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

In the Matter of the Accusation Against **Henry Bert Starkes, Jr., M.D.** **Physician's and Surgeon's Certificate No. G 31686** **Respondent.**	**Case No. 800-2017-029210**

DECISION

The attached Stipulated Surrender of License and 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 NOV 30 2020 **.**

IT IS SO ORDERED NOV 23 2020 **.**

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
SARAH J. JACOBS
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **HENRY BERT STARKES, JR., M.D.** **9914 Jetmar Way** **Elk Grove, CA 95624** **Physician's and Surgeon's Certificate No. G 31686** Respondent.	Case No. 800-2017-029210 OAH No. 2020050588 **STIPULATED SURRENDER OF LICENSE AND ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Surrender and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Sarah J. Jacobs, Deputy Attorney General.

2. Henry Bert Starkes, Jr., M.D. (Respondent) is represented in this proceeding by attorney Dominique A. Pollara, whose address is: 100 Howe Avenue, Suite 165N, Sacramento, CA 95825.

3. On or about May 7, 1976, the Board issued Physician's and Surgeon's Certificate No. G 31686 to Henry Bert Starkes, Jr., 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. 800-2017-029210 and will expire on October 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-029210 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 December 31, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-029210 is attached as Exhibit A and is incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-029210. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

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CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-029210, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

10. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G 31686, all of the charges and allegations contained in Accusation No. 800-2017-029210 shall be deemed true, correct and fully admitted by Respondent for purposes of that reinstatement proceeding or any other licensing proceeding involving respondent in the State of California.

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

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 31686 without further notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his

consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 31686, issued to Respondent Henry Bert Starkes, Jr., M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-029210 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2017-029210 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 11/4/2020

HENRY BERT STARKES, JR., M.D.
Respondent

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

DATED: 11/4/2020

DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: 11-9-2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

SARAH J. JACOBS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-029210

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **HENRY BERT STARKES, JR., M.D.** **9914 Jetmar Way** **Elk Grove, CA 95624** **Physician's and Surgeon's Certificate No. G31686,** Respondent.	Case No. 800-2017-029210 **A C C U S A T I O N**

PARTIES

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

2. On or about May 7, 1976, the Board issued Physician's and Surgeon's Certificate No. G31686 to Henry Bert Starkes, Jr., M.D. (Respondent). Physician's and Surgeon's Certificate No. G31686 was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2020, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states, 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 2228.1 of the Code states, in pertinent part:

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:
> (1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:
> ...
> (D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.
> (2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.
> (b) A licensee is required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

6. 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:

...

(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.

...

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."

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FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G31686 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, C, and D,[1] as more particularly alleged hereafter:

Patient A

9. On or about September 19, 2018, Respondent gave a summary of Patient A's treatment and care to Board investigators. Respondent stated that Patient A had a history of recurrent falls associated with severe trauma and a history of bipolar disorder. He also said that Patient A had long-term, chronic shoulder pain. Patient A complained of lower back pain and an abdominal mass, both conditions that Respondent thought were made up. He also said that Patient A had trigeminal autonomic cephalgia,[2] which he defined as pain in the face.

10. As her primary care physician, Respondent saw Patient A at his clinic approximately every one to three months from March 5, 2014 through September 25, 2017. Respondent's documented assessments for Patient A during this time period included the following: (1) joint pain; (2) shoulder joint pain; (3) supraspinatus[3] pain; (4) chronic pain; (5) anxiety, including Generalized Anxiety Disorder; (6) chronic pain due to trauma; (7) opioid dependence; (8) low back pain; intra-abdominal pelvic swelling; (9) tumors in the uterus; and (10) other spondylosis with myelopathy in the cervical region.

11. From on or about March 5, 2014 through September 25, 2017, Respondent generally treated Patient A's ailments by prescribing a combination of medications including Norco,[4]

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

[2] Trigeminal autonomic cephalgia is a type of headache where the pain occurs on one side of the head in the trigeminal nerve area and symptoms in autonomic systems on the same side.

[3] The supraspinatus is one of four rotator cuff muscles.

[4] Norco is the brand name for hydrocodone and acetaminophen. Effective October 6, 2014, Hydrocodone was rescheduled from Schedule III to a Schedule II controlled substance.

Soma,[5] and Klonopin.[6] Respondent prescribed these medications in fluctuating dosages without adequate documentation justifying or explaining the reasons for the changes. On almost a monthly basis, Respondent gave Patient A prescriptions for approximately 120 to 240 tablets of Norco, 90 to 120 tablets of Soma, and 60 tablets of Klonopin. Respondent failed to develop or document a treatment plan that would include tapering Patient A off these medications.

12. Respondent's progress notes documenting his treatment of Patient A were sparsely detailed. These notes often lacked documentation detailing Patient A's chief complaint, the medical conditions that were causing Patient A's pain, and any supporting symptoms for any assessments. Respondent often documented normal physical exams that contradicted his assessments and diagnoses. Respondent did not document any discussions he might have had with Patient A about her chronic, long-term use of opioids and benzodiazepines. Lastly, Respondent did little to no documented monitoring to ensure that Patient A was taking her medications as prescribed.

13. The following examples support the deficiencies raised in paragraphs 9 through 12, above:

14. On or about January 2, 2014, Patient A, then a sixty-two-year old woman, saw a nurse practitioner who worked at the same clinic as Respondent. On this date, Patient A had run out of her Norco medication a week prior. Patient A also reported pain from a recent left shoulder injury due to a fall. The nurse practitioner assessed Patient A with chronic pain due to trauma and opioid dependence, and gave her a month's prescription for Norco, 10-500 milligrams (mg), with four refills. The nurse practitioner documented that he confronted Patient A about her Norco use, which exceeded 240 tablets a month, or eight tablets per day. The nurse practitioner recommended that Patient A talk to Respondent about her opiate use and suggested that she switch to Suboxone.[7] On or about January 3, 2014, Patient A filled a prescription for 180 tablets of Norco.

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[5] Soma, brand name for carisoprodol, is a muscle relaxant.

[6] Klonopin, brand name for clonazepam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[7] Suboxone, brand name for buprenorphine and naloxone, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e).

15. On or about January 20, 2014, Patient A returned to the clinic and saw a physician other than Respondent. The physician, who had previously treated Patient A for bronchitis, discussed a plan to taper Patient A's pain medications in the future, and suggested methadone[8] as a substitute treatment.

16. On or about January 29, 2014, Patient A filled a prescription for 60 tablets of Norco, written by Respondent. On or about February 1, 2014, Patient A filled a prescription for 120 tablets of Norco, written by Respondent.

17. On or about February 28, 2014, Patient A called the clinic and requested a prescription to obtain additional Norco. Patient A complained that she normally received 180 tablets but only received 120 for her last refill. Respondent gave Patient A a prescription for 10 additional tablets.

18. On or about March 5, 2014, Patient A returned to the clinic and saw Respondent. Respondent documented a physical exam with no remarkable findings. He assessed Patient A with chronic pain syndrome, and gave her refills for Norco, Soma, and Klonopin. In his progress note for this visit, Respondent did not document where Patient A was experiencing chronic pain, nor did he document any acknowledgment or reference to the two prior practitioners' recommendations to taper Patient A's medications.

19. On or about July 22, 2014, Patient A returned to the clinic and saw Respondent to discuss her medications and chronic pain syndrome. Respondent documented a physical exam, noting pain in the supraspinatus. He assessed Patient A with joint pain, refilled Patient A's medications, and ordered a CT scan of the shoulder. Respondent failed to document any discussion with Patient A about her medications or more detail about Patient A's joint pain, other than noting a previous left shoulder injury in the medical history portion of the note.

20. On or about October 7, 2014, Patient A returned to the clinic and saw Respondent for medication refills. Patient A reported she was recovering from a root canal. Respondent documented a physical exam with no remarkable findings. He refilled Patient A's Norco, Soma,

[8] Methadone is used to treat moderate to severe pain or narcotic addiction. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

and Klonopin prescriptions and ordered labs. There was no follow up on the shoulder CT scan that was ordered at the July 22, 2014 visit.

21. On or about October 20, 2014, Patient A filled a prescription for 120 tablets of Soma, written by Respondent. Respondent failed to document the reasons for increasing Patient A's monthly Soma prescription from 90 to 120 tablets.

22. On or about November 12, 2014, Patient A submitted to a drug screen ordered by Respondent. The sample tested positive for Norco, Soma, and Klonopin.

23. On or about November 20, 2014, Patient A returned to the clinic and saw Respondent. Patient A told Respondent that she had stopped taking all her medications. Respondent documented a physical exam with no remarkable findings, but wrote that Patient A had joint and left shoulder pain. He documented that he gave Patient A a prescription for 120 tablets of Norco. According to pharmacy and California's Controlled Substances Utilization and Evaluation System (CURES) records, Patient A filled a prescription for 180 tablets of Norco on or about that same day.

24. On or about December 22, 2014, Patient A appeared at the clinic as a walk-in patient. She had a scheduled appointment for that morning which she missed for flu-like symptoms. Patient A came to the clinic later on because she needed medication refills. Respondent examined Patient A, and documented a physical exam with no remarkable findings. He assessed Patient A with anxiety and gave her a prescription for 150 tablets of Norco, with no explanation for the change in dose. Patient A filled that prescription on or about December 23, 2014.

25. On or about January 23, 2015, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings, and made no notes on the efficacy of Patient A's medications. He gave Patient A a prescription for 180 tablets of Norco, which Patient A filled on or about the same day. No justification for decreasing and increasing Patient A's Norco dose was documented in the medical records.

26. On or about March 5, 2015, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His

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assessment of Patient A was chronic pain and anxiety, although no related symptoms were noted. Respondent refilled Patient A's Norco and Soma prescriptions.

27. On or about April 8, 2015, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. Despite the normal exam, Respondent assessed Patient A with joint and shoulder pain, and he gave Patient A a prescription for 180 tablets of Norco.

28. On or about May 6, 2015, Patient A returned to the clinic and saw Respondent for a possible urinary tract infection (UTI). Respondent documented a physical exam with no remarkable findings. His assessment listed generalized anxiety disorder (GAD) and spasm, despite no documented symptoms associated with either condition. Without ordering a urinalysis, Respondent prescribed an antibiotic, presumably for the UTI, and Soma and Norco refills. In his progress note, Respondent erroneously documented the antibiotic prescription as part of the treatment for Patient A's GAD.

29. On or about July 6, 2015, Patient A returned to the clinic and saw Respondent to reevaluate her back and shoulder pain. Respondent documented a physical exam with no remarkable findings. Respondent's assessment of Patient A included lumbar sprain and strain and lumbar spinal cord injury. Respondent failed to document any symptoms or work up justifying these diagnoses. He gave Patient A prescriptions for Norco and Soma and ordered a referral for an orthopedist.

30. On or about August 5, 2015, Patient A returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented a physical exam with no remarkable findings. Respondent's assessment of Patient A included joint pain in the shoulder. Respondent failed to document any symptoms justifying this diagnosis. No medication refills were documented.

31. On or about August 17, 2015, Patient A returned to the clinic and saw a physician other than Respondent. Patient A complained of left shoulder pain and requested pain medications. The physician ordered Kenalog[9] and Toradol[10] injections for Patient A's pain and

[9] Kenalog, brand name for triamcinolone acetonide, is a synthetic corticosteroid used to treat joint conditions in injection-form.

[10] Toradol, brand name for ketorolac, is a nonsteroidal anti-inflammatory drug (NSAID).

ordered referrals for orthopedic surgery, pain medicine, and acupuncture.

32. On or about September 2, 2015, Patient A returned to the clinic and saw Respondent. Patient A complained of left ear pain and the inability to walk long distances. Respondent documented a physical exam with no remarkable findings. He gave Patient A prescriptions for Norco and Soma.

33. On or about September 23, 2015, x-rays were taken of Patient A's left scapula and shoulder. No abnormalities or fractures were found.

34. On or about October 7, 2015, Patient A returned to the clinic and saw Respondent to follow up on her chronic shoulder pain. Respondent documented a physical exam with no remarkable findings and no other descriptions of Patient A's symptoms. He documented that he gave Patient A a prescription for 120 tablets of Norco and a referral to pain medicine for Toradol and Kenalog injections.

35. On or about October 8, 2015, Patient A filled a prescription for 180, not 120, tablets of Norco, written by Respondent.

36. On or about October 22, 2015, Patient A returned to the clinic and saw Respondent. She reported that her Norco tablets had been stolen and that she needed an early refill. Respondent noted that she brought in a police report, and gave her an early refill. On or about the same day, Patient A filled a prescription for 85 tablets of Norco.

37. On or about November 4, 2015, Patient A returned to the clinic and saw another practitioner for a back pain evaluation. The practitioner noted that Patient A's shoulder pain was caused by an old work injury, and that her shoulder was tender to palpitation. He gave Patient A a 14-day supply of Norco and advised her to follow up with Respondent, her primary care provider. On or about November 5, 2015, Patient A filled the prescription written by the practitioner for 60 tablets of Norco.

38. On or about November 18, 2015, Patient A returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented a physical exam with no remarkable findings and failed to provide any description of Patient A's symptoms. He wrote that he refilled Patient A's Norco prescription, but failed to note the quantity of tablets prescribed.

39. On or about November 19, 2015, Patient A filled a prescription for 60 tablets of Norco, written by Respondent.

40. On or about December 2, 2015, Patient A returned to the clinic and saw Respondent with a possible sinus infection, dizziness, aches, and a possible UTI. Respondent documented a physical exam with no remarkable findings. His assessment included a UTI, acute frontal sinusitis, and upper arm joint pain. He prescribed Patient A an antibiotic and 150 tablets of Norco.

41. On or about January 5, 2016, Patient A returned to the clinic and saw another practitioner. Patient A complained of trouble breathing, sinus pressure, and an upper respiratory infection. She also needed a medication refill and a low back evaluation. The practitioner did a physical exam and noted rales at both bases of Patient A's lungs, and that her spine was "nontender to palpation." He gave Patient A prescriptions for Norco and an antibiotic, and made a referral to a pain management specialist.

42. On or about February 2, 2016, Patient A returned to the clinic and saw a nurse practitioner. Patient A complained of sinus pain, cough, and general discomfort. She also told the nurse practitioner that she had run out of her pain medications five days prior because "the doctor said [she] was taking too many and cut [her] down." Patient A last received 120 tablets of Norco on or about January 6, 2016. The nurse practitioner noted that Patient A's last Norco prescription had been written on January 5, 2016, and that Patient A's runny nose could be a symptom of opiate withdrawal syndrome. He ordered x-rays of Patient A's sinuses, which were normal.

43. On or about February 10, 2016, Patient A returned to the clinic and saw Respondent. She reported that she had been dizzy for the past two weeks and needed medication refills. Respondent documented a physical exam with no remarkable findings. Despite this normal exam, Respondent's assessment was for chronic pain due to trauma, opioid type dependence, and lumbago. His assessment also included abdominal or pelvic swelling and tumors of the uterus. No prescriptions were documented in the progress note for this visit.

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44. On or about March 2, 2016, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included chronic pain due to trauma, opioid type dependence, lumbago, abdominal swelling, and upper arm joint pain. He gave Patient A prescriptions for Norco and Soma.

45. On or about April 5, 2016, Patient A returned to the clinic and saw Respondent to discuss physical therapy and pain management. Once again, Respondent documented a physical exam with no remarkable findings. His assessment included chronic pain due to trauma, opioid dependence, low back pain, intra-abdominal tumors, and joint pain. According to his note, Respondent's plan was to treat Patient A's family history of malignant neoplasm with an antibiotic, continue prescribing Norco and Soma, and give Patient A referrals to neurology and physical therapy.

46. On or about May 3, 2016, Patient A returned to the clinic and saw Respondent to reevaluate her back pain and obtain medication refills. Respondent documented a physical exam, noting that Patient A had a paraspinal muscle spasm in her back and tenderness over her lumbar-sacral spine. No follow up was noted regarding the referrals that were given at the last visit. Respondent's assessment included chronic pain due to trauma, opioid dependence, low back pain, intra-abdominal and pelvic swelling, and tumors in the uterus, despite no work up of Patient A's abdominal swelling. Respondent gave Patient A prescriptions for Norco and Soma.

47. On or about June 7, 2016, Patient A returned to the clinic and saw Respondent to follow up on her back pain. Respondent documented a physical exam with no remarkable findings. According to his note, Respondent's plan was to treat Patient A's acute bronchitis by refilling her Norco and Soma prescriptions. He ordered a Toradol/Ketorolac injection. On or about the same day, Patient A filled prescriptions for Norco and Soma.

48. On or about July 5, 2016, Patient A returned to the clinic and saw Respondent for a chronic UTI and medication refills. Respondent documented a physical exam, noting that Patient A had back spasms, cough, and nasal congestion, and that Patient A was complaining of back pain radiating down her left leg. Respondent's assessment of Patient A included a UTI, chronic

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pain due to trauma, and sinusitis. He prescribed an antibiotic and refilled Patient A's Norco and Soma prescriptions.

49. On or about August 2, 2016, Patient A returned to the clinic and saw Respondent for medication refills. Patient A complained of increased back pain. Respondent documented a physical exam, noting back spasms and sacroiliac joint tenderness. His assessment included herpes, opioid dependence, low back pain, intra-abdominal swelling, and joint pain. He prescribed Oxycontin,[11] Norco, and an antibiotic and ordered labs. Respondent failed to document why he was prescribing Oxycontin to Patient A in addition to Norco.

50. On or about August 12, 2016, Patient A called the clinic and said that the Oxycontin prescription was not covered, and that she wanted a prescription for Klonopin. Patient A was told that she could not get a prescription for Klonopin because she was already taking Soma.

51. On or about August 30, 2016, Patient A returned to the clinic and saw Respondent. She complained of ear and shoulder pain and needed medication refills. Respondent noted that Patient A's pain was seven out of 10. Respondent documented a physical exam with no remarkable findings. His assessment for Patient A included herpes, a UTI, sinusitis, chronic pain due to trauma, opioid dependence, low back pain, and joint pain. He prescribed another antibiotic and gave Patient A refills for Norco and Soma.

52. On or about September 28, 2016, Patient A returned to the clinic and saw Respondent. She complained of dizziness and nausea for the past four months. Respondent documented a physical exam with no remarkable findings. He gave Patient A prescriptions for Norco and Klonopin. Respondent failed to document the medical indication for re-prescribing Klonopin, or explain why he increased the daily dose from two to four milligrams.

53. On or about October 25, 2016, Patient A returned to the clinic and saw Respondent. Patient A complained of back pain and depression. Respondent documented a physical exam with no remarkable findings and ordered a urine dip screening which was positive for bacteria. He failed to note Patient A's symptoms relating to depression or Patient A's family history of any

[11] Oxycontin, brand name for oxycodone, is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

depression or mental illness. His assessment included low back pain, sinusitis, and a UTI. He prescribed a month's supply of Lexapro[12] with three refills, an antibiotic, and Lasix.[13] Respondent failed to document any indications for prescribing Lasix. Respondent also refilled Patient A's Norco and Soma prescriptions.

54. On or about November 23, 2016, Patient A returned to the clinic and saw Respondent for her chronic pain syndrome. Respondent documented a physical exam with no remarkable findings. He gave Patient A a refill for Norco.

55. On or about December 27, 2016, Patient A returned to the clinic and saw Respondent. Respondent documented a physical exam, noting back spasms and sacroiliac joint tenderness. His assessment included chronic pain due to trauma, low back pain, opioid dependence, intra-abdominal swelling, and joint pain. He refilled Patient A's Norco and Klonopin prescriptions.

56. On or about January 24, 2017, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam, noting back spasms and sacroiliac joint tenderness. His assessment was that Patient A had opioid dependence. He refilled Patient A's Soma and Norco prescriptions.

57. On or about February 27, 2017, Patient A returned to the clinic and saw Respondent. Patient A reported that she had fallen and had pelvic strain. She also requested medication refills. Respondent documented a physical exam, noting that Patient A had pain in the left pubic ramus area and the inguinal ligament area. He refilled Patient A's Norco and Soma prescriptions.

58. On or about February 27, 2017, x-rays were taken of Patient A's pelvis. Small surgical clips were noted in the left groin region, but no acute findings were reported.

59. On or about February 27, 2017, Patient A filled a prescription for 120 tablets of Soma.

60. Days later, on or about March 1, 2017, Patient A filled prescriptions for 120 tablets of Norco and another 120 tablets of Soma.

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[12] Lexapro, brand name for escitalopram, is an anti-depressant.

[13] Lasix, brand name for furosemide, is a diuretic used to treat fluid retention among other medical conditions.

61. On or about March 27, 2017, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included low back pain and joint pain, and he refilled Patient A's Norco and Soma medications.

62. On or about April 19, 2017, Patient A returned to the clinic and saw Respondent for medication refills. Patient A complained that her pain intensity was 10 out of 10. Respondent documented a physical exam, noting that Patient A had back spasms on the left and tenderness in her lumbar-sacral spine. He gave Patient A refills for Norco and Soma.

63. On or about May 1, 2017, Patient A returned to the clinic and saw a physician other than Respondent for medication refills. Patient A also complained of sleep disturbance and wanted a prescription for Ambien.[14] The physician gave Patient A prescriptions for Norco and Ambien.

64. On or about May 15, 2017, Patient A returned to the clinic and saw a nurse practitioner. She complained of right arm pain and lower back pain after falling eight days prior. Patient A reported that she had been taking more Norco and Soma because of the pain. The nurse practitioner ordered x-rays of Patient A's spine and a referral for physical therapy, ordered a Toradol and Ketorolac injection, and gave Patient A a prescription for 10 tablets of Klonopin. The nurse practitioner told Patient A to follow up with her primary care provider, and advised her to stretch and use heating pads.

65. On or about May 17, 2017, x-rays were taken of Patient A's lumbar spine. No acute fractures were found, although moderate lumbar dextroscoliosis and moderate to severe right sided neural foraminal narrowing at L4 and L5 were noted.

66. On or about May 24, 2017, Patient A returned to the clinic and saw Respondent to follow up on her fall. Respondent documented a physical exam with no remarkable findings. He refilled Patient A's Norco and Soma prescriptions.

[14] Ambien, brand name for zolpidem tartrate, is a sedative-hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

67. On or about June 7, 2017, Patient A returned to the clinic and saw another practitioner. Patient A was complaining of injuries relating to her fall, specifically pain and numbness in her left shoulder and arm. The practitioner documented a physical exam with more detailed findings of Patient A's pain. The practitioner also noted that Patient A had repeatedly requested a prescription for Ativan.[15] The practitioner also reviewed scans of Patient A's spine which showed degenerative changes at C5. He diagnosed Patient A with spondylosis with myelopathy, and ordered additional cervical spine imaging. He also ordered a Kenalog injection.

68. On or about June 7, 2017, x-rays were taken of Patient A's cervical spine. No acute findings were reported.

69. On or about June 26, 2017, Patient A returned to the clinic and saw Respondent. Patient A was complaining of chronic pain and insomnia. Respondent documented a physical exam with no remarkable findings. His assessment included pain due to trauma, opioid dependence, and low back pain. His plan was to stop Lyrica[16] and give refills for Norco and other medications. Patient A's medical records never reference any prescription given to Patient A for Lyrica. In direct contradiction to the medical records, pharmacy records from Walgreens show that Respondent wrote Patient A a prescription for Lyrica on this visit date.

70. On or about June 29, 2017, Patient A was given a prescription for Neurontin[17] with three refills. It is not clear from the medical records if Respondent was the prescriber.

71. On or about July 15, 2017, Patient A returned to the clinic and saw a nurse practitioner. Patient A complained of bilateral shoulder pain which ranged from eight to 10 out of 10. Patient A also told the nurse practitioner that she had not had any Klonopin for three months. Respondent never documented that he was discontinuing Klonopin, and the last documented Klonopin prescription was given to Patient A on or about December 27, 2016. The nurse practitioner noted shoulder tenderness and painful range of motion. Patient A received a Kenalog injection, and the nurse practitioner's plan was for Patient A to continue taking Neurontin and

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[15] Ativan, brand name for lorazepam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[16] Lyrica, brand name for pregabalin, is a nerve pain medication.

[17] Neurontin, brand name for gabapentin, is a nerve pain medication.

consult with a chronic pain specialist. The nurse practitioner noted that Patient A needed to take her medications as prescribed, and that Patient A needed to consult with a therapist to improve her coping skills to deal with chronic pain.

72. On or about July 25, 2017, Patient A returned to the clinic and saw another practitioner to request an orthopedic referral. The practitioner reviewed Patient A's cervical and lumbar x-ray scans.

73. On or about July 26, 2017, Patient A returned to the clinic and saw Respondent. Patient A complained of migraines for four days and chronic shortness of breath. She also needed medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included chronic back pain, low back pain, and acute bronchitis. He gave Patient A a refill for Norco and an antibiotic prescription.

74. On or about August 14, 2017, Patient A returned to the clinic and saw a nurse practitioner. Patient A told the nurse practitioner that she had fallen in May and had previously been treated with a Kenalog injection. She also told the nurse practitioner that her heart raced at night and that she had insomnia. She told the nurse practitioner that she had been taken off Klonopin and Soma by Respondent. The nurse practitioner did a physical exam and documented that Patient A had a slow and irregular heartbeat with no murmur. He assessed Patient A with cardiac arrhythmia, insomnia, and a sinus infection. He ordered an electrocardiogram (EKG), an antibiotic, and Silenor[18] for insomnia.

75. On or about August 22, 2017, in a cardiopulmonary report, it was noted that Patient A reported that she had consumed wine while taking her medication and had driven herself to the hospital.

76. On or about August 25, 2017, Patient A returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. Respondent failed to document any discussion with Patient A about the report that she had been drinking. He refilled Patient A's Norco prescription.

[18] Silenor, brand name for doxepin, is a nerve pain medication and anti-depressant.

77. On or about September 25, 2017, Patient A returned to the clinic and saw Respondent. She complained of a headache and chronic pain in her lower abdomen. Respondent documented a physical exam with no remarkable findings. His diagnoses for Patient A included trigeminal autonomic cephalgia and cystitis. Respondent gave Patient A a refill for Norco.

78. Respondent has committed gross negligence in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent failed to adequately document Patient A's medical conditions and any related work up alleged to be the cause of Patient A's pain;

b. Despite believing that Patient A's lower back pain was fake, Respondent continued to prescribe controlled substances to Patient A for a long period of time and failed to document any discussion with Patient A about her dependence on controlled substances;

c. Respondent failed to properly document his findings and assessment for cervical spondylosis when the medical records give conflicting reports regarding this diagnosis;

d. Respondent failed to adequately document any information regarding Patient A's specialty consultations while he was managing Patient A's related conditions on an ongoing basis;

e. Respondent failed to adequately document Patient A's history and physical findings with regard to Patient A's chronic shoulder pain to justify referrals to specialists or continued opioid prescribing;

f. Respondent prescribed benzodiazepines to Patient A and failed to adequately document related symptoms, history, or treatment goals, and failed to adequately document the reasons for discontinuing benzodiazepines and restarting them later at a higher dose;

g. Respondent prescribed Soma without any documented discussion regarding the indications for the medication, alternatives, counseling, warnings, plan to

taper or any ongoing treatment updates or goals based on Patient A's history, symptoms, or physical findings;

h. Respondent failed to document the current status of Patient A's symptoms, treatment efficacy, or any discussion about plans to wean or taper the medications, ignoring other providers' chart notes of their concerns;

i. Respondent failed to adequately document any treatment goals or plans for Patient A;

j. Respondent failed to adequately document any reassessment of pain treatment goals, non-opioid alternatives to treatment, checking CURES, use of a pain contract, or periodic urine drug screening;

k. Respondent prescribed Oxycontin and Norco in the same visit without any explanation or justification;

l. Respondent prescribed and discontinued Lyrica to Patient A without any documentation of any discussion of indication, risks, and overall plan of care;

m. Respondent prescribed Neurontin to Patient A and failed to adequately document the indications for doing so;

n. Respondent started prescribing controlled substances to Patient A for two months while she was still an unknown patient to him, having seen a nurse practitioner for her initial visit;

o. Respondent failed to adequately document a discussion or attempt to wean Patient A off her medications, despite the fact that weaning was discussed with Patient A at her initial visit;

p. Respondent repeatedly prescribed overlapping prescriptions of controlled substances with refills without documented reasons;

q. Respondent failed to properly document associated symptoms with his anxiety diagnosis during a visit on or about December 22, 2014, which did not match Patient A's complaints, documented history, or any treatment plan;

r. Respondent concluded that Patient A's abdominal mass was not real without performing an appropriate investigation or ordering the appropriate studies;

s. Respondent failed to document accurate medical records in that the chief complaint, history of present illness, assessment, and plan often did not correlate in his progress notes; and

t. Respondent prescribed an anti-depressant and diuretic at a visit on or about October 25, 2016, without listing relevant symptoms, indications and/or history.

Patient B

79. On or about September 19, 2018, Respondent gave a summary of Patient B's treatment and care to Board investigators. Respondent stated that Patient B had a history of gastroesophageal reflux disease (GERD), hemorrhoids, insomnia, asthma, supraumbilical hernias, and pain. Respondent told investigators that Patient B previously had surgery at another health care facility for pseudomyxomatous peritonei[19] and a hernia repair. Respondent did not know when these surgeries were done, nor did he document these surgeries or conditions in Patient B's medical records. He acknowledged that he never tried to obtain Patient B's prior treatment records. Respondent said that Patient B's pain was caused by abdominal pain, a ventral hernia, and cervical degenerative disc disease.

80. As her primary care physician, Respondent saw Patient B at the clinic approximately every one to three months from January 15, 2014 through October 3, 2017. Respondent's documented assessments for Patient B during this time period included the following: (1) rectal bleeding; (2) chronic pain syndrome; (3) lumbosacral spondylosis without myelopathy; (4) anxiety; (5) carpal tunnel syndrome; (6) joint pain; (7) insomnia; (8) sacroiliitis[20]; and (9) cervicalgia.[21] Respondent treated Patient B's ailments by prescribing a combination of Norco, Soma, Klonopin or Ativan, and Ambien. Respondent told Board investigators he prescribed

[19] Pseudomyxomatous peritonei is a rare malignant growth characterized by the progressive accumulation of mucus-secreting tumor cells within the abdomen and pelvis.

[20] Sacroiliitis is the inflammation of one or both of the sacroiliac joints, located at the connection of the lower spine and pelvis.

[21] Cervicalgia is a type of injury that occurs in the neck and/or shoulders.

Ativan to Patient B for nervousness, and Ambien for insomnia. On almost a monthly basis, Respondent gave Patient B prescriptions for approximately 120 to 180 tablets of Norco, 90 to 120 tablets of Soma, 30 tablets of Ambien, and varying doses of Klonopin or Ativan.

81. Respondent's progress notes documenting his treatment of Patient B were sparsely detailed. These notes often lacked documentation detailing Patient B's chief complaint, the medical conditions that were causing Patient B's pain, and any supporting symptoms for any assessments. Respondent often documented normal physical exams that contradicted his assessments and diagnoses. Respondent did not document any discussions he might have had with Patient B about her chronic, long-term use of opioids and benzodiazepines. Lastly, Respondent did little to no documented monitoring to ensure that Patient B was taking her medications as prescribed.

82. The following examples support the deficiencies raised in paragraphs 79 through 81, above:

83. On or about January 15, 2014, Patient B, then a thirty-six-year old female, saw Respondent to establish care and receive medication refills. Patient B complained of rectal bleeding, possibly from hemorrhoids. Respondent documented a physical exam with no remarkable findings. Patient B's current medications included Norco, Ambien, Claritin, and Nexium. The progress note for this visit fails to document the indication for Patient B's Norco's use. Respondent's assessment included an anal and rectal polyp, anal or rectal pain, and abdominal pain. Respondent prescribed Norco and Ambien with refills, and Naprosyn.[22] On or about the same day, Patient B filled prescriptions for 120 tablets of Norco, 10-325 mg, and Ambien.

84. From on or about February 4, 2014 through March 4, 2014, Patient B was treated by other treatment providers for epigastric pain and underwent a colonoscopy.

85. On or about May 15, 2014, Patient B returned to the clinic and saw Respondent. Patient B needed medication refills and complained of a lump on the side of her neck and bilateral leg pain. Respondent documented a physical exam, finding a seven-millimeter mass on the left

[22] Naprosyn, brand name for naproxen, is a non-steroidal anti-inflammatory medication.

side of Patient B's neck, left heel pain, and right calf tenderness. Respondent's assessment included chronic neck pain and joint pain in the ankle, foot, and lower leg. He ordered x-rays of Patient B's left foot, an ultrasound of Patient B's leg, and other labs. He requested a referral to dermatology for Patient B's neck mass. Lastly, he gave Patient B prescriptions for Norco, Ambien, and Ativan, among other medications. Respondent failed to document the reasons for starting Patient B on Ativan. On or about the same day, Patient B filled prescriptions for Ambien and 30 tablets of 0.5 mg Ativan.

86. From on or about June 13, 2014 through August 12, 2014, Patient B continued to fill prescriptions for Norco, Ambien, and Ativan, written by Respondent.

87. On or about August 28, 2014, Patient B returned to the clinic and saw Respondent for medication refills. Patient B complained of a skin lesion on her left lower leg. Respondent documented a physical exam with no remarkable findings, other than noting facial acne. Respondent's assessment included chronic pain syndrome, lumbosacral spondylosis without myelopathy, anxiety, acne, and a soft tissue mass on the left lower leg. Respondent's progress note fails to indicate the evidence supporting the chronic pain syndrome, lumbosacral spondylosis, and anxiety diagnoses. He refilled Patient B's prescriptions for Norco, Ambien, and Ativan, and treated the leg lesion with cryotherapy. On or about the same day, Patient B filled prescriptions for 120 tablets of Norco, 60 tablets of 1 mg Ativan, and Ambien. Respondent failed to document the reasons why Patient B's Ativan dose was increased from 0.5 mg to two mg daily.

88. On or about August 28, 2014, x-rays were taken of Patient B's left foot which showed probable plantar subluxation of the second proximal interphalangeal joint.

89. On or about September 23, 2014, Patient B returned to the clinic and saw Respondent to follow up on her foot x-rays. Respondent's assessment included degeneration of the intervertebral disc,[23] lipoma, deformity of orbit due to trauma or surgery, and bilateral deformities in the feet. Respondent failed to document where the lipoma was and give more detail about the deformity of orbit. His plan was to order a CT scan of Patient B's foot and to follow up in four weeks.

[23] The intervertebral disc is located in the spine.

90. On or about November 19, 2014, Patient B called the clinic and requested a referral to a specialist for her feet. She also complained of carpal tunnel pain in both of her hands.

91. On or about December 8, 2014, Patient B returned to the clinic and saw Respondent for medication refills. Patient B complained of chronic left foot pain and bilateral arm pain due to carpal tunnel syndrome. Respondent's assessment included carpal tunnel, chronic pain, and joint pain in the lower leg. He documented that Patient B was given prescriptions for 180 tablets of Norco and Ambien with three refills. No reasons were documented for increasing Patient B's Norco dose.

92. On or about December 8, 2014, Patient B filled prescriptions for 120, not 180, tablets of Norco and Ambien, written by Respondent.

93. On or about February 5, 2015, Patient B returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam, noting that Patient B's back was tender to palpation over the lumbar-sacral spine and muscle spasm. His assessment included insomnia, sacroiliitis, and sprain and strain of the sacroiliac ligament. He refilled Patient B's Ativan and Ambien tablets, and prescribed 180 tablets of Norco. Again, no reasons were documented for increasing Patient B's Norco dose.

94. On or about March 5, 2015, Patient B returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included generalized muscle weakness, joint pain in multiple sites, and cervicalgia. He ordered x-rays of Patient B's cervical spine and gave medication refills. On or about the same day, Patient B filled a prescription for 120 tablets of Norco. No reasons were documented for decreasing Patient B's Norco dose.

95. On or about April 2, 2015, Patient B returned to the clinic and saw Respondent for medication refills and the x-ray results. Under the history of present illness section of the note, Respondent noted that Patient B had back pain for years and pain when bending over. His assessment included sacroiliac region sprain and strain. He gave Patient B refills for Norco and Ambien.

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96. On or about April 2, 2015, the results of the CT scan were reported. The radiologist noted degenerative findings, specifically multilevel spondylotic endplate changes.

97. On or about April 30, 2015, Patient B returned to the clinic and saw Respondent. Respondent's note documents that Patient B also wanted a CT scan of her "cervical," and that she complained of neck pain. Respondent documented a physical exam with no remarkable findings. His assessment included chest pain, cervicalgia, and chronic back pain. Respondent did not document a review of the prior CT findings from the previous visit. Respondent ordered another CT of Patient B's cervical spine and an x-ray of Patient B's lumbosacral spine. He refilled Patient B's prescriptions for Norco, Ativan, and Ambien.

98. On or about May 11, 2015, the results of the CT scan of Patient B's cervical spine were reported. Degenerative changes were noted with osteophytic protrusion at C5 to C6 and C6 to C7.

99. On or about May 28, 2015, Patient B returned to the clinic and saw Respondent to follow up on the CT scan. Noting the findings, Respondent's assessment included cervicalgia and outlet flow syndrome.[24] He ordered a referral to neurology for Patient B's neck pain and refilled Patient B's Norco, Ativan, and Ambien prescriptions.

100. On or about June 25, 2015, Patient B returned to the clinic and saw Respondent. Respondent documented a physical exam with no remarkable findings. His assessment included sacroiliitis, degeneration of the lumbar or lumbosacral intervertebral disc, and sciatica.[25] His plan was for Patient B to continue taking Norco and Ambien.

101. On or about July 23, 2015, Patient B returned to the clinic and saw Respondent. Respondent referenced the last cervical x-ray which noted degenerative changes. Respondent also documented a physical exam, noting a supple neck, full range of motion, no cervical lymphadenopathy, but tenderness at C5, C6, and C7. Respondent's assessment included cervicalgia, degeneration of the intervertebral disc, and degeneration of the cervical intervertebral

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[24] Thoracic outlet syndrome occurs when there is compression, injury, or irritation of the nerves and/or blood vessels in the lower neck and upper chest area.

[25] Sciatica is pain in the back that may run down the legs caused by a problem with the sciatic nerve.

disc. Respondent ordered another referral to neurology for neck pain and pain and tingling in the hands and arms. In the progress note, Respondent wrote that he gave Patient B prescriptions for 120 tablets of Norco and Ativan. On or about the same day, Patient B filled prescriptions for 180 tablets of Norco, Ativan, and Ambien.

102. On or about August 19, 2015, Patient B returned to the clinic and saw Respondent to reevaluate her neck pain and arm numbness. Patient B reported that she had an appointment with neurology in two days. Respondent's assessment included cervicalgia, anxiety disorder, insomnia, and dermatitis. Respondent failed to document any symptoms associated with anxiety disorder, insomnia, and dermatitis.

103. On or about October 5, 2015, Patient B returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented a physical exam with no remarkable findings. His assessment was intervertebral disc degeneration and sacroiliitis. Respondent gave Patient B refills including prescriptions for Norco, Ativan, and Ambien. On or about the same day, Patient B filled a prescription for 120 tablets of Norco.

104. On or about November 11, 2015, Patient B returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included low back pain, and he documented that he gave Patient B a prescription for 120 tablets of Norco at the 5-325 mg dose.

105. On or about November 23, 2015, Patient B filled prescriptions for 120 tablets of Norco at the 10-325 mg dose, 60 tablets of Ativan, and Ambien, written by Respondent.

106. On or about December 14, 2015, Patient B returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented in the history of present illness section of the progress note that Patient B had chronic back pain, a history of rectal bleeding, chronic pain syndrome, chronic anxiety, and reflux. He documented a physical exam, noting paraspinal muscle spasms. His assessment was GERD and malabsorption due to intolerance. He documented that he gave Patient B prescriptions for Norco at the 5-325 mg dose, Ativan, and Ambien, among other medications.

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107. On or about December 23, 2015, Patient B filled prescriptions for 120 tablets of Norco at the 10-325 mg dose, Ativan, and Ambien, written by Respondent.

108. On or about February 11, 2016, Patient B returned to the clinic and saw Respondent to reevaluate her back pain and for medication refills. Respondent documented a physical exam, noting paraspinal muscle spasms. His assessment included reflux esophagitis, hemorrhage of rectum and anus, chronic pain syndrome, anxiety, and chronic back pain. He gave Patient B prescriptions for Norco, Ativan, and Ambien.

109. From on or about March 18, 2016 to July 26, 2016, Patient B returned to the clinic and saw Respondent to receive medication refills which included Norco at the 10-325 mg dose, Ativan, and Ambien. Respondent's assessment remained unchanged.

110. On or about August 24, 2016, Patient B returned to the clinic and saw Respondent for pain management and a new neurology referral. Patient B complained of chronic pain and headaches with blurred vision and sensitivity to light. Respondent documented a physical exam, noting paraspinal muscle spasms and sacroiliac joint tenderness. His assessment included headache, chronic pain syndrome, GERD, other intestinal malabsorption, and anxiety disorder. He ordered an x-ray of Patient B's skull and a referral to neurology for carpal tunnel syndrome. He also gave Patient B prescriptions for Norco, Ativan, and Ambien.

111. On or about September 15, 2016, Patient B returned to the clinic and saw Respondent to follow up on her arms. Patient B complained of chronic pain. Respondent documented a physical exam with no remarkable findings. His assessment included anxiety disorder, intestinal malabsorption, GERD, headache, and chronic pain syndrome. He gave Patient B refills for Norco and Ambien. He noted that Patient B wanted carpal tunnel surgery.

112. On or about October 11, 2016, Patient B returned to the clinic and saw Respondent for pain management and her carpal tunnel symptoms. Respondent noted that Patient B's pain measured at seven out of 10, and that with medication, it was four out of 10. Respondent documented a physical exam with no remarkable findings. His assessment remained unchanged from the last visit. He gave Patient B prescriptions for Norco, Ativan, and Ambien.

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113. On or about November 15, 2016, Patient B returned to the clinic and saw Respondent for pain management and her carpal tunnel symptoms. His assessment included chronic pain syndrome, GERD, intestinal malabsorption, anxiety disorder, and carpal tunnel syndrome. He gave Patient B prescriptions for Norco, Ativan, and Ambien.

114. On or about December 27, 2016, Patient B returned to the clinic and saw Respondent for pain management. Respondent documented a physical exam with no remarkable findings. He noted that Patient B was to see a dietician that day. His assessment included the findings from the previous visit and headache. He ordered a surgical referral for carpal tunnel surgery and gave Patient B prescriptions for Norco and other medications.

115. On or about January 13, 2017, Patient B returned to the clinic and saw Respondent for medication refills, sinus pressure, and a cough. Respondent documented a physical exam with no remarkable findings. His assessment included acute ethmoidal sinusitis, GERD, headache, intestinal malabsorption, anxiety disorder, and acute frontal sinusitis. He gave Patient B prescriptions for Norco, an antibiotic, and other medications.

116. On or about January 26, 2017, Patient B returned to the clinic and saw an orthopedist, who noted that Patient B had an EMG nerve conduction study done by another physician in September which had shown moderate to severe nerve changes in the median nerve of both wrists. The physician who conducted the study recommended splints which had not helped. The orthopedist also noted that he reviewed Patient B's cervical spine x-rays from the prior year, which showed "some degenerative changes of the lower cervical spine, but no frank foraminal stenosis." The orthopedist recommended carpal tunnel release for both hands, starting with the right. Patient B agreed to the surgical procedure.

117. On or about February 24, 2017, Patient B returned to the clinic and saw a physician other than Respondent. Patient B complained of neck and bilateral shoulder pain. The physician performed a physical exam that included a gait analysis. She diagnosed Patient B with cervical disc disorder with radiculopathy and low back pain. She gave Patient B a prescription for Norco. The physician also signed a pain management agreement with Patient B. On or about the same day, Patient B filled a prescription for 120 tablets of Norco.

118. On or about March 3, 2017, Patient B called the clinic and requested a refill for Ativan, which was granted. On or about the same day, Patient B filled a prescription for 60 tablets of Ativan, written by Respondent.

119. On or about March 7, 2017, Patient B returned to the clinic and saw a physician other than Respondent for a preoperative visit. The physician ordered labs and Patient B was to follow up in one week.

120. On or about March 13, 2017, Patient B returned to the clinic and saw Respondent for pain management and medication refills. Respondent documented a physical exam with no remarkable findings, and noted that Patient B's "cts [carpal tunnel surgery] healing well no problems." His assessment included carpal tunnel syndrome, cervical disc disorder with radiculopathy, intestinal malabsorption, and GERD. He gave Patient B prescriptions for Norco, Ativan, and Ambien. Respondent documented that Patient B's Ativan prescription had been decreased to 30 tablets per month, with the plan to discontinue in the next month. On or about the same date, Patient B filled prescriptions for Norco, 30 tablets of Ativan, and Ambien.

121. On or about March 24, 2017, Patient B filled prescriptions for Norco and Ambien, written by Respondent. On or about April 1, 2017, Patient B filled another prescription for 30 tablets of Ativan, written by Respondent.

122. On or about April 11, 2017, Patient B returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included chronic pain syndrome, headache, GERD, intestinal malabsorption, anxiety disorder, carpal tunnel syndrome, cervical disc disorder, and low back pain. He gave Patient B prescriptions for Norco, Ambien, and Ativan, despite his plan to discontinue this medication.

123. On or about April 21, 2017, Patient B filled prescriptions for Norco, Ambien, and 30 tablets of Ativan.

124. On or about May 22, 2017, Patient B returned to the clinic and saw Respondent for medication refills. Patient B complained of shooting pain down her shoulder and to her scapula. Respondent documented a physical exam, noting tenderness to palpation over the lumbar sacral spine and paraspinal spasms. His assessment remained unchanged from the last visit. He gave

Patient B prescriptions for Norco and Ambien. On or about the same day, Patient B filled prescriptions for 120 tablets of Norco and 30 tablets of Ativan.

125. On or about June 7, 2017, Patient B returned to the clinic and saw Respondent for medication refills. Patient B complained of chronic headaches. Respondent documented a physical exam with no remarkable findings. His assessment was the same as the last visit and added migraine. Respondent gave Patient B prescriptions for Norco, Ambien, Imitrex,[26] and promethazine.[27]

126. On or about July 17, 2017, Patient B returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included intestinal malabsorption, carpal tunnel syndrome, cervical disc disorder with radiculopathy, and low back pain. He gave Patient B prescriptions for Norco and Ativan. Respondent failed to document why he restarted Patient B on Ativan after discontinuing the medication. On or about the same day, Patient B filled prescriptions for Norco, Ambien, and 30 tablets of Ativan.

127. On or about August 14, 2017, Patient B returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam, noting paraspinal muscle spasms and tenderness over the lumbar-sacral spine. His assessment included carpal tunnel syndrome, low back pain, GERD, and anxiety disorder. He gave Patient B prescriptions for Norco and Ambien. Respondent reduced Patient B's Ambien prescription from ten to five milligrams daily. On or about the same day, Patient B filled prescriptions for Norco and Ambien.

128. On or about September 13, 2017, Patient B returned to the clinic and saw Respondent. Patient B told Respondent that the Ambien was not working. Respondent documented a physical exam, noting paraspinal muscle spasm and tenderness over the lumbar-sacral spine. His assessment included intestinal malabsorption, anxiety disorder, carpal tunnel syndrome, cervical disc disorder with radiculopathy, and low back pain. He gave Patient B

[26] Imitrex, brand name for sumatriptan, is a migraine medication.
[27] Promethazine is an antiemetic and antihistamine.

prescriptions for Norco and Ambien. On or about the same day, Patient B filled prescriptions for Norco and Ambien.

129. On or about October 3, 2017, Patient B returned to the clinic and saw Respondent to follow up on her back pain. Respondent documented a physical exam, noting paraspinal muscle spasm and tenderness over the lumbar-sacral spine. His assessment was unchanged from the prior visit. He gave Patient B another prescription for Norco and other medications. On or about the same day, Patient B filled prescriptions for Norco and Ambien.

130. Respondent committed gross negligence in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent failed to adequately document Patient B's prior medical history, current complaints, possible abnormal exams, and all current diagnoses when prescribing multiple medications or controlled substances;

b. Respondent failed to adequately document attempts to obtain prior medical records for Patient B, who had a complex medical history and chronic pain issues;

c. Respondent failed to adequately substantiate, treat, and research Patient B's pseudomyxoma peritonei diagnosis;

d. Respondent prescribed a short-acting benzodiazepine to Patient B for a long period of time, then discontinued and restarted Patient B on the medication absent adequate documentation regarding Patient B's symptoms, history, or treatment goals;

e. Respondent started and continued to prescribe Ambien to Patient B for a long period of time absent documentation regarding Patient B's symptoms, history, or treatment goals;

f. Respondent prescribed a combination of Norco, Ativan, and Ambien for a long period of time absent any documentation on Patient B's substance abuse history, current status of symptoms, treatment efficacy, or discussions to taper or reduce the medications;

g. Respondent prescribed short-acting benzodiazepines on a regular and long-term basis to treat a chronic mood disorder without documenting a discussion of alternative treatments;

h. Respondent continued to prescribe controlled substances to Patient B on a regular basis without any documentation of periodic drug screens over several years;

i. Respondent failed to use CURES or other means to check for outside prescribing;

j. Respondent failed to adequately document Patient B's symptoms, history, or exam findings leading to a rectal bleeding diagnosis;

k. Respondent failed to adequately document Patient B's symptoms, history, or exam findings leading to the cervicalgia-outlet flow syndrome diagnosis;

l. Respondent failed to document a proper evaluation and treatment plan for arthritis in Patient B's neck;

m. Respondent failed to document an adequate evaluation and treatment plan for Patient B's skin lesion including detailed physical exam findings;

n. Respondent failed to document an adequate evaluation and treatment plan for Patient B's foot pain; and

o. Respondent failed to document an adequate evaluation and treatment plan for Patient B's hand pain and carpal tunnel syndrome diagnosis.

Patient C

131. On or about September 19, 2018, Respondent gave a summary of Patient C's treatment and care to Board investigators. Respondent stated that Patient C had a history of bronchitis, recurrent pneumonia, asthma, pre-diabetes, muscle pain, and chronic obstructive pulmonary disease (COPD). Patient C also had a history of motor vehicle accidents, which caused hand fractures, a shattered patella in 2011, and a broken left foot. Respondent said that Patient C's pain was caused by the injuries from the motor vehicle accidents and lower back pain.

132. As her primary care physician, Respondent saw Patient C at the clinic approximately every one to three months from February 5, 2013 through October 17, 2016. Respondent's documented assessments for Patient C during this time period included the following: (1) chronic pain syndrome; (2) hypertension; (3) GERD; (4) depression; (5) muscle spasms; (6) insomnia; (7) COPD exacerbation; (8) bronchitis; (9) anxiety disorder; and (10) chronic respiratory failure. Respondent treated Patient C's ailments by prescribing a combination of Norco, Vicodin,[28] Soma, Valium,[29] Klonopin, and Ambien. On almost a monthly basis, Respondent gave Patient C prescriptions for approximately 180 tablets of Norco, 120 tablets of Soma, Ambien, and varying amounts of Valium and/or Ativan and/or Klonopin.

133. Respondent's progress notes documenting his treatment of Patient C were sparsely detailed. These notes often lacked documentation detailing Patient C's chief complaint, the medical conditions causing Patient C's pain, and any supporting symptoms for any assessments. Respondent often documented normal physical exams that contradicted his assessments and diagnoses. Respondent did not document any discussions he might have had with Patient C about her chronic, long-term use of opioids and benzodiazepines. Lastly, Respondent did little to no documented monitoring to ensure that Patient C was taking her medications as prescribed.

134. The following examples support the deficiencies raised in paragraphs 131 through 133, above:

135. On or about February 5, 2013, Respondent saw Patient C, then a thirty-four-year old woman, for medication refills. She was requesting refills for four months because she was going out of town. Respondent's assessment for Patient C was back pain and COPD. He gave Patient C prescriptions for Soma, Lexapro, Valium, Vicodin, Ativan, and Klonopin.

136. On or about April 15, 2013, Patient C returned to the clinic and saw Respondent. Patient C was requesting a change in her medication regimen. Respondent documented Patient C's Soma prescription as 350 mg to be taken three times daily, and 10 mg Valium taken three times daily.

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[28] Vicodin is the brand name for hydrocodone and acetaminophen.

[29] Valium, brand name for diazepam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

137. On or about May 6, 2013, Patient C returned to the clinic and saw Respondent. Respondent appears to have documented a physical exam with no remarkable findings. Respondent's assessment was chronic pain, hypertension, depression, GERD, and muscle spasms. Respondent documented that he gave Patient C three refills on all medications, checked labs for results, and adjusted Patient C's Lexapro dose.

138. On or about July 15, 2013, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. Under assessment, he wrote "chronic back" and wrote "Rx meds" under the plan.

139. On or about August 28, 2013, Patient C returned to the clinic and saw Respondent to discuss her medications and follow up on her "IP stay." Respondent documented a physical exam, noting wheezing and asthma. His assessment was COPD exacerbation, and he gave Patient C prescriptions for Seroquel[30] and DuoNeb[31] treatments.

140. On or about September 24, 2013, Patient C returned to the clinic and saw Respondent. Patient C complained of insomnia. Respondent documented a physical exam with no remarkable findings. He gave Patient C a prescription for Ambien with five refills.

141. On or about October 14, 2013, Patient C returned to the clinic and saw another practitioner for medication refills. This practitioner noted that Patient C had been a former methamphetamine user. He or she documented that Patient C's pain medications were filled, but did not give the medication names.

142. On or about November 26, 2013, Patient C returned to the clinic and saw Respondent for medication refills and to follow up on her COPD. Respondent documented a physical exam, noting respiratory issues. His assessment included chronic back pain. He gave Patient C a prescription for Norco and Spiriva.[32]

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[30] Seroquel, brand name for quetiapine, is an antipsychotic.

[31] DuoNeb, brand name for ipratropium bromide/albuterol, is a combination medication used to treat COPD.

[32] Spiriva, brand name for tiotropium, is a bronchodilator used to prevent bronchospasm and reduce COPD symptoms.

143. On or about December 24, 2013, Patient C returned to the clinic and saw Respondent for a checkup and medication refills. The progress note listed Patient C's current medications which were the following: Saphris,[33] fluoxetine,[34] loratadine, Singulair, Ambien, omerprazole, Norco, Soma, Valium, ProAir, and DuoNeb. Respondent documented a physical exam with no remarkable findings. His assessment listed a depression screening, although the note contains no discussion or description of Patient C's depression symptoms. Respondent gave Patient C prescriptions for fluoxetine, Saphris, loratadine, Singulair, Ambien, omerprazole, Norco, Soma, Valium, ProAir, and DuoNeb.

144. On or about December 30, 2013, Patient C returned to the clinic and saw a nurse practitioner. Patient C was following up at the clinic after spending the previous night in the ER for asthma exacerbation. Patient C reported that she had been given a Solu-Medrol injection and prednisone, and that she was not currently taking an inhaled corticosteroid. The nurse practitioner noted that Patient C had shortness of breath and wheezing. The nurse practitioner also noted that Patient C had been in a car accident in 2011 resulting in a broken left hand, a fractured right hand, a shattered knee cap, and a broken foot. He also noted that Patient C used to be a heroin and methamphetamine user, discontinuing both in 2007. The nurse practitioner documented a physical exam, noting wheezing. He prescribed Patient C a new aerosol solution and advised her to continue with her other medications.

145. On or about January 14, 2014, Patient C returned to the clinic and saw Respondent. According to the progress note from that visit, Patient C wanted to know why she was only receiving 120 tablets of Norco instead of 180. She also complained of vomiting. Respondent did not document a physical exam. He diagnosed Patient C with acute bronchitis and noted that she needed nebulizer therapy. He refilled Patient C's prescriptions, including Norco, Soma, Valium, and Ambien. There are no notes addressing Patient C's concerns about her Norco prescription.

146. On or about March 5, 2014, Patient C returned to the clinic and saw Respondent for medication refills. Patient C also wanted labs to be done and to discuss prednisone with

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[33] Saphris, brand name for asenapine, is an atypical antipsychotic medication.
[34] Fluoxetine, brand name Prozac, is an anti-depressant.

Respondent. Respondent did not document a physical exam. He diagnosed Patient C with asthma and chronic pain syndrome. He refilled Patient C's prescriptions including Norco, Soma, Valium, and Ambien. He also made a referral to orthopedic surgery.

147. On or about March 19, 2014, Patient C returned to the clinic and saw Respondent to ask about lidocaine patches and to follow up on an ER visit. Respondent failed to document any other details of Patient C's ER visit. He documented a physical exam with no remarkable findings. Assessing Patient C with chronic pain syndrome, he gave her a prescription for lidocaine patches.

148. On or about April 8, 2014, Patient C returned to the clinic and saw another physician for an orthopedic consult.

149. On or about April 16, 2014, Patient C returned to the clinic and saw Respondent to follow up on another ER visit. Patient C had gone to the ER for shortness of breath. Respondent documented a physical exam with no remarkable findings. He gave her a prescription for prednisone.

150. On or about April 24, 2014, Patient C returned to the clinic and saw Respondent. Patient C still complained of shortness of breath, wheezing, and allergies. Respondent documented a physical exam, noting rhonchi, diminished breath sounds, and wheezing. He diagnosed Patient C with shortness of breath, asthma, and bronchitis. He ordered labs, and noted that he communicated with the ER and that Patient C was to be transferred there.

151. On or about April 27, 2014, a CT scan of Patient C's chest showed mixed findings, showing haziness in the right costophrenic sulcus.

152. On or about May 27, 2014, Patient C returned to the clinic and saw Respondent for medication refills. Patient C still complained of shortness of breath and wheezing. Respondent noted bilateral wheezing and rales and diagnosed asthma. Patient C was given a nebulizer treatment and a Solu-Medrol injection.

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153. On or about May 29, 2014, Patient C returned to the clinic and saw Respondent to follow up on her shortness of breath. Respondent documented a physical exam with no remarkable findings. He diagnosed asthma and polydipsia.[35] Respondent ordered labs.

154. On or about June 2, 2014, Patient C returned to the clinic and saw Respondent. Patient C complained that she was having trouble breathing and needed oxygen. Patient C was given an oxygen tank. A physical exam showed diminished breath sounds and scattered wheezes. Respondent diagnosed bronchitis, prescribed an antibiotic, and ordered a Solu-Medrol injection.

155. On or about June 9, 2014, Patient C returned to the clinic and saw Respondent. Patient C was going to have surgery on her right knee and needed a preoperative evaluation. Respondent documented a physical exam with no remarkable findings.

156. On or about June 11, 2014, Patient C underwent a right knee arthroscopy, performed by a physician other than Respondent. The physician wanted to do a diagnostic arthroscopy to rule out any internal derangement of the knee and to remove hardware. The physician removed hardware that had been left in Patient C's knee.

157. On or about June 19, 2014, Patient C returned to the clinic and saw Respondent for medication refills. Patient C reported that her medications had been stolen from her home and that a police report was taken. Respondent documented a physical exam with no remarkable findings. He diagnosed Patient C with obstructive chronic bronchitis and gave her prescriptions for Norco, Soma, and Valium.

158. On or about June 25, 2014, Respondent wrote Patient C a prescription for 180 tablets of Norco. Respondent failed to document why he increased Patient C's dose from 120 to 180 tablets.

159. On or about July 10, 2014, Patient C returned to the clinic and saw Respondent for medication refills. According to Respondent's progress note, Patient C's medications "got messed up." Respondent failed to provide any more detail. Respondent did not document a physical exam. He diagnosed Patient C with bronchitis. Respondent ordered a chest x-ray, a

[35] Polydipsia is intense thirst despite drinking plenty of fluids.

Solu-Medrol injection, and gave Patient C prescriptions for 120 tablets of Norco, Valium, and Ambien.

160. On or about July 24, 2014, Patient C returned to the clinic and saw Respondent. Patient C complained of shortness of breath and wanted to discuss her medications. Patient C had been to the ER to be treated for her bronchitis. Respondent documented a physical exam, noting diminished breath sounds and rhonchi in both sides. He diagnosed Patient C with acute bronchitis. He prescribed albuterol and gave Patient C a prescription for 180 tablets of Norco with four refills. Respondent failed to document any assessment of Patient C's chronic pain or indications for increasing her Norco dose.

161. On or about August 29, 2014, Respondent wrote a Norco prescription for Patient C for 180 tablets of Norco.

162. On or about September 24, 2014, Patient C returned to the clinic and saw Respondent for a "follow up consultation re: discontinuation of Soma." Respondent documented a physical exam with no remarkable findings. He diagnosed Patient C with chronic respiratory failure and gave Patient C a prescription for 180 tablets of Norco with four refills and Prozac. On or about the same day, Patient C filled prescriptions for 180 tablets of Norco and 90 tablets of 10 mg Valium. Respondent failed to document in the note whether he was no longer prescribing Soma to Patient C.

163. On or about September 28, 2014, Patient C filled a prescription for 120 tablets of Soma, written by Respondent.

164. On or about October 9, 2014, Patient C returned to the clinic and saw a nurse practitioner. Patient C complained of blurry vision, nausea, and vomiting. The nurse practitioner documented a physical exam with no remarkable findings. The nurse practitioner diagnosed Patient C with chronic respiratory failure and an adrenal gland disorder. The nurse practitioner ordered labs.

165. On or about October 10, 2014, Patient C returned to the clinic and saw a physician other than Respondent. The physician noted that Patient C had been in the ER the day prior, and

that she wanted her lab results. The physician diagnosed Patient C with spinal stenosis, chronic airway obstruction, and asthma.

166. On or about October 29, 2014, Patient C returned to the clinic and saw Respondent for medication refills and lab results. Respondent noted Patient C's recent hospital visit for asthma and shortness of breath, and Patient C's history of irritable bowel syndrome and polyps with rectal bleeding. Respondent documented a physical exam with no remarkable findings. He diagnosed Patient C with gastritis and ordered labs and a CT scan of Patient C's abdomen. He also gave Patient C prescriptions for Norco and Valium. On or about the same day, Patient C filled prescriptions for 180 tablets of Norco and 60 tablets of 5 mg Valium. Respondent failed to document why he reduced Patient C's Valium dose.

167. On or about November 18, 2014, Patient C returned to the clinic and saw Respondent for medication refills and the lab results. Patient C reported that she had fainted twice in the prior two weeks. Respondent documented that the abdomen CT scan was negative. Respondent documented a physical exam with no remarkable findings. He diagnosed Patient C with syncope and collapse. He ordered a brain CT scan, and gave Patient C a prescription for Valium, increasing the dose from 5 mg to 10 mg, and a prescription for Norco. Respondent failed to document why he increased Patient C's Valium dose.

168. On or about November 20, 2014, Patient C called the clinic and said she was very depressed and upset. She came to the clinic and saw a nurse practitioner, as a walk-in. Patient C was crying and feeling overwhelmed. She told the nurse practitioner that she had a head CT scan that day, that she cried every day, and was not taking Saphris as prescribed. Patient C explained that she had the CT scan for blacking out and falling. The nurse practitioner diagnosed Patient C with bipolar disorder and anxiety. The nurse practitioner instructed Patient C to take her medications as prescribed, increased her Prozac dose, and gave her a prescription for 90 tablets of 1 mg Ativan. On or about the same day, Patient C filled the prescription for 90 tablets of Ativan.

169. On or about November 20, 2014, a pharmacist called the clinic, concerned about Patient C's controlled substance prescriptions. The pharmacist wanted to know the diagnoses and rationale for prescribing Ativan to Patient C. The pharmacist reported that Patient C was

instructed to take either Ativan or Valium but not both. The medical records indicate that the pharmacist was told that Patient C had been diagnosed with chronic knee pain, derangement of the knee, and failed knee surgery.

170. On or about November 20, 2014, the head CT scan results were reported as unremarkable.

171. On or about November 24, 2014, Patient C called the clinic and left a message, reporting that her medications were not working and that she was having emotional problems. When a clinic employee called, Patient C reported that her neighbor had given her Klonopin "to get her by." An appointment was made for Patient C to see the behavioral health unit.

172. On or about November 25, 2014, another clinic worker called Patient C, who said she was doing better that day. On or about the same day, Patient C filled a prescription for 180 tablets of Norco, written by Respondent.

173. On or about November 26, 2014, Patient C left a voicemail at the clinic, stating that she was very depressed. Later on the same day, Patient C returned to the clinic and saw a nurse practitioner. Patient C reported that she had an "episode" and had thrown out her Xanax and Valium prescriptions. The nurse practitioner noted that Patient C had dyed her hair purple. The nurse practitioner refused to refill Patient C's Xanax and Valium prescriptions and told Patient C that she must have a psychiatrist or Respondent prescribe them. She gave Patient C a prescription for hydroxyzine.[36]

174. On or about December 9, 2014, Patient C returned to the clinic and saw Respondent for the pap smear results from an earlier visit. Patient C also wanted to discuss her medications. Respondent documented a physical exam with no remarkable findings. His assessment for Patient C was chronic respiratory failure, sacroiliitis, and degeneration of the lumbar or lumbosacral intervertebral disc. His plan was for Patient C to continue using lidocaine patches and refill her other medications including Norco and Ambien. Respondent also ordered a referral to pulmonary diseases. Respondent failed to document any discussion he might have had with

[36] Hydroxyzine is an antihistamine that can be used to treat anxiety.

Patient C about her medications or the psychiatric issues Patient C had experienced. On or about the same day, Patient C filled prescriptions for 180 tablets of Norco and Ambien.

175. On or about December 16, 2014, Patient C filled a prescription for 60 tablets of 10 mg Valium, written by Respondent.

176. On or about December 22, 2014, Patient C returned to the clinic for a follow up of an upper respiratory infection. She wanted a lower back x-ray and the results for her pap smear. Respondent documented a physical exam with no remarkable findings. His assessment included respiratory conditions due to smoke inhalation and lumbosacral root lesions, despite any documentation that would support these diagnoses. Respondent ordered a CT of the dorsal lumbar sacral spine.

177. On or about December 26, 2014, the results of a radiology report showed that Patient C had slight anterolisthesis of L5-S1 with bilateral L5 spondylosis and a mild bulging disc with mild bilateral neural foraminal narrowing.

178. According to CURES, on or about January 9, 2015, Patient C filled a prescription for 20 tablets of 10 mg Valium, written by Respondent. This prescription was not documented in Patient C's medical records.

179. According to CURES, on or about January 17, 2015, Patient C filled another prescription for 60 tablets of 10 mg Valium, written by Respondent. This prescription was also not documented in Patient C's medical records.

180. On or about January 20, 2015, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment of Patient C was chronic respiratory failure, pneumonia due to anaerobes, and lumbosacral root lesions. He gave Patient C a prescription for Norco and ordered a referral to orthopedic surgery and x-rays for right knee pain.

181. On or about February 3, 2015, Patient C returned to the clinic and saw Respondent for a follow up. Patient C had knee surgery and reported that her knee pain was abating. Respondent documented a physical exam with no remarkable findings. His assessment was for chronic pain and joint pain. He ordered labs and x-rays of Patient C's knee.

182. On or about February 5, 2015, Patient C returned to the clinic and saw a physician other than Respondent. Patient C complained of right knee pain with popping. The physician's assessment was for sprain and strain of the knee and leg.

183. On or about February 17, 2015, Patient C returned to the clinic and saw Respondent for medication refills. She complained of shortness of breath. Respondent documented a physical exam with no remarkable findings. His assessment was for chronic airway obstruction. He ordered refills of Patient C's COPD medications and Norco. He also ordered a nebulizer treatment and a Solu-Medrol injection.

184. On or about March 3, 2015, Patient C returned to the clinic and saw Respondent for medication refills and for a follow up after a hospital visit. Respondent did not document a physical exam, nor did he document why Patient C went to the hospital. He diagnosed Patient C with diabetes mellitus, type II and prescribed corresponding medications. Respondent also refilled Patient C's Norco and Valium prescriptions. On or about the same day, Patient C filled prescriptions for 180 tablets of Norco and 60 tablets of 1 mg Klonopin. Respondent failed to document this Klonopin prescription in his progress note.

185. On or about March 17, 2015, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment was COPD and chronic respiratory failure. He gave Patient C a prescription for 60 tablets of 5 mg Valium with four refills.

186. On or about April 2, 2015, Patient C returned to the clinic and saw Respondent for pain management and diabetes medical management. Respondent documented a physical exam with no remarkable findings. Respondent's assessment was for diabetes. He gave Patient C refills for her prescriptions, including Norco.

187. On or about April 8, 2015, Patient C returned to the clinic and saw a physician other than Respondent. Patient C complained of knee pain. The physician ordered a CT of Patient C's right knee. The CT scan taken that day showed no acute findings, no meniscal tear was visualized, and there was evidence of prior avascular necrosis.

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188. On or about April 28, 2015, Patient C returned to the clinic and saw Respondent for pain management and follow up on an ER visit. Respondent documented a physical exam with no remarkable findings. He diagnosed Patient C with pneumonia. He gave Patient C refills for her prescriptions, including Norco.

189. On or about April 30, 2015, Patient C returned to the clinic and saw a physician other than Respondent. On or about the same day, a CT scan of Patient C's right knee was taken. The subsequent report found that screws had been inserted, a degenerative osteophyte formation was noted, and no fractures were seen.

190. On or about May 12, 2015, Patient C returned to the clinic and saw a physician other than Respondent. The physician diagnosed chondromalacia of the patella.

191. On or about May 26, 2015, Patient C returned to the clinic and saw Respondent for pain management. Respondent noted that Patient C was diabetic and taking steroids. Respondent documented a physical exam with no remarkable findings. His assessment was diabetes mellitus and chronic respiratory failure. He gave Patient C refill prescriptions and ordered labs. Respondent also gave Patient C new prescriptions for gabapentin and baclofen. Respondent failed to document the indications for prescribing these new medications.

192. On or about June 9, 2015, Patient C returned to the clinic and saw a physician other than Respondent. The physician diagnosed sprain and strain of the knee and leg and ordered imaging of Patient C's right knee. The radiology report found lateral tibial subluxation and irregularity of the patellar articular surface, but no acute findings.

193. On or about June 23, 2015, Patient C returned to the clinic and saw a physician other than Respondent. He diagnosed Patient C with unspecified internal derangement of the knee.

194. On or about June 25, 2015, Patient C returned to the clinic and saw Respondent. The purpose of the visit was to discuss Patient C's pain management, diabetes, and prednisone prescription. Respondent documented a physical exam with no remarkable findings. Respondent's assessment was chronic pain syndrome, diabetes, and reflux esophagitis. He gave Patient C a refill for Norco and a new prescription for a diabetes medication.

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195. On or about July 9, 2015, Patient C returned to the clinic and saw Respondent. Patient C reported that she had surgery scheduled on July 22, 2015, and that the baclofen and gabapentin were not helping for restless leg syndrome. Respondent had never documented a restless leg syndrome diagnosis for Patient C. He documented a physical exam with no remarkable findings and noted that Patient C had a history of polyps in the complaint section of the note. His assessment was for diabetes and chronic respiratory failure. He ordered a neurology referral for Patient C's restless leg syndrome, and a surgical referral for a rectal protrusion.

196. On or about July 28, 2015, Patient C returned to the clinic and saw Respondent. She reported she had hardware removed from her right tibia. Respondent documented a physical exam, noting the surgical wound on Patient C's right leg and mild erythema. His assessment was chronic pain due to trauma. He gave Patient C a refill for Norco.

197. On or about August 3, 2015, and August 30, 2015, Patient C filled prescriptions for 30 tablets of Ambien, written by another practitioner.

198. On or about August 31, 2015, Patient C returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented a physical exam, noting paraspinal muscle spasm on the left and sacroiliac joint tenderness. His assessment for Patient C was degeneration of the lumbar or lumbosacral intervertebral disc, sprain and strain of the lumbosacral joint, diabetes, and COPD. He gave Patient C a refill for Norco and a prescription for an Epi-Pen.

199. On or about September 9, 2015, Patient C returned to the clinic and saw a physician other than Respondent. The physician's assessment of Patient C included opioid-induced constipation, colon polyps, and rectal bleeding. The physician ordered labs and scheduled a colonoscopy.

200. On or about September 17, 2015, Patient C returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented a physical exam with no remarkable findings. His diagnoses for Patient C were attention or concentration deficit, reflux esophagitis, insomnia, and diabetes. Respondent did not document any corresponding symptoms or

indications for his attention or concentration deficit assessment. He gave Patient C a refill for Norco.

201. On or about October 2, 2015, Patient C returned to the clinic and saw a physician other than Respondent for the removal of a cecal polyp.

202. On or about October 14, 2015, Patient C returned to the clinic and saw Respondent to follow up on MRIs, medication refills, and complaints of disc disease. Respondent documented a physical exam with no remarkable findings. His assessment was intervertebral disc degeneration, sacroiliitis, asthma, COPD, and diabetes. He gave Patient C a refill for Norco and gabapentin.

203. On or about October 26, 2015, Patient C filled a prescription for 30 tablets of Ambien, written by another practitioner.

204. On or about November 11, 2015, Patient C returned to the clinic and saw a physician other than Respondent as a follow up to the prior colonoscopy. Patient C was scheduled for a hemorrhoidectomy.

205. On or about November 16, 2015, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment included sprain of the lumbar spine, radiculopathy, and hemorrhoids. He noted that he discussed replacing Patient C's Norco prescription with Hyslinga.[37] Respondent gave Patient C a refill for 180 tablets of Norco.

206. On or about December 1, 2015, Patient C filled a prescription for 30 tablets of Ambien, written by another practitioner.

207. On or about December 2, 2015 and December 4, 2015, Patient C was treated by a physician other than Respondent, and Patient C underwent the hemorrhoidectomy.

208. On or about December 16, 2015, Patient C returned to the clinic and saw Respondent to reevaluate her back pain. Respondent documented a physical exam with no remarkable findings. His assessment included asthma and sacroiliitis. He gave Patient C a prescription for 150 tablets of Norco refill. Respondent failed to document why he was decreasing Patient C's Norco dose.

[37] Hyslinga ER is an extended release, tamper-resistant form of hydrocodone.

209. On or about December 24, 2015, Patient C returned to the clinic and saw Respondent. Patient C complained of cough, nausea, and shortness of breath. Respondent treated Patient C for COPD and treated Patient C's symptoms with prednisone and an anti-emetic medication.

210. On or about January 14, 2016, Patient C returned to the clinic and saw another practitioner for medication refills. The practitioner documented a physical exam, noting scars on Patient C's right leg, in addition to tenderness and numbness. The practitioner assessed Patient C with joint pain in the lower leg and chronic pain. He gave Patient C a prescription for 40 tablets of Norco and told her to follow up with Respondent.

211. On or about January 22, 2016, Patient C returned to the clinic and saw a physician other than Respondent to discuss her pain management. The physician documented that Patient C had chronic pain for many years and surgeries on her knee, ankle, and hands. Patient C reported that she saw another physician who gave her 40 tablets of Norco and told her to follow up with someone else. The physician documented a physical exam, noting that Patient C's back had full range of motion and there was no cervical lymphadenopathy. He noted seeing healed surgical scars on both knees, ankle, and hands, and no evidence of swelling. Patient C had mild pain in her right knee. The physician's assessment was chronic pain, joint pain in the lower leg, degeneration of the lumbar and lumbosacral intervertebral disc, and bipolar disorder. He gave Patient C a Norco refill and talked to her about home remedies to treat her chronic pain. He also advised Patient C to follow up with her primary care physician and to establish care with a mental health specialist to continue with her psychiatric medications.

212. On or about February 9, 2016, Patient C returned to the clinic and saw Respondent for medication refills. Patient C complained of anxiety, depression, and chronic pain. Respondent documented a physical exam with no remarkable findings. His assessment was major depressive disorder, bipolar, COPD, asthma, diabetes, chronic pain syndrome, GERD, and Attention-Deficit/Hyperactivity Disorder (ADHD). He gave Patient C refills for Norco and Klonopin. On or about the same day, Patient C filled prescriptions for 120 tablets of Norco and 60 tablets of 1 mg Klonopin.

213. On or about February 24, 2016, Patient C filled another prescription for 120 tablets of Norco, written by Respondent.

214. On or about March 9, 2016, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment was for diabetes, COPD, low back pain, and pain in the right knee. He gave Patient C a refill for 150 tablets of Norco and Klonopin. Respondent did not document why he increased Patient C's Norco dose. On or about the same day, Patient C refilled her prescription for 60 tablets of 1 mg Klonopin.

215. On or about March 13, 2016, Patient C filled the prescription for 150 tablets of Norco.

216. On or about April 11, 2016, Patient C returned to the clinic and saw Respondent for medication refills. Patient C reported concern about her diabetes medications. She also complained of chronic knee pain and diarrhea. Respondent documented a physical exam with no remarkable findings. His assessment was ADHD, bipolar disorder, diabetes, insomnia, restless leg syndrome, GERD, and nausea. He gave Patient C prescription refills. On or about the same day, Patient C filled a prescription for 120 tablets of Norco and 90 tablets of 1 mg Klonopin. Respondent failed to document the reasons for decreasing Patient C's Norco dose and increasing her Klonopin dose.

217. On or about April 20, 2016, Patient C filled a prescription for 30 tablets of Ambien, written by another practitioner.

218. On or about May 2, 2016, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment was for ADHD, insect allergy, psychophysiologic insomnia, asthma, diabetes, and restless leg syndrome. He gave Patient C prescriptions for her medications including Klonopin, Norco, and gabapentin.

219. On or about May 9, 2016, Patient C filled prescriptions for 120 tablets of Norco and 90 tablets of 1 mg Klonopin, written by Respondent. On or about May 18, 2016, Patient C filled a prescription for 30 tablets of Ambien, written by another practitioner.

220. On or about June 1, 2016, Patient C returned to the clinic and saw Respondent to discuss her medications and ADHD. Respondent did not document any details of any discussion with Patient C about her medications or ADHD. Respondent documented a physical exam with no remarkable findings. His assessment was for ADHD, insomnia, restless leg syndrome, and right knee pain. He gave Patient C a refill for Norco, administered a Zofran injection, and ordered a right knee x-ray. The x-ray report noted suspect joint effusion, postoperative changes with one orthopedic screw removed, and no dislocation.

221. On or about June 3, 2016 and June 4, 2016, Patient C filled prescriptions for 120 tablets of Norco and 60 tablets of Klonopin, written by Respondent.

222. On or about June 9, 2016, Patient C saw a physician other than Respondent regarding her right knee. The physician ordered an MRI of the right knee and an x-ray for both knees.

223. On or about June 13, 2016 and June 16, 2016, Patient C returned to the clinic to follow up with the physician she had seen on June 9, 2016. The physician noted that Patient C had a screw in her tibia that could not be surgically removed, and that she had thigh atrophy. The physician recommended physical therapy to strengthen Patient C's quad. The physician did not recommend knee replacement but told Patient C of other treatment modalities.

224. On or about June 18, 2016, Patient C filled a prescription for 30 tablets of Ambien, written by another practitioner.

225. On or about June 21, 2016 and June 30, 2016, Patient C returned to the clinic and saw a physician other than Respondent. The physician had reviewed x-ray and MRI imaging of Patient C's spine. He noted that Patient C had persistent pain in the right leg and lower back, and that previous films had shown grade 1 spondylolisthesis. He noted that Patient C needed a referral to either a neurosurgeon or an orthopedic spine surgeon if her symptoms persisted.

226. From on or about June 21, 2016 to August 12, 2016, Patient C had multiple physical therapy sessions to treat Patient C's right knee and lumbosacral pain.

227. On or about July 2, 2016, Patient C filled a prescription for 90 tablets of 1 mg Klonopin, written by Respondent.

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228. On or about July 6, 2016, Patient C returned to the clinic and saw Respondent for medication refills. Patient C complained of bowel activity. Respondent documented a physical exam with no remarkable findings. He assessed Patient C with hemorrhage of the anus and rectum, ADD, insomnia, restless leg syndrome, and right knee pain. He gave Patient C medication refills, including Norco and Klonopin.

229. On or about July 11, 2016 and July 21, 2016, Patient C returned to the clinic and saw a physician other than Respondent. During this time period, Patient C reported less pain with the exercises she was doing in physical therapy. On or about July 21, 2016, the physician ordered a Kenalog injection in Patient C's right knee to alleviate the pain.

230. On or about July 22, 2016, Patient C told her physical therapist that her right knee pain was minimal, and she was planning to get patellar replacement surgery.

231. On or about July 27, 2016, Patient C told her physical therapist that her lumbosacral pain was temporarily relieved with treatment, and that her right knee pain had decreased after getting an injection.

232. On or about August 3, 2016, Patient C returned to the clinic and saw Respondent for medication refills and to follow up on her leg pain. Respondent documented a physical exam with no remarkable findings. His assessment was for hemorrhage of the anus and rectum, ADD, insomnia, restless leg syndrome, right knee pain, and patellofemoral disorders in the left knee. He gave Patient C refills for her medications including Norco and Klonopin. He also gave Patient C a pain medicine referral for her knee pain. On or about the same day, Patient C filled prescriptions for 120 tablets of Norco and 90 tablets of 1 mg Klonopin.

233. From on or about August 5, 2016 through August 12, 2016, Patient C continued to go to physical therapy. While her right knee pain seemed to be improving, Patient C's left knee was getting worse.

234. On or about August 16, 2016, Patient C returned to the clinic and saw a physician other than Respondent. He diagnosed Patient C with patellofemoral disorder of the left knee, and

noted that physical therapy seemed to be aggravating Patient C's symptoms. He started a Voltaren[38] gel trial and noted that Patient C may need a partial knee replacement in the future.

235. On or about August 31, 2016, Patient C returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment was for hemorrhage of the anus and rectum, ADD, insomnia, restless leg syndrome, right knee pain, and patellofemoral disorder in the left knee. He gave Patient C a refill for Norco and ordered a referral to osteopathic manipulative therapy for Patient C's chronic knee pain.

236. On or about September 5, 2016, Patient C returned to the clinic and saw a nurse practitioner. Patient C complained of right knee and low back pain. The nurse practitioner noted that Patient C had four surgeries for hardware implantation following a car accident in 2011. The nurse practitioner documented a physical exam, noting pain in Patient C's knee and shin and referencing an MRI of the lumbar spine showing spondylothesis. The nurse practitioner assessed Patient C with right knee pain, spondylosis with radiculopathy, and opioid dependence. He spoke to Patient C about treatment options for her back pain, including local blocks, referral to a pain management specialist, and alternative treatments. The nurse practitioner ordered a urine drug screen.

237. On or about September 26, 2016, Patient C returned to the clinic and saw Respondent for medication refills and to follow up from a recent hospital visit. Patient C complained of chronic respiratory problems. Respondent documented a physical exam with no remarkable findings. His assessment was for hemorrhage of the anus and rectum, fatal familial insomnia, restless leg syndrome, right knee pain, patellofemoral disorder of the left knee, and spondylosis with radiculopathy. He gave Patient C refills of her medications, including prednisone and Norco.

238. On or about October 17, 2016, Patient C returned to the clinic and saw Respondent. She needed medication refills and complained of a swollen left ankle. Respondent documented a physical exam with no remarkable findings. His assessment was for left foot sprain and he ordered x-rays. He also gave Patient C a Norco refill.

[38] Voltaren, brand name for diclofenac, is a NSAID.

239. Respondent committed gross negligence in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent failed to adequately document the following: (1) the indications for the prescriptions given; (2) sufficient documentation of medication effectiveness or side effects; (3) justification for the continuation, changes or addition of medications; (4) pertinent physical exams; (5) adequate support for assessments and plans; and (6) congruency between diagnoses and therapies; and

b. Respondent failed to timely sign completed notes.

Patient D

240. On or about September 19, 2018, Respondent gave a summary of Patient D's treatment and care to Board investigators. Respondent stated that he had started treating Patient D in 2013, and that Patient D had a history of lower back problems due to multiple car and motorcycle accidents. Patient D also had a history of coronary artery disease and COPD.

241. On or about September 19, 2018, Respondent told Board investigators that he prescribed Norco to Patient D because of the pain caused by a motorcycle accident fracturing Patient D's pelvis, back, and ribs, and causing trauma to his legs. He also noted Patient D's history of leukemia and chronic back problems. Respondent stated that he prescribed Valium to calm Patient D down because he got anxious and agitated. He prescribed Soma to Patient D for muscle relaxation. Respondent said he did a detailed back examination for Patient D, but did not document it. Respondent noted that Patient D tried to use an old Soma prescription written by Respondent after Respondent had discontinued that medication on or about October 24, 2017.

242. As his primary care physician, Respondent saw Patient D at the clinic approximately every one to three months from January 6, 2014 through August 25, 2017. Respondent's documented assessments for Patient D during this time period included the following: (1) leukemic reticuloendotheliosis of lymph nodes - in remission; (2) degeneration of the thoracic or thoracolumbar intervertebral disc; (3) chronic pain syndrome; (4) osteoporosis; (5) spondylosis; (6) depressive type psychosis; (7) sacroiliitis; (8) reflux esophagitis; and (9) joint pain. On almost

a monthly basis, Respondent gave Patient D prescriptions for approximately 120 to 180 tablets of Norco, 90 to 120 tablets of Soma, and varying doses of Ativan and Valium.

243. Respondent's progress notes documenting his treatment of Patient D were sparsely detailed. These notes often lacked documentation detailing Patient D's chief complaint, the medical conditions that were causing Patient D's pain, and any supporting symptoms for any assessments. Respondent often documented normal physical exams that contradicted his assessments and diagnoses. Respondent did not document any discussions he might have had with Patient D about his chronic, long-term use of opioids and benzodiazepines. Lastly, Respondent did little to no documented monitoring to ensure that Patient D was taking his medications as prescribed.

244. The following examples support the deficiencies raised in paragraphs 240 through 243, above:

245. On or about January 6, 2014, Patient D, then a fifty-nine-year old male, came to the clinic and saw Respondent for medication refills and a nail fungal infection. Respondent documented a physical exam with no remarkable findings. Respondent diagnosed Patient D with tinea nigra and ischiocapsular sprain and strain. He gave Patient D refills for his medications, including Norco, Soma, Ativan, and Cymbalta.[39]

246. On or about April 7, 2014, Patient D returned to the clinic and saw Respondent for medication refills. Patient D reported no acute problems. Respondent documented a physical exam with no remarkable findings. His documented assessment at this visit was "leukemic reticuloendotheliosis of lymph nodes - resolved," presumably referring to Patient D's prior treatment for cancer. Respondent gave Patient D prescription refills. Respondent increased Patient D's Soma prescription from 90 to 120 tablets with no documented explanation. Respondent prescribed 30 tablets of Hyslinga instead of Norco with no documented explanation for the medication change. Respondent also gave Patient D a prescription for sertraline[40] with four refills, again with no documented explanation for changing Patient D's medications.

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[39] Cymbalta, brand name for duloxetine, is a nerve pain medication and anti-depressant.
[40] Sertraline, brand name Zoloft, is an anti-depressant.

247. According to pharmacy records, on or about May 1, 2014, prescriptions for Norco, Soma, and Ativan were made by phone in Respondent's name. On or about the same day, Patient D filled prescriptions for 120 tablets of Norco, 120 tablets of Soma, and Ativan, written by Respondent. Respondent's records fail to note these prescription refills.

248. On or about May 12, 2014, Patient D returned to the clinic and saw Respondent for medication refills, with the chief complaint documented as chronic pain syndrome. Respondent documented a physical exam with no remarkable findings and no mention of pain. He diagnosed Patient D with degeneration of the thoracic or thoracolumbar intervertebral disc and chronic pain syndrome. He gave Patient D refills for 180 tablets of Norco and 90 tablets of Soma. Respondent failed to document why he increased Patient D's Norco dose and decreased Patient D's Soma dose.

249. On or about June 20, 2014, Patient D returned to the clinic and saw Respondent. Patient D had recently been in the hospital. Patient D's medical history was documented, listing chronic lymphocytic leukemia, chronic back pain, osteoporosis, and depression. Patient D reported near syncopal episodes, numbness in both arms, and back pain. He reported having anxiety and refused catheterization. Respondent's assessment for Patient D was chest pain, leukemic reticuloendotheliosis, syncope and collapse, osteoarthrosis, and lumbosacral spondylosis without myelopathy. Respondent ordered labs, imaging of Patient D's back, and a referral to cardiology.

250. On or about July 7, 2014, Patient D returned to the clinic and saw Respondent to follow up on the lab and x-ray results. Respondent documented that Patient D's spondylosis continued and caused leg pain and other discomfort. Respondent documented a physical exam with no remarkable findings. He made no reference to the previously ordered back imaging. His assessment of Patient D was spondylosis and depressive type psychosis. Respondent failed to document any symptoms that would support depressive type psychosis. Respondent gave Patient D a refill for Soma.

251. On or about July 31, 2014, Patient D returned to the clinic and saw Respondent for a follow up on a motorcycle accident. Respondent noted that Patient D had a history of "mc

[motorcycle] accident, fracture of hip ribs, puncture of lung left, orbital fracture." Respondent documented a physical exam, noting lumbosacral pain, muscle spasms, hip fracture, and pain in the upper extremities. His assessment of Patient D was closed fractures involving the skull, multiple closed pelvic fractures, and the closed fracture of three ribs. He gave Patient D prescriptions for 10 Fentanyl[41] transdermal patches, 180 tablets of Norco, Valium, and 120 tablets of Soma. Respondent failed to document why he switched Patient D's benzodiazepine prescription from Ativan to Valium. Respondent also ordered labs and gave Patient D a Toradol injection. On or about the same day, Patient D filled prescriptions for Fentanyl patches, Soma, and 90 tablets of 5 mg Valium.

252. On or about August 25, 2014, Patient D returned to the clinic and saw Respondent for a follow up. Respondent documented a physical exam with no remarkable findings. His assessment was chronic pain syndrome.

253. From on or about September 29, 2014 to October 28, 2014, Patient D filled prescriptions for Norco, Soma, and Valium, written by Respondent.

254. On or about November 12, 2014, Patient D returned to the clinic and saw Respondent for medication refills and with questions about his sugar levels. Respondent did not document a physical exam. His assessment for Patient D was a screening for depression and osteoporosis. Respondent failed to document any additional information associated with the depression screening or Patient D's sugar levels. He gave Patient D refills for his medications, including but not limited to Norco and Soma.

255. On or about November 12, 2014, Patient D submitted a urine sample for drug screening. The sample tested positive for Soma and marijuana. There were no traces of hydrocodone and Valium metabolite, which was inconsistent with Patient D's prescribed medications.

256. On or about December 10, 2014, Patient D returned to the clinic and saw Respondent for medication refills. Patient D reported that a dresser had fallen on his foot. Respondent did

[41] Fentanyl, brand name Duragesic, is an opiate painkiller and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

not document a physical exam. Respondent did not address the inconsistent drug screen results from the previous visit. His assessment was hip fracture aftercare and degeneration of the lumbar or lumbosacral intervertebral disc. Respondent gave Patient D a prescription for 180 tablets of Norco.

257. On or about January 8, 2015, Patient D called the clinic and requested a Soma refill, which was given.

258. On or about January 28, 2015, Patient D returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam with no remarkable findings. His assessment of Patient D was sacroiliitis. He gave Patient D refills for his medications including Norco and Valium.

259. On or about January 31, 2015, Patient D filled prescriptions for 180 tablets of Norco and 60 tablets of 5 mg Valium.

260. On or about January 31, 2015 through March 4, 2015, Patient D continued to fill prescriptions for Norco, Valium, and Soma.

261. On or about March 17, 2015, Patient D returned to the clinic and saw Respondent for medication refills. Patient D also reported allergy symptoms and that he had fallen and was in pain. Respondent documented a physical exam with no remarkable findings. Respondent's assessment was sacroiliitis and joint pain. He ordered a Toradol injection in the right deltoid, and gave Patient D refill prescriptions for Norco and Valium. Respondent doubled Patient D's Valium prescription from five to ten milligrams three times daily. Respondent failed to document why he had increased the dose for this medication.

262. On or about April 30, 2015, Patient D returned to the clinic and saw Respondent for pain management and medication refills. Respondent documented a physical exam with no remarkable findings. His assessment for Patient D was a depression screening, reflux esophagitis, gastritis, malaise, and fatigue. Respondent failed to document any associated symptoms or indications for his assessment. He gave Patient D refills for his medications including Norco, Soma, and Valium, and gave Patient D a new prescription for Zoloft. Respondent documented

that he gave Patient D a prescription for 60 tablets of 5 mg Valium and failed to document the reason for decreasing the dose.

263. On or about May 26, 2015, Patient D returned to the clinic and saw Respondent for medication refills. The progress note references "chronic pain over the last 2000 with injruy [sic] at work," acid reflux, and a motorcycle accident the previous July. Respondent documented a physical exam, noting back spasms and tenderness at the lumbar-sacral spine. His assessment was reflux esophagitis, chronic pain, and sacroiliitis. He ordered a Toradol injection and gave Patient D refills for his medications including Norco, Zoloft, and 120 tablets of Soma. Patient D left the clinic before getting the injection.

264. On or about May 27, 2015, Patient D filled a prescription for 90 tablets of Soma. Respondent's written prescription was for 90 tablets, which was inconsistent with the amount of tablets documented in the previous progress note.

265. On or about June 29, 2015, Patient D returned to the clinic and saw Respondent for pain management. Patient D complained of chronic leg and back pain and muscle spasms. Respondent documented a physical exam, noting muscle spasms and tenderness in the lumbar-sacral spine and sacroiliac joint. His assessment for this visit was "chronic leukemia of unspecified cell type, without mention of having achieved remission," chronic back pain, osteoporosis, and reflux esophagitis. Respondent gave Patient D refills for his medications including Norco and 120 tablets of Soma.

266. On or about July 27, 2015, Patient D returned to the clinic and saw Respondent for chronic pain and pain management. Respondent documented a physical exam with no remarkable findings. His assessment was adjustment disorder with anxiety and chronic pain syndrome. Respondent failed to document any symptoms or indications for adjustment disorder. He noted that he gave Patient D refill prescriptions for his medications including Norco and 60 tablets of 10 mg Valium. On or about the same day, Patient D filled a prescription for 90 tablets of 10 mg Valium, which is inconsistent with Respondent's progress note.

267. On or about September 8, 2015, Patient D returned to the clinic and saw Respondent for pain management. Patient D complained of hip pain and pain in his right leg where he had a

metal prosthesis. Respondent documented a physical exam, noting paraspinal muscle spasm on the right. His assessment was for reflux esophagitis, depression screening, and pure hypercholesterolemia. Respondent gave Patient D prescriptions for Norco and Valium. On or about the same day, Patient D filled prescriptions for 180 tablets of Norco and 60 tablets of 10 mg Valium.

268. On or about October 6, 2015, Patient D returned to the clinic and saw Respondent to reevaluate his back pain. Respondent documented a physical exam with no remarkable findings. His assessment was for chronic leukemia of unspecified cell type (in remission), chronic pain, osteoporosis, GERD with esophagitis, and screening for "other disorder." Respondent gave Patient D refill prescriptions for his medications, including Norco and Zoloft.

269. On or about October 6, 2015, Patient D filled a prescription for 120 tablets of Soma, written by Respondent. This prescription dated October 5, 2015, was not documented in Respondent's medical records.

270. On or about October 8, 2015, Patient D filled a prescription for 180 tablets of Norco, written by Respondent. This prescription dated October 5, 2015, was not documented in Respondent's medical records.

271. On or about November 18, 2015, Patient D returned to the clinic and saw Respondent. Patient D complained of COPD, a history of back pain, and a history of pneumonia. Respondent documented a physical exam with no remarkable findings. His assessment was for sacroiliitis, bronchopneumonia, and chronic respiratory failure. He gave Patient D refill prescriptions for his medications including Soma. Respondent also prescribed Hyslinga and ibuprofen. Respondent failed to document the reasons for switching Patient D from Norco to Hyslinga, or any discussion he had with Patient D about his medications.

272. On or about December 7, 2015, Patient D filled a prescription for 30 tablets of 30 mg Hyslinga, written by Respondent.

273. On or about December 14, 2015, Patient D returned to the clinic and saw Respondent. The note appears to state that Patient D had a fire in his moustache and had been seen in the ER. Respondent noted that Patient D needed to see a pulmonologist and psychiatrist for bipolar

disorder. Respondent documented a physical exam, noting rhonchi in the lungs. His assessment was for chronic respiratory failure. Respondent ordered referrals to pulmonary disease for recurrent pneumonia and psychiatry for bipolar disorder. Respondent gave Patient D refill prescriptions for his medications, including Soma and Zoloft.

274. On or about December 23, 2015, Patient D returned to the clinic and saw Respondent. Patient D reported that he was waking in the middle of the night and could not breathe. Respondent documented a physical exam noting no remarkable findings. His assessment remained unchanged from the previous visit. Respondent prescribed albuterol.

275. On or about January 7, 2016, Patient D returned to the clinic and saw a physician other than Respondent. Patient D was following up from a hospital visit after fracturing a rib from coughing. Patient D reported that he was also treated for pneumonia while in the hospital for five days. The physician documented a physical exam, noting tenderness in the right rib area. The physician's assessment was joint pain, chronic back pain, COPD, and osteoporosis. The physician suggested using moist heat for the joint pain and for Patient D to continue treatment at the cancer center.

276. On or about January 20, 2016, Patient D returned to the clinic and saw Respondent to follow up on his joint pain and pain management. Respondent noted that Patient D had recurrent pneumonia. He documented a physical exam with no remarkable findings. Respondent's assessment was influenza, sacroiliitis, joint pain, reflux esophagitis, chronic back pain, and osteoporosis. He gave Patient D prescriptions for flu medications as well as Hyslinga and Soma.

277. On or about February 17, 2016, Patient D returned to the clinic and saw Respondent. Patient D complained of increased back and rib pain and needed medication refills. Respondent documented a physical exam, noting pain in the back at the supra and infra spinatus, and tenderness at the trapezius muscles of the back. His assessment was for sacroiliitis and pain in the right shoulder. He ordered a referral to physical medicine.

278. On or about February 19, 2016, Patient D filled a prescription for 120 tablets of Soma, written by Respondent.

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279. On or about March 16, 2016, Patient D returned to the clinic and saw Respondent for medication refills. Respondent documented a physical exam, noting muscle spasms in the back and tenderness over the lumbar-sacral spine and sacroiliac joint. His assessment was chronic pain, reflux esophagitis, and sacroiliitis. He gave Patient D a refill for Soma and increased Patient D's Hyslinga dose from 30 to 40 mg. Respondent failed to document why he increased the dose for this medication.

280. On or about April 18, 2016, Patient D returned to the clinic and saw Respondent to reevaluate his back pain. Respondent documented a physical exam with no remarkable findings. His assessment was for sacroiliitis, joint pain, reflux esophagitis, chronic pain, and chronic back pain. He gave Patient D refill prescriptions for his medications, including Soma.

281. On or about May 24, 2016, Patient D returned to the clinic and saw Respondent to discuss his medications and chronic pain. Respondent documented a physical exam, noting back and joint tenderness and muscle spasm. His assessment was sacroiliitis, joint pain, reflux esophagitis, chronic pain, chronic back pain, and "other psychoactive substance dependence, in remission." Respondent gave Patient D refill prescriptions for his medications, including Hyslinga and Soma.

282. On or about June 21, 2016, Patient D returned to the clinic and saw Respondent to follow up on his pneumonia and for medication refills. Patient D complained of mild wheezing. Respondent documented a physical exam noting no remarkable findings. His assessment was sacroiliitis, joint pain, GERD, low back pain, and other chronic pain. Respondent gave Patient D refill prescriptions for his medications, including Hyslinga and Soma.

283. On or about July 19, 2016, Patient D returned to the clinic and saw Respondent for pain management and medication refills. Respondent documented a physical exam with no remarkable findings. His assessment was sacroiliitis, GERD, joint pain, low back pain, and other chronic pain. He gave Patient D prescriptions for 120 tablets of Norco, Soma, and ibuprofen. Respondent failed to document when he was switching Patient D's pain medication back to Norco.

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284. From on or about August 16, 2016 through May 24, 2017, Patient D returned to the clinic and saw Respondent on a monthly basis. Respondent's assessments included sacroiliitis, joint pain, GERD, low back pain, and chronic pain. Patient D continued to fill monthly prescriptions written by Respondent for 120 tablets of Norco and 120 tablets of Soma.

285. On or about June 26, 2017, Patient D returned to the clinic and saw Respondent for pain management. Respondent documented a physical exam, noting back spasms. His assessment was sacroiliitis, GERD with esophagitis, chronic pain, and COPD. Respondent gave Patient D refill prescriptions, including Norco, and noted that a urine drug screen was scheduled for the next visit.

286. On or about July 5, 2017, Patient D called the clinic requesting a Soma refill. According to his medical records, Respondent approved the request and prescribed 60 tablets of Soma, one tablet to be taken twice daily, reducing Patient D's normal dose by half. Respondent's records fail to note why Soma was being decreased and whether Patient D was counseled about this change in his medications.

287. On or about July 24, 2017, Patient D returned to the clinic and saw Respondent for pain management and medication refills. Patient D complained of chronic pain and lower back pain. Respondent documented a physical exam, noting muscle spasms and tenderness in the back. His assessment remained unchanged from the previous visit. He gave Patient D refill prescriptions, including Norco. Respondent did not document whether a urine drug screening was done, per the previous progress note.

288. Respondent committed gross negligence in his care and treatment of Patient D, which includes, but is not limited to, the following:

a. Respondent failed to adequately document the indications for the prescriptions given, sufficient documentation of medication effectiveness or side effects, justification for the continuation, changes or addition of medications, pertinent physical exams, adequate support for assessments and plans, congruency between diagnoses and therapies; and

b. Respondent also failed to timely sign completed progress notes.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

289. Respondent has further subjected his Physician's and Surgeon's Certificate No. G31686 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereafter:

Patient A

290. Respondent committed repeated negligent acts which include, but are not limited to, the following:

a. Paragraphs 9 through 78, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent prescribed an opioid, benzodiazepine, and muscle relaxant to Patient A for years without adequate documentation of Patient A's substance abuse history, potential drug interactions (including alcohol), and consideration of the addiction potential;

c. Respondent prescribed short-acting opioids on a regular and long-term basis without any attempt to convert to a long-acting opioid; and

d. Respondent failed to document and/or do tobacco cessation counseling with Patient A.

Patient B

291. Respondent committed repeated negligent acts in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Paragraphs 79 through 130, above, are hereby incorporated by reference and re-alleged as if fully set forth herein; and

b. Respondent failed to document any discussion with Patient B about the use of short-acting opiates versus long-acting opiates, or any attempts to convert to long-acting opiates.

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Patient C

292. Respondent committed repeated negligent acts in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Paragraphs 131 through 239, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent failed to order drug screens; and

c. Respondent failed to adequately document the justification for prescribing opiates to Patient C.

Patient D

293. Respondent committed repeated negligent acts in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Paragraphs 240 through 288, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent failed to order drug screens; and

c. Respondent failed to adequately document the justification for prescribing opiates to Patient D.

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

294. Respondent has further subjected his Physician's and Surgeon's Certificate No. G31686 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 Patients A, B, C, and D, as more particularly alleged in paragraphs 9 through 293, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G31686, issued to Respondent Henry Bert Starkes, Jr., M.D.;

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

3. Ordering Respondent Henry Bert Starkes, Jr., M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent, Henry Bert Starkes, Jr., M.D., if placed on probation for five years or more, to disclose the disciplinary order to patients pursuant to Business and Professions Code section 2228.1; and

5. Taking such other and further action as deemed necessary and proper.

DATED: December 31, 2019

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer
Affairs State of California
Complainant