills for Suboxone, clonidine, and carbamazepine. On or about the same day, Patient B filled prescriptions for 60 tablets of diazepam, 5 mg, 60 tablets of diazepam, 10 mg, and Suboxone.

62. On or about August 24, 2016, Patient B admitted to doubling his prescribed dose of diazepam while tapering his Suboxone dose. Patient B also complained that his right testicle was swollen and painful. Respondent noted, "[h]e apparently made the appointment to be here today to get out of a court date," and that "[his urine drug screen] was all negative 2 weeks ago also, suggesting possible diversion." Respondent performed a physical exam and found no abnormalities. He noted that Patient B's aberrant drug screen result was either from diversion,

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someone else's urine, or specimen dilution. Respondent refused to refill Patient B's diazepam prescription early.

63. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to continuing to prescribe benzodiazepines in combination with opioids to a patient who repeatedly failed to comply with Respondent's instructions, at times tested positive for other illicit substances, and/or tested negative for all substances, suggesting possible diversion.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

64. Respondent has further subjected his Physician's and Surgeon's Certificate No. C41489 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patients A, B, and C, for the following:

65. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but was not limited to, the following:

a. Paragraphs 9 through 50, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Failing to perform a substance abuse history in a patient with a documented history of substance misuse;

c. Failing to include objectives for the management of chronic pain while prescribing high doses of opioids;

d. Failing to provide information regarding the risks of polypharmacy and sedating medications or to obtain informed consent; and

e. Failing to document a clear medication list and excessively cutting and pasting prior medical records.

66. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but was not limited to, the following:

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a. Paragraphs 51 through 63, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Failing to take a more thorough psychiatric history in a patient who is self-medicating with street drugs;

b. Failing to obtain informed consent regarding the risk of combining medications, especially with a patient who failed to comply with Respondent's directions;

c. Failing to adjust the treatment plan based on the patient's non-compliance; and

d. Failing to offer outside psychiatric, psychological, and substance abuse treatment for a patient with continued anxiety and continued abuse of substances.

Patient C

67. On or about July 23, 2013, Patient C, then a 41-year old man, saw Respondent for narcotic addiction and treatment. Patient C had a history of taking hydrocodone/APAP, oxycodone, diazepam, and alprazolam. He had previously done well on buprenorphine. Respondent prescribed Patient C buprenorphine and counseled Patient C on the appropriate therapy including the risks of taking the medication.

68. From on or about September 16, 2013 through July 9, 2014, Respondent continued to monitor Patient C's use of buprenorphine and continued to give him monthly refills of the medication.

69. On or about August 1, 2014, Respondent counseled Patient C to consider reducing his buprenorphine dose. Nevertheless, Respondent continued prescribing him buprenorphine at the same dose.

70. On or about September 19, 2014, Respondent again counseled Patient C to gradually reduce his buprenorphine dose. Respondent's medical records note that Patient C was given a schedule to reduce his dose, which was not included in the records. Respondent continued to prescribe buprenorphine at the same dose.

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71. On or about November 20, 2014, Patient C reported that he had been taking two-thirds of a tab of buprenorphine two or three times a day. Once again, Respondent refilled the buprenorphine prescription and noted that Patient C had a schedule to slowly reduce the dose.

72. From on or about December 18, 2014 through May 6, 2015, Respondent continued to see Patient C and prescribe buprenorphine at the same dose.

73. On or about May 11, 2015, Patient C reported that his wife wanted to separate, and that he had been using cannabis oil and diazepam as a result. Respondent refilled his buprenorphine prescription and encouraged Patient C to "live drug free."

74. On or about June 8, 2015 and July 6, 2015, Respondent continued to see Patient C and prescribe buprenorphine at the same dose.

75. On or about August 31, 2015, Patient C reported that he was feeling depressed and was using cannabis and diazepam for anxiety. Patient C also told Respondent that he had run out of buprenorphine four days early and was taking the medication three times a day. Respondent counseled Patient C to stop using cannabis and benzodiazepines, and to take his buprenorphine as prescribed. Respondent gave Patient C another refill for buprenorphine.

76. On or about December 1, 2015, Patient C told Respondent that he had been taking 8 mg of alprazolam daily since October 20, 2015, was drinking approximately six beers daily, and was smoking cannabis to help him sleep. Respondent counseled Patient C on depression, anxiety, and abuse of benzodiazepines and alcohol and the associated risks. He gave Patient C prescriptions for alprazolam, 3 mg in the morning and 2 mg as needed, and diazepam, 20 mg daily. Respondent documented a tapering schedule to reduce Patient C's alprazolam dose from 5 mg to 2 mg daily and increase his daily diazepam dose from 20 mg to 50 mg. Respondent also gave Patient C a prescription for clonidine for anxiety.

77. On or about December 1, 2015, Patient C filled prescriptions for alprazolam, 2 mg, quantity 49, diazepam, 10 mg, quantity 98, and Suboxone.

78. On or about December 14, 2015, Patient C reported that he had adhered to Respondent's tapering schedule. He also said he had lost his medications when he left his

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backpack in a taxi. Respondent gave Patient C prescriptions for alprazolam and diazepam, and directed Patient C to continue reducing alprazolam and increasing diazepam.

79. On or about January 4, 2016, Patient C reported that he was taking 2 mg of alprazolam and 40 mg of diazepam daily. Patient C also told Respondent that he had reduced his Suboxone dose. Respondent gave Patient C another tapering schedule to gradually discontinue alprazolam and increase his daily diazepam dose from 50 mg to 70 mg. Respondent advised Patient C that he should taper off the benzodiazepines before trying to taper off Suboxone.

80. On or about January 4, 2016, Patient C filled prescriptions for alprazolam, 2 mg, quantity 11, and diazepam, 10 mg, quantity 161. On or about January 5, 2016, Patient C filled a prescription for Suboxone.

81. On or about February 1, 2016, Patient C told Respondent that he stopped taking alprazolam and had reduced his diazepam dose to 60 mg daily. Respondent gave Patient C another schedule to taper off diazepam and refilled his Suboxone prescription.

82. On or about February 1, 2016, Patient C filled a prescription for diazepam, 10 mg, quantity 175. On or about February 2, 2016 and March 1, 2016, Patient C refilled his Suboxone prescription.

83. On or about March 5, 2016, Patient C told Respondent he had reduced his diazepam dose to 40 mg daily. Patient C's urine drug screen was positive for tetrahydrocannabinol (THC), buprenorphine, and benzodiazepines. Respondent gave Patient C another tapering schedule for diazepam and another refill for Suboxone.

84. On or about March 5, 2016, Patient C filled prescriptions for 14 tablets of diazepam, 2 mg, and 102 tablets of diazepam, 10 mg.

85. From on or about March 15, 2016 through June 13, 2016, Respondent continued to prescribe Patient C Suboxone and clonidine.

86. At a follow up visit on or about July 1, 2016, Patient C reported that he had stopped taking diazepam in mid-May. As a result, Patient C experienced bad withdrawal symptoms and increased his buprenorphine dose. He was also drinking approximately six beers daily during that period of time. Patient C's urine drug screen was positive for THC and buprenorphine.

Respondent counseled Patient C to limit his alcohol use and refilled Patient C's buprenorphine prescription with the directions that Patient C was to taper downward as tolerated.

87. From on or about July 11, 2016 through November 9, 2016, Patient C continued to fill prescriptions for Suboxone and clonidine, written by Respondent.

88. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but was not limited to, the following:

a. Failing to provide informed consent regarding the risks of combining benzodiazepines with opioids; and

b. Failing to check CURES and prescribing large quantities of two benzodiazepines to a person with a history of polysubstance abuse.

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

89. Respondent has further subjected his Physician's and Surgeon's Certificate No. C41489 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records for Patient A, as more particularly alleged in paragraphs 9 through 50, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

90. Respondent has further subjected his Physician's and Surgeon's Certificate No. C41489 to disciplinary action under sections 2227 and 2234 of the Code, in that he committed general unprofessional conduct in the care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 9 through 89, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C41489, issued to Respondent Stephen Peter Bradley, M.D.;

2. Revoking, suspending or denying approval of Respondent Stephen Peter Bradley, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Stephen Peter Bradley, 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: April 12, 2019

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

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