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

In the Matter of the Accusation Against: David Michael Kolinsky, M.D. Physician's and Surgeon's Certificate No. A 60010 Respondent.	Case No. 800-2020-069085

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

DEC 29 2020.

IT IS SO ORDERED DEC 22 2020.

MEDICAL BOARD OF CALIFORNIA

Jennifer Jones for William Prasifka
William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
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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: **DAVID MICHAEL KOLINSKY, M.D.** **2511 Garden Road, Suite C125** **Monterey, CA 93924** **Physician's and Surgeon's Certificate No. A 60010,** Respondent.	Case No. 800-2020-069085 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. 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 Lawrence Mercer, Deputy Attorney General.

2. David Michael Kolinsky, M.D. (Respondent) is represented in this proceeding by his attorney Marvin Firestone, M.D., J.D., 1700 El Camino Real, Suite 408, San Mateo, CA 94402.

3. On or about April 12, 1996, the Board issued Physician's and Surgeon's Certificate No. A 60010 to David Michael Kolinsky, M.D. (Respondent). Effective September 29, 2017,

Respondent's certificate was revoked, the revocation was stayed, and he was placed on a five-year probation with terms and conditions. The Physician's and Surgeon's Certificate expired on April 30, 2020, has not been renewed, and Respondent is currently prohibited from engaging in the practice of medicine.

JURISDICTION

4. Accusation No. 800-2020-069085 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 October 1, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-069085 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-069085. 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.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2020-069085, 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 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

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

12. 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.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 60010, issued to Respondent DAVID MICHAEL KOLINSKY, M.D., is surrendered and accepted by the Board.

1. 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.

2. 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.

3. 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. 800-2020-069085 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney. 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: 10/27/2020

DAVID MICHAEL KOLINSKY, M.D.
Respondent

I have read and fully discussed with Respondent DAVID MICHAEL KOLINSKY, 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: 10/30/2020

MARVIN FIRESTONE, M.D, J.D.
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: Nov. 3, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2020-069085

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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: **David Michael Kolinsky, M.D.** **2511 Garden Road, Suite C125** **Monterey, CA 93940** **Physician's and Surgeon's Certificate No. A 60010,** Respondent.	Case No. 800-2020-069085 **ACCUSATION**

PARTIES

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

2. On or about April 12, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 60010 to David Michael Kolinsky, M.D. (Respondent). On September 29, 2017, the Physician's and Surgeon's Certificate was revoked, the order of revocation stayed, and a five year probation, with terms and conditions, was imposed. The Physician's and Surgeon's Certificate expired on April 30, 2020, and has not been renewed. On or about March 14, 2020, Respondent ceased practicing medicine in California, whereupon his probation tolled.

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:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

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

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> . . . (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single

negligent act.

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

6. Section 2228.1 of the Code provides, in pertinent part, that the Board shall require a licensee who is disciplined based on inappropriate prescribing resulting in harm to patients, to disclose to his or her patients information regarding his or her probation status. The licensee is required to disclose: Probation status, the length of the probation, the probation end date, all practice restrictions placed on the license 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 Board's Internet Web site.

FACTUAL ALLEGATIONS

7. At all relevant times, Respondent was providing care and treatment for chronic pain patients, with a specialization in fibromyalgia and myofascial pain syndrome, at his offices in Monterey, California. From September 29, 2017 through March, 2020, Respondent was on probation with the Board, with terms that included clinical competence assessment, a practice monitor, and to maintain a record of all controlled substances prescribed.

8. In and before September, 2017, Patient 1[1], a 57 year old female, was under Respondent's care and treatment for chronic pain. Respondent provided treatment for the patient's condition with trigger point injections, opiates, muscle relaxants and benzodiazepines. After he was placed on probation, Respondent began to taper the patient's pain medications. In 2017-2018, Oxycontin[2], 40 mg, TID, #90, was eliminated. Norco[3], 10/325 mg, 8/day, #240, was

[1] Patient names are redacted to protect privacy rights.

[2] Oxycontin (oxycodone hydrochloride) is a potent narcotic used to treat moderate to severe pain. Oxycontin exposes patients and other users to the risks of opioid addiction, abuse and misuse.

[3] Norco is a trade name for hydrocodone bitartrate and acetaminophen, a controlled substance and an opiate medication with the potential for habituation and use.

reduced to #150 (5/day), Soma[4], #120 was reduced from 4/day to 3/day, with clonazepam[5], 2 mg/day, added to the regimen. Although he tapered her opioid medications, Respondent did not perform periodic comprehensive reassessments of her chronic pain, but instead maintained her on a treatment plan of trigger point injections and medications without appropriate consultations or referrals for physical therapy, psychotherapy and other adjunct treatments for her condition. In addition to her opioid medications, Respondent maintained the patient on a benzodiazepine and muscle relaxant, despite the risk of CNS depression and respiratory arrest presented by this combination of medications. Whether due to inadequate pain control or a substance abuse disorder, Patient 1 obtained and used street drugs, including heroin and methamphetamine. Respondent did not perform a complete physical examination, which would have revealed track marks as evidence of the patient's intravenous drug abuse, nor did he order routine urine toxicology screens to detect drug abuse. She died of a drug overdose on February 13, 2019, approximately a month after being discharged from Respondent's care.

9. In and before September 2017, Patient 2, a 38 year old female, was under Respondent's care and treatment for fibromyalgia. Patient 2 could not tolerate trigger point injections and Respondent's treatment consisted of prescribing opioids and benzodiazepines. Prior to September 2017, Patient 2 had been on extremely high doses of opioid medications, exceeding an MME[6] of 400. In and after 2017, Respondent gradually tapered the patient's opioid medications. In September, 2017, Respondent prescribed oxycodone hydrochloride[7], 20 mg, Q 4-6 hours, #150, Dilaudid[8], 8 mg, BID, #60, Adderall[9], 30 mg, ½ tablet BID, #30, which dosage

[4] Soma (carisoprodol) is a muscle relaxant and a controlled substance, which can have dangerous addictive side effects when taken with opioids.

[5] Clonazepam, which is marketed under the trade name Klonopin, is a benzodiazepine used to treat panic disorder and which can have dangerous additive side effects when taken in combination with opioids.

[6] Morphine Milligram Equivalents (MME) are used to quantify the amount of opioids across multiple drugs. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ⩾50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ⩾90 MME/day or carefully justify a decision to titrate dosage to ⩾90 MME/day.

[7] See fn. 2 above.

[8] Hydromorphone hydrochloride, which is marketed under the trade name Dilaudid, is a potent opioid agonist and controlled substance.

[9] Adderall (amphetamine salt combination) is a potent stimulant with a high potential for

he modified over time, substituting Percocet[10], 10/325 mg, for oxycodone HCL, and reducing the patient's MME to approximately 75 MME/day. At the same time that he was prescribing opioids, Respondent prescribed Valium, a benzodiazepine, 10 mg, TID, thereby increasing the risk of respiratory arrest. Patient 2 frequently missed appointments for several months at a time; however, Respondent continued to prescribe dangerous medications to her without an in-person meeting, examination or comprehensive reevaluation of the patient's condition. Patient 2 reported little or no relief from her opioid medications. Despite her lack of improvement, Respondent did not refer her for physical therapy, psychotherapy or other alternative modes of treatment for her diagnosis of fibromyalgia.

10. In and before September 2017, Patient 3, a 34 year old male, was under Respondent's care and treatment for myofascial pain syndrome. Respondent's treatment plan consisted of trigger point injections, opioid and benzodiazepine medications. In September 2017, Respondent was prescribing methadone[11], 10 mg, 5/day, oxycodone HCL, 20 mg, BID, #60, and clonazepam, 2 mg, TID, #120. Respondent did not refer the patient for a multidisciplinary approach to treat his diagnosed myofascial pain syndrome, nor did he perform a periodic comprehensive reevaluation of the patient's condition. Respondent did taper Patient 3's opioid and benzodiazepine medications to oxycodone HCL, 10 mg, 1.5 tablets/day, #45, and clonazepam, 1 mg, QD, #30; however, the combination of opioids and benzodiazepines created a risk of CNS depression and overdose.

11. Patient 4, a 65 year old female, was under Respondent's care and treatment for myofascial pain syndrome of the neck and shoulders from September 20, 2016 through April 9, 2019. Respondent provided treatment for the patient's chronic pain with trigger point injections and Percocet, 10/325 mg, TID, #90. This treatment plan remained in place for the course of

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misuse and abuse.

[10] Percocet (oxycodone/APAP) is a controlled substance and an opioid indicated for treatment of moderate to severe pain.

[11] Methadone hydrochloride is a controlled substance and an opioid indicated for the treatment of pain severe enough to require around-the-clock long-term opioid management and for which alternative treatments have failed. Methadone exposes users to the risks of opioid addiction, misuse and abuse, which can lead to overdose and death.

Patient 4's treatment without appropriate consultations or referrals for multidisciplinary treatments for her myofascial pain syndrome. The trigger point injections utilized by Respondent contained local anesthetics, i.e., Marcaine[12], 0.5%, and lidocaine[13], 1%. The package insert for Marcaine states:

> Local anesthetics should be employed only by clinicians who are well versed in diagnosis and management of dose-related toxicity and other acute emergencies . . . and then only after insuring the immediate availability of oxygen, other resuscitative drugs, cardiopulmonary resuscitative equipment, and the personnel resources needed for proper management of toxic reactions and related emergencies . . .

Although Respondent routinely administered trigger point injections with local anesthetics, he did not have oxygen, other resuscitative drugs or cardiopulmonary resuscitative equipment available in his office. Respondent was not certified in basic life support or advanced cardiovascular life support. On April 9, 2019, while administering trigger point injections on Patient 4, Respondent performed an injection in the vicinity of the cervical spine. After the injections, Patient 4 reported that she was not feeling well and, later, stated that both her arms were numb. Patient 4 subsequently collapsed in Respondent's office. Arriving fire department paramedics found her pulseless and apneic. Patient 4 was rushed to a hospital where she was resuscitated after her cardiac arrest.

CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts)

12. Respondent David Michael Kolinsky, M.D. is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) in that he engaged in unprofessional conduct and/or gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent failed to perform periodic complete reassessment of the patient's condition and reevaluation of the overall treatment plan;

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[12] Marcaine (bupivacaine hydrochloride) is a local anesthetic. It is longer acting than lidocaine and can be used for a spinal block.

[13] Lidocaine, which is marketed under the trade name Xylocaine, is a local anesthetic or numbing medication used for local or regional anesthesia.

B. Respondent limited his treatment of fibromyalgia and myofascial pain syndrome to trigger point injections and opioid medications and failed to refer his patients for appropriate multidisciplinary treatment of their conditions, including physical therapy and psychotherapy;

C. Respondent failed to conduct a complete physical examination or to perform urine toxicology screens on Patient 1;

D. Respondent prescribed potent and potentially dangerous drugs to Patient 2 without regular face-to-face evaluations;

E. Respondent inappropriately prescribed benzodiazepines in combination with opioids;

F. Respondent provided trigger point injections without having basic resuscitative equipment available for airway management, emergency resuscitative drugs or cardiopulmonary resuscitative equipment available.

DISCIPLINARY CONSIDERATIONS

13. To determine the degree of discipline, if any, to be imposed on Respondent David Michael Kolinsky, M.D., Complainant alleges that on or about September 29, 2017, in a prior disciplinary action titled "In the Matter of the Accusation Against David Michael Kolinsky, M.D." (Case Number 8002016024569), Respondent's license was placed on probation based on allegations of inappropriate and excessive prescribing of opioids and benzodiazepines. That decision is now final and is incorporated by reference 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 Number A 60010, issued to David Michael Kolinsky, M.D.;

2. Revoking, suspending or denying approval of David Michael Kolinsky, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering David Michael Kolinsky, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: OCT 0 1 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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