

**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**

Case No. 800-2016-021643

Respondent.

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**

1 XAVIER BECERRA
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
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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 **STEPHEN P. BRADLEY, M.D.**
14 **5375 Lakeshore Blvd.**
Lakeport, CA 95453-6123

15 **Physician's and Surgeon's Certificate**
16 **No. C 41489**

17 Respondent.

Case No. 800-2016-021643

OAH No. 2019080680

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

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

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

1 10. For the purpose of resolving the Accusation without the expense and uncertainty of
2 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
3 basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest
4 those charges.

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

8 **CONTINGENCY**

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

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

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

25 **DISCIPLINARY ORDER**

26 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 41489 issued
27 to Respondent Stephen P. Bradley, M.D. is revoked. However, the revocation is stayed and
28 Respondent is placed on probation for three (3) years on the following terms and conditions:

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

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

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

25 Respondent shall submit a certification of successful completion to the Board or its
26 designee not later than 15 calendar days after successfully completing the course, or not later than
27 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

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

27 A professionalism program taken after the acts that gave rise to the charges in the
28 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

1 or its designee, be accepted towards the fulfillment of this condition if the program would have
2 been approved by the Board or its designee had the program been taken after the effective date of
3 this Decision.

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

6 5. PRACTICE MONITORING Within 30 calendar days of the effective date of this
7 Decision, Respondent shall submit to the Board or its designee for prior approval as a practice
8 monitor the name and qualifications of one or more licensed physicians and surgeons whose
9 licenses are valid and in good standing, and who are preferably American Board of Medical
10 Specialties (ABMS) certified. A monitor shall have no prior or current business or personal
11 relationship with Respondent, or other relationship that could reasonably be expected to
12 compromise the ability of the monitor to render fair and unbiased reports to the Board, including
13 but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree
14 to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

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

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

9 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
10 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
11 name and qualifications of a replacement monitor who will be assuming that responsibility within
12 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
13 calendar days of the resignation or unavailability of the monitor, 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. Respondent shall cease the practice of medicine until a
16 replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

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

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

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

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

16 10. GENERAL PROBATION REQUIREMENTS.

17 Compliance with Probation Unit

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

19 Address Changes

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

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1 Place of Practice

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

5 License Renewal

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

8 Travel or Residence Outside California

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

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

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

18 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
19 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
20 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
21 defined as any period of time Respondent is not practicing medicine as defined in Business and
22 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
23 patient care, clinical activity or teaching, or other activity as approved by the Board. If
24 Respondent resides in California and is considered to be in non-practice, Respondent shall
25 comply with all terms and conditions of probation. All time spent in an intensive training program
26 which has been approved by the Board or its designee shall not be considered non-practice and
27 does not relieve Respondent from complying with all the terms and conditions of probation.
28 Practicing medicine in another state of the United States or Federal jurisdiction while on

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

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

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

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

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

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

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

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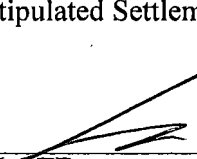
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I have read and fully discussed with Respondent Stephen P. Bradley, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

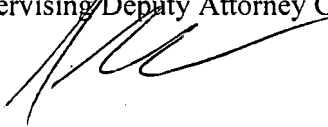
DATED: 2-3-20


ADAM G. SROTE
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

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 12 20 19
BY D. Richard ANALYST

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

13 In the Matter of the Accusation Against:

Case No. 800-2016-021643

14 **STEPHEN PETER BRADLEY, M.D.**
15 **5375 Lakeshore Blvd.**
Lakeport, CA 95453-6123

ACCUSATION

16 **Physician's and Surgeon's Certificate**
17 **No. C41489,**

18 Respondent.

19
20 Complainant alleges:

21 **PARTIES**

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

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

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 (Code) unless otherwise
4 indicated.

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

6 “(a) A licensee whose matter has been heard by an administrative law judge of
7 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
8 Code, or whose default has been entered, and who is found guilty, or who has entered
9 into a stipulation for disciplinary action with the board, may, in accordance with the
10 provisions of this chapter:

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

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

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

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

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

21 “...”

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

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

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

28 “(b) Gross negligence.

1 Patient A

2 9. Respondent began treating Patient A, then a 49-year old woman, on or about April
3 30, 2008.² Patient A had a history of chronic back pain, hypertension, migraines, and obesity,
4 among other ailments. Patient A had sustained injuries to her back, left knee, and left foot in or
5 around 1999 after operating a forklift. She had a history of surgeries on her knee and spine, and
6 had been tried on a number of opiates for pain relief, including methadone,³ hydrocodone/APAP,⁴
7 Oxycontin,⁵ morphine,⁶ and Suboxone.⁷ Prior to 2013, she had also tried diclofenac⁸ and
8 Celebrex⁹ for pain relief.

9 10. In his records for Patient A, Respondent noted that Patient A had previously sold
10 some of her hydrocodone/APAP tablets to a neighbor sometime around June 2012. His medical
11 records also document that Patient A had taken excessive amounts of narcotics and diazepam¹⁰
12 and had become overly sedated following spinal surgery in or around June 2012. At the time, the
13 medications were either discarded or taken away by Patient A's relatives.

14
15 ² Conduct occurring more than seven years from the filing date of this Accusation is for
16 informational purposes only and is not alleged as a basis for disciplinary action.

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

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

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

28 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.

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

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

7 13. On or about September 30, 2013, Respondent changed Patient A's prescription to
8 hydrocodone/APAP, 7.5/325 mg, to comply with the Food and Drug Administration's regulations
9 on acetaminophen intake. This prescription was refilled after a visit on or about October 30,
10 2013.

11 14. On or about December 2, 2013, Patient A saw Respondent and complained of pain in
12 her lower right extremity and numbness in her right hand and forearm. Respondent ordered an
13 MRI and refilled Patient A's hydrocodone/APAP prescription. Respondent also prescribed
14 gabapentin¹¹ for pain.

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

21 16. From on or about January 22, 2014 through August 5, 2014, Respondent saw Patient
22 A monthly and continued to prescribe hydrocodone/APAP at the same dose. At an office visit on
23 or about January 22, 2014, Patient A reported that she had fallen on her porch on or about January
24 19, 2014, had gone to the hospital, and had received oxycodone.

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

27
28 ¹¹ Gabapentin (Neurontin®) is a nerve pain medication and anticonvulsant and is a dangerous drug pursuant to Business and Professions Code, section 4022.

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

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

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

19 20. On or about November 17, 2014, Patient A requested a muscle relaxant because she
20 was having back spasms at night. Respondent prescribed tizanidine¹³ and refilled Patient A's
21 hydrocodone/APAP prescription.

22 21. On or about December 15, 2014, Patient A reported that she had been to the
23 emergency room multiple times and had tried cyclobenzaprine¹⁴ for her back pain. Respondent
24

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

27 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.

28 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.

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

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

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

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

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

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

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

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

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

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

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

17 32. On or about June 10, 2016, Patient A went to the hospital and reported that
18 hydrocodone/APAP was not helping her knee pain. She requested additional pain medication.
19 Patient A received oxycodone tablets and was told that she needed to get refills from her primary
20 care physician. The records for this hospital visit were faxed to Respondent on or about June 11,
21 2016.

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

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

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

5 35. On or about August 12, 2016, Patient A complained of nausea and vomiting from the
6 morphine, which she eventually stopped. She requested to resume hydrocodone/APAP, but
7 Respondent noted that she had taken it excessively and she "may do better on a more potent
8 opiate." He prescribed Patient A oxycodone/APAP,¹⁵ 10/325 mg, quantity 240, one or two
9 tablets to be taken four times daily. On or about the same day, Patient A filled the
10 oxycodone/APAP prescription and received a 30-day refill after a visit on or about September 12,
11 2016.

12 36. On or about October 4, 2016, Patient A saw Respondent because she had run out of
13 her pain medication. Patient A reported that she had increased her oxycodone/APAP dosage to
14 10 to 12 tablets a day, even though she was not to exceed eight tablets daily. Respondent issued a
15 prescription for 120 tablets of oxycodone, 30 mg, one tablet to be taken every six hours as needed
16 for pain.

17 37. On or about October 19, 2016, Patient A went to the hospital for left hip pain. She
18 said that while getting out of the shower, she heard a pop in her hip. She was given Dilaudid¹⁶ in
19 the emergency room, but left against medical advice. She was also given oxycodone. Records of
20 this hospital visit were faxed to Respondent on or about October 20, 2016.

21 38. On or about October 31, 2016, Patient A told Respondent that she had gone to the
22 hospital and that she had taken more than four oxycodone daily because of her left hip pain.
23 Respondent noted that Patient A was three days early in receiving her pain medication refill, but
24

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

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

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

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

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

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

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

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

25
26 ¹⁷ Oxymorphone ER (Opana®), an opioid analgesic, is a Schedule II controlled substance pursuant
27 to Health and Safety Code, section 11055, subdivision (b), and is a dangerous drug pursuant to Business
28 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.

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

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

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

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

14 48. On or about January 9, 2018, Patient A reported that she had lowered her
15 hydrocodone/APAP dose from eight to six tablets daily. Respondent gave her a prescription for
16 180 hydrocodone/APAP tablets.

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

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

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1 Patient B

2 51. On or about January 26, 2016, Patient B, then a 32-year old man, saw Respondent for
3 opiate and benzodiazepine addiction. Patient B had a history of taking lorazepam¹⁹ and
4 alprazolam,²⁰ and was then currently taking both medications. He also had a history of taking
5 oxycodone/APAP and heroin, which he was also currently using. Respondent prescribed Patient
6 B Suboxone and gave him instructions on how to take the medication. Respondent also
7 prescribed alprazolam, 2 mg, quantity 120, 16 mg daily, and diazepam,²¹ 10 mg, quantity 120, 40
8 mg daily. Respondent also prescribed carbamazepine²² for withdrawal seizures and clonidine²³
9 for anxiety.

10 52. On or about February 17, 2016, Patient B told Respondent he had been taking 7 mg of
11 alprazolam, less than the prescribed dose, and 40 mg of diazepam daily. Despite taking less than
12 or the prescribed dose, Patient B inexplicably reported that he had run out of his benzodiazepines
13 11 days early and had borrowed some of his mother's lorazepam. Respondent refilled Patient B's
14 Suboxone prescription and instructed Patient B to gradually taper his daily alprazolam dose in
15 four weeks from 6.5 mg to 5 mg. Respondent advised Patient B to continue to take 40 mg of
16 diazepam daily. Respondent gave Patient B prescriptions for 81 tablets of alprazolam, 2 mg, and
17 112 tablets of diazepam, 10 mg.

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

22 ¹⁹ Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative, that is a
23 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.

24 ²⁰ Alprazolam (Xanax®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a
25 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.

26 ²¹ Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a
27 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.

28 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.

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

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

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

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

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

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

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

1 60 mg of diazepam and was counseled to follow the tapering schedule he provided. Patient B
2 was given another tapering schedule to reduce his diazepam use from 70 mg to 55 mg daily in
3 four weeks. On or about the same day, Patient B filled prescriptions for 60 tablets of diazepam, 5
4 mg, 105 tablets of diazepam, 10 mg, and Suboxone.

5 60. On or about July 1, 2016, Patient B reported that he had a seizure on or about June
6 20, 2016, after running out of diazepam and was treated at a hospital. Patient B also bought more
7 Suboxone and alprazolam, taking approximately 4 mg daily. Patient B took a urine drug screen
8 which was positive for buprenorphine, tricyclic antidepressants, benzodiazepines, amphetamines,
9 opiates, and methamphetamine. When questioned by Respondent, Patient B denied knowledge of
10 taking opiates or methamphetamine, but said he bought some pills. Respondent counseled Patient
11 B on following the prescribed treatment. Respondent gave Patient B another schedule to reduce
12 his diazepam from 55 mg to 42.5 mg daily in four weeks, and was given another prescription for
13 Suboxone. On or about the same day, Patient B filled prescriptions for diazepam, 5 mg, quantity
14 60, diazepam 10 mg, quantity 105, and Suboxone.

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

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

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

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

8 **SECOND CAUSE FOR DISCIPLINE**
9 **(Repeated Negligent Acts)**

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

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

- 16 a. Paragraphs 9 through 50, above, are hereby incorporated by reference and
17 re-alleged as if fully set forth herein;
- 18 b. Failing to perform a substance abuse history in a patient with a documented
19 history of substance misuse;
- 20 c. Failing to include objectives for the management of chronic pain while
21 prescribing high doses of opioids;
- 22 d. Failing to provide information regarding the risks of polypharmacy and
23 sedating medications or to obtain informed consent; and
- 24 e. Failing to document a clear medication list and excessively cutting and
25 pasting prior medical records.

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

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

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

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

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

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

12 Patient C

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 84. On or about March 5, 2016, Patient C filled prescriptions for 14 tablets of diazepam,
22 2 mg, and 102 tablets of diazepam, 10 mg.

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

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

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

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

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

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

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

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

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

18 **FOURTH CAUSE FOR DISCIPLINE**
19 **(General Unprofessional Conduct)**

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

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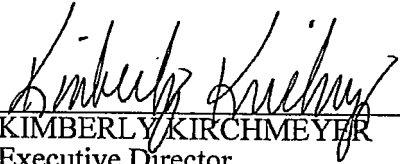
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PRAYER

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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