

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

In the Matter of the Accusation Against:

Jennifer Ann Wilson, M.D.

Physician's & Surgeon's
Certificate No. A 86620

Respondent.

Case No. 800-2017-035705

DECISION

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

This Decision shall become effective at 5:00 p.m. on February 18, 2021.

IT IS SO ORDERED January 19, 2021.

MEDICAL BOARD OF CALIFORNIA



Kristina D. Lawson, J.D., Chair
Panel B

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LYNNE K. DOMBROWSKI
Deputy Attorney General
4 State Bar No. 128080
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 510-3439
6 Facsimile: (415) 703-5480
E-mail: Lynne.Dombrowski@doj.ca.gov
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:
13 **JENNIFER ANN WILSON, M.D.**
14 Community Health Clinic OLE
1141 Pear Tree Lane Ste 100
15 Napa, CA 94558
16 Physician's and Surgeon's Certificate
No. A 86620
17
18 Respondent.

Case No. 800-2017-035705
OAH No. 2020090574
**STIPULATED SETTLEMENT FOR
PUBLIC REPRIMAND AND
DISCIPLINARY ORDER**

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

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Xavier Becerra, Attorney General of the State of California, by Lynne K. Dombrowski,
26 Deputy Attorney General.

27 2. Respondent Jennifer Ann Wilson, M.D. (Respondent) is represented in this
28 proceeding by attorney Joseph S. Picchi, Esq. whose address is: Galloway, Lucchese, Everson &

1 Picchi, 2300 Contra Costa Blvd., Suite 350, Pleasant Hill, CA 94523-2398, tel. no. 925-930-
2 9090, email: jp Picchi@glattys.com.

3 3. On or about April 2, 2004, the Board issued Physician's and Surgeon's Certificate No.
4 A 86620 to Jennifer Ann Wilson, M.D. (Respondent). The Physician's and Surgeon's Certificate
5 was in full force and effect at all times relevant to the charges brought in Accusation No. 800-
6 2017-035705 and will expire on April 30, 2022, unless renewed.

7 **JURISDICTION**

8 4. Accusation No. 800-2017-035705 was filed before the Board, and is currently
9 pending against Respondent. The Accusation and all other statutorily required documents were
10 properly served on Respondent on January 11, 2019. Respondent timely filed her Notice of
11 Defense contesting the Accusation.

12 5. A copy of Accusation No. 800-2017-035705 is attached as Exhibit A and is
13 incorporated herein by reference.

14 **ADVISEMENT AND WAIVERS**

15 6. Respondent has carefully read, fully discussed with counsel, and understands the
16 charges and allegations in Accusation No. 800-2017-035705. Respondent has also carefully read,
17 fully discussed with her counsel, and understands the effects of this Stipulated Settlement and
18 Disciplinary Order.

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

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

27 ///

28 ///

1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 800-2017-035705, if proven at a hearing, constitute cause for imposing discipline upon her
4 Physician's and Surgeon's Certificate.

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

9 11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to
10 discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the
11 Disciplinary Order below.

12 CONTINGENCY

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

23 13. The parties understand and agree that Portable Document Format (PDF) and facsimile
24 copies of this Stipulated Settlement for Public Reprimand and Disciplinary Order, including PDF
25 and facsimile signatures thereto, shall have the same force and effect as the originals.

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

1 **DISCIPLINARY ORDER**

2 A. PUBLIC REPRIMAND

3 IT IS HEREBY ORDERED that Respondent Jennifer Ann Wilson, M.D., Physician's and
4 Surgeon's Certificate No. A 86620, shall be and hereby is publicly reprimanded pursuant to
5 California Business and Professions Code section 2227, subdivision (a)(4). This public
6 reprimand, which is issued in connection with Respondent's conduct as set forth in Accusation
7 No. 800-2017-035705, is as follows:

8 You demonstrated unprofessional conduct through your acts and omissions in the
9 treatment of Patient A and by failing to maintain adequate patient medical records,
10 pursuant to Business and Professions Code section 2234, subdivision (c) and section 2266.

11
12 B. IT IS FURTHER ORDERED:

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

22 A prescribing practices course taken after the acts that gave rise to the charges in the
23 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
24 or its designee, be accepted towards the fulfillment of this condition if the course would have
25 been approved by the Board or its designee had the course been taken after the effective date of
26 this Decision. Respondent shall submit a certification of successful completion to the Board or its
27 designee not later than 15 calendar days after successfully completing the course, or not later than
28 15 calendar days after the effective date of the Decision, whichever is later.

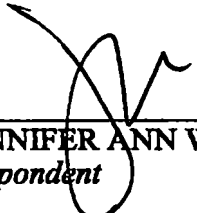
1 2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
2 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
3 advance by the Board or its designee. Respondent shall provide the approved course provider
4 with any information and documents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

10 A medical record keeping course taken after the acts that gave rise to the charges in the
11 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
12 or its designee, be accepted towards the fulfillment of this condition if the course would have
13 been approved by the Board or its designee had the course been taken after the effective date of
14 this Decision. Respondent shall submit a certification of successful completion to the Board or its
15 designee not later than 15 calendar days after successfully completing the course, or not later than
16 15 calendar days after the effective date of the Decision, whichever is later.

17 **ACCEPTANCE**

18 I have carefully read the above Stipulated Settlement for Public Reprimand and
19 Disciplinary Order and have fully discussed it with my attorney, Mr. Joseph S. Picchi. I
20 understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate.
21 I enter into this Stipulated Settlement for Public Reprimand and Disciplinary Order voluntarily,
22 knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical
23 Board of California. I fully understand that any failure to comply with the terms and conditions
24 of the Disciplinary Order set forth above shall constitute unprofessional conduct and that my
25 Physician's and Surgeon's Certificate will be subject to further disciplinary action.

26
27 DATED: 11/9/20

28 


JENNIFER ANN WILSON, M.D.
Respondent

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

ACCEPTANCE

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

DATED: November 13, 2020



JOSEPH S. PICCHI, ESQ.
Attorney for Respondent

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28


ENDORSEMENT

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

DATED: 11/16/2020

Respectfully submitted,

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


LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

SF2018201631

Exhibit A

Accusation No. 800-2017-035705

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LYNNE K. DOMBROWSKI
Deputy Attorney General
4 State Bar No. 128080
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 510-3439
6 Facsimile: (415) 703-5480
E-mail: Lynne.Dombrowski@doj.ca.gov
7 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 11 20 19
BY K. Young ANALYST

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

12
13 In the Matter of the Accusation Against:

Case No. 800-2017-035705

14 **JENNIFER ANN WILSON, M.D.**
Community Health Clinic OLE
15 1141 Pear Tree Lane, Suite 100
Napa, CA 94558

ACCUSATION

16 Physician's and Surgeon's Certificate
17 No. A 86620,

18 Respondent.

19
20 Complainant alleges:

21 **PARTIES**

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

25 2. On or about April 2, 2004, the Medical Board issued Physician's and Surgeon's
26 Certificate Number A 86620 to Jennifer Ann Wilson, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
28 herein and will expire on April 30, 2020, unless renewed.

1 3. At all times alleged herein, Respondent was board-certified in Family Medicine and
2 worked at the Community Health Clinic OLE ("Clinic OLE") in Napa, California.

3 **JURISDICTION**

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

6 5. Section 2234 of the Code, states:

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

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

12 "(b) Gross negligence.

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

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

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

23 "(d) Incompetence.

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

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

27 "(g) The practice of medicine from this state into another state or country without meeting
28 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not

1 apply to this subdivision. This subdivision shall become operative upon the implementation of the
2 proposed registration program described in Section 2052.5.

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

6 6. Section 2228 of the Code states, in pertinent part:

7 “The authority of the board . . . to discipline a licensee by placing him or her on probation
8 includes, but is not limited to, the following:

9 “(a) Requiring the licensee to obtain additional professional training and to pass an
10 examination upon the completion of the training. The examination may be written or oral, or
11 both, and may be a practical or clinical examination, or both, at the option of the board or the
12 administrative law judge.

13 “(b) Requiring the licensee to submit to a complete diagnostic examination by one or more
14 physicians and surgeons appointed by the board. If an examination is ordered, the board shall
15 receive and consider any other report of a complete diagnostic examination given by one or more
16 physicians and surgeons of the licensee’s choice.

17 “(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including
18 requiring notice to applicable patients that the licensee is unable to perform the indicated
19 treatment, where appropriate.

20 “(d) Providing the option of alternative community service in cases other than violations
21 relating to quality of care.”

22 7. Section 2242 of the Code states:

23 “(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022
24 without an appropriate prior examination and a medical indication, constitutes unprofessional
25 conduct.

26 “(b) No licensee shall be found to have committed unprofessional conduct within the
27 meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of
28 the following applies:

1 “(1) The licensee was a designated physician and surgeon or podiatrist serving in the
2 absence of the patient’s physician and surgeon or podiatrist, as the case may be, and if the drugs
3 were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return
4 of his or her practitioner, but in any case no longer than 72 hours.

5 “(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed
6 vocational nurse in an inpatient facility, and if both of the following conditions exist:

7 “(A) The practitioner had consulted with the registered nurse or licensed vocational nurse
8 who had reviewed the patient’s records.

9 “(B) The practitioner was designated as the practitioner to serve in the absence of the
10 patient’s physician and surgeon or podiatrist, as the case may be.

11 “(3) The licensee was a designated practitioner serving in the absence of the patient’s
12 physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized
13 the patient’s records and ordered the renewal of a medically indicated prescription for an amount
14 not exceeding the original prescription in strength or amount or for more than one refill.

15 “(4) The licensee was acting in accordance with Section 120582 of the Health and Safety
16 Code.”

17 8. Section 725 of the Code states:

18 “(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering
19 of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated
20 acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of
21 the community of licensees is unprofessional conduct for a physician and surgeon, dentist,
22 podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language
23 pathologist, or audiologist.

24 “(b) Any person who engages in repeated acts of clearly excessive prescribing or
25 administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of
26 not less than one hundred dollars (\$100) nor more than six hundred dollars (\$600), or by
27 imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and
28 imprisonment.

1 “(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or
2 administering dangerous drugs or prescription controlled substances shall not be subject to
3 disciplinary action or prosecution under this section.

4 “(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section
5 for treating intractable pain in compliance with Section 2241.5.”

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

9 **PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS**

10 10. Alprazolam, known by the trade name Xanax, is a psychotropic triazolo-analogue of
11 the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the
12 management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a
13 dangerous drug as defined in section 4022 and a Schedule IV controlled substance and narcotic as
14 defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central
15 nervous system depressant effect and patients should be cautioned about the simultaneous
16 ingestion of alcohol and other CNS depressant drugs during treatment.

17 11. Diazepam, known by the trade name Valium, is a psychotropic drug of the
18 benzodiazepine class that is used for the management of anxiety disorders or for the short-term
19 relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a
20 Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

21 12. Gabapentin, known by the trade name Neurontin, is an anticonvulsant that is used to
22 prevent and control seizures and is also used to relieve nerve pain, peripheral neuropathy. It is a
23 dangerous drug as defined in Business and Professions Code section 4022.

24 13. Hydrocodone bitartrate with acetaminophen, which is known by the trade names
25 Norco or Vicodin, is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance as
26 defined by section 11055, subdivision (b) of the Health and Safety Code, and by section 1308.13

1 (e) of Title 21 of the Code of Federal Regulations¹, and is a dangerous drug as defined in
2 Business and Professions Code section 4022.

3 14. Methadone hydrochloride is a synthetic narcotic analgesic with multiple actions
4 quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and
5 a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of
6 the Health and Safety Code. Methadone can produce drug dependence of the morphine type and,
7 therefore, has the potential for being abused. Psychic dependence, physical dependence, and
8 tolerance may develop upon repeated administration of methadone, and it should be prescribed
9 and administered with the same degree of caution appropriate to the use of morphine.

10 15. Seroquel, a trade name for quetiapine fumarate, is an antipsychotic drug that is
11 sedating and is used to treat mental/mood disorders such as schizophrenia, major depressive
12 disorder, and bipolar disorder. It is a dangerous drug as defined in Business and Professions
13 Code section 4022.

14 16. Temazepam, known by the trade name Restoril, is a benzodiazepine hypnotic agent
15 used in the short-term treatment of insomnia symptoms. It is a Schedule IV controlled substance
16 and narcotic as defined by section 11057 of the Health and Safety Code and is a dangerous drug
17 as defined in Business and Professions Code section 4022.

18 17. Zolpidem tartrate, known by the trade name Ambien, is a non-benzodiazepine central
19 nervous system (CNS) depressant of the imidazopyridine class. It is a Schedule IV controlled
20 substance under Health and Safety Code section 11057, subdivision (d)(32), and is a dangerous
21 drug as defined in Business and Professions Code section 4022. It is indicated for the short-term
22 treatment of insomnia. It is a CNS depressant and should be used cautiously in combination with
23 other CNS depressants. It should be administered cautiously to patients exhibiting signs or
24 symptoms of depression because of the risk of suicide. Because of the risk of habituation and
25 dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be
26 carefully monitored while receiving Ambien.

27 ¹ Effective 10/06/2014, all hydrocodone combination products were re-scheduled from
28 Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency
("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

1 FIRST CAUSE FOR DISCIPLINE

2 **(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or**
3 **Excessive Prescribing and/or Prescribing without Appropriate Examination: Patient A.)**

4 18. Respondent is subject to disciplinary action for unprofessional conduct for gross
5 negligence and/or repeated acts of negligence and/or prescribing without appropriate prior
6 examination and medical indications and/or repeated acts of clearly excessive prescribing, under
7 sections 2234, subd. (b) and/or 2234, subd. (c) and/or 2242 and/or 725, as described herein below.

8 19. In or about October 2006, Respondent began treating Patient A for chronic pain
9 syndrome. The patient's chronic pain arose from a work-related injury that nearly amputated his
10 leg. Patient A also had a history of alcohol abuse and suffered from major depression and
11 anxiety.

12 20. In or about January 2007, Patient A began participating in a monthly Chronic Pain
13 Management Support Group at Clinic OLE that included monthly visits with Respondent.

14 21. During the course of Patient A's treatment, Respondent prescribed methadone in
15 combination with other controlled substances while Patient A was also struggling with alcohol
16 abuse.

17 22. From about October 2009 to November 2010, Patient A moved from Napa County to
18 Lake County and received treatment and controlled substances from another physician in Lake
19 County.

20 23. On or about February 7, 2012, Respondent saw Patient A and prescribed to him
21 multiple controlled substances: #150 Norco 10-325 mg., #150 Methadone HCl 10 mg., #90
22 Ibuprofen 800 mg. Respondent stopped prescribing Valium 5 mg. and prescribed #60
23 Temazepam. Respondent referred Patient A to a Licensed Clinical Social Worker, a behavioral
24 health consultant, because he was struggling with alcohol abuse and depressive symptoms.

25 24. On or about February 13, 2012, Patient A saw a Licensed Clinical Social Worker
26 ("LCSW") at the Clinic OLE. During that session, Patient A disclosed that, four months earlier
27 he had attempted suicide with a gun and that he had a history of alcohol and of marijuana abuse.
28

1 25. On or about July 24, 2012, Respondent saw Patient A who was complaining of
2 increased knee pain. Respondent noted that the patient reported that his last alcoholic drink was
3 five weeks ago and that he had been arrested for having an altered firearm, a shotgun.
4 Respondent continued to prescribe monthly for Patient A: #150 Methadone 10 mg., #120 Norco
5 10-325 mg., #60 Temazepam 30 mg., and #90 Ibuprofen 800 mg. Respondent also added a
6 prescription for Gabapentin 100 mg.

7 26. On or about August 2, 2012, Patient A saw the LCSW about his depression. The
8 LCSW noted in the patient's chart a diagnosis of Psychotic Disorder NOS.

9 27. On or about August 14, 2012, Respondent saw Patient A and noted in his chart that it
10 was unclear whether his Psychotic Disorder NOS was "substance-abuse related or true mental
11 illness." Respondent noted that the patient began to drink alcohol at age 13 and consistently
12 consumed alcohol for 40 years. Although Respondent mentioned in the chart note that she
13 discussed with the patient how each prescribed medication worked, she did not document a
14 discussion about the dangers of a potential overdose should he drink alcohol while consuming the
15 combination of prescribed drugs. Respondent refilled prescriptions for #150 Methadone, #120
16 Norco 10-325 mg., Ibuprofen 800 mg., and #90 Gabapentin 100 mg. Respondent also added a
17 prescription for #30 Seroquel 200 mg. with three refills.

18 28. On or about September 4, 2012, Respondent saw Patient A as part of his monthly
19 chronic pain group session. Respondent continued to prescribe Gabapentin 100 mg., Ibuprofen
20 800 mg., Temazepam 30 mg., #180 Methadone HCl 10 mg., and #120 Norco 10-325 mg., and
21 #30 Risperdal 3 mg. Respondent noted that the patient agreed to meet with a consulting
22 psychiatrist "for clarification of diagnosis." Respondent also noted that the patient reported that
23 he could not afford the Seroquel and did not get the Risperdal prescription.

24 29. On or about September 12, 2012, Respondent saw Patient A for a psychiatric
25 consultation. Respondent noted a discussion with the consultant psychiatrist at Clinic OLE who
26 agreed that the patient was exhibiting psychotic symptoms and agreed with using Seroquel and
27 avoiding all benzodiazepines. Patient A asked for a prescription for Xanax because he had tried
28 some of his friend's supply and felt great. Respondent noted that she reiterated that he was to

1 avoid all benzodiazepines "given his extensive struggle with alcohol." Respondent also noted
2 that the patient was to start Seroquel and avoid all other sleep aids. Respondent prescribed #60
3 Seroquel 100 mg. with three refills and noted that she was stopping the Risperdal 3 mg. and
4 Temazepam 30 mg.

5 30. In August 2012, Respondent documented reviewing a CURES report for Patient A
6 and obtaining a urine toxicology screen, which did not include a test for alcohol.

7 31. On or about January 8, 2013, Respondent next saw Patient A who reported that he did
8 not want to take Norco. Respondent increased the prescription of Methadone to #180 Methadone
9 10 mg., and added a prescription for #30 Zolpidem tartrate 12.5 mg. extended release. Patient A
10 was also still taking Gabapentin 100 mg., Ibuprofen 800 mg., and Seroquel 100 mg. Respondent
11 noted that the "patient will price the sleep aid and purchase whichever is most affordable,
12 pharmacy instructed to void other Rx."

13 32. In January, February, April, and May 2013, Patient A filled concurrent prescriptions
14 from Respondent for both Zolpidem tartrate and Temazepam.

15 ~~33. On or about February 5, 2013, Respondent saw Patient A and ordered a urine~~
16 toxicology drug screen, which did not include testing for alcohol. Although it was noted in the
17 patient's chart that a "pain contract" was done, there was no copy of a pain contract in Patient A's
18 records. Respondent noted stopping the Norco and continuing prescriptions for Gabapentin,
19 Methadone, and Ibuprofen.

20 34. On or about March 5, 2013, Respondent saw Patient A and refilled the prescription
21 for #180 Methadone HCl 10 mg. and continued Ibuprofen 800 mg. Patient A was to follow-up in
22 four weeks, to attend the chronic pain management support group. Respondent made a note
23 under "depression" that appears to indicate that Gabapentin was to be replaced with Temazepam
24 30 mg. at bedtime, although neither drug is indicated for treatment of depression. Respondent,
25 however, did not stop the Gabapentin but actually increased the dose of Gabapentin from 100 mg.
26 to 300 mg. Respondent's chart note for the visit was not signed until March 16, 2018.

27 35. From March through May 2013, Patient A continued to fill prescriptions from
28 Respondent for Methadone, Temazepam, and Zolpidem tartrate.

1 36. Patient A's next, and last, visit with Respondent was on or about July 2, 2013. This
2 visit was focused on the patient's shoulder pain and numbness. The patient reported being seen
3 and getting medications from a physician in Lake County. Respondent noted that the patient
4 reported drinking 1-2 beers a night. It was noted that the patient said that the Methadone was
5 making him sick and that the Seroquel was not working as well, wanted to go back to taking
6 Temazepam. Respondent appears to have prescribed (restarted) gabapentin for Patient A. It is
7 mentioned under the treatment plan for chronic pain but without an explanation for why it was
8 stopped and restarted. Respondent prescribed #180 Methadone HCl and wrote a prescription for
9 Temazepam, without documenting medical indications for these prescriptions. Respondent also
10 prescribed #90 Gabapentin 300 mg. with three refills, #90 Ibuprofen 800 mg., and Seroquel 100
11 mg. and issued a new prescription for #30 Lunesta with three refills. The patient was to follow-
12 up with a visit in four weeks. Respondent's chart note for the visit was not signed until July 9,
13 2013.

14 37. At an interview during the Medical Board's investigation, Respondent stated that she
15 thought that, at the July 2, 2013 visit, Patient A's reported nausea from Methadone was related to
16 his drinking alcohol and that his gastritis was also related to alcohol abuse.

17 38. On July 4, 2013, Patient A, at age 55, was pronounced dead due to acute methadone
18 toxicity, per the coroner's investigation.

19 39. Respondent's overall conduct, acts and/or omissions, with regard to Patient A, as set
20 forth in paragraphs 18 through 38 herein, constitutes unprofessional conduct through gross
21 negligence and/or repeated negligent acts, and/or prescribing without an appropriate prior
22 examination and a medical indication and/or excessive prescribing, pursuant to Business and
23 Professions Code Sections 2234, subdivisions (b) and/or (c), and/or section 2242 and/or section
24 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of
25 unprofessional conduct with regard to Patient A as follows:

26 a. Respondent failed to adequately monitor Patient A while prescribing controlled
27 substances and other prescription medications with synergistic sedating properties in a patient
28

1 with a substance use (alcohol) disorder, which constitutes an extreme departure from the standard
2 of care.

3 b. Respondent prescribed Methadone to Patient A, in combination with Gabapentin and
4 benzodiazepines, with the knowledge of Patient A's continued use/abuse of alcohol, without
5 clearly documenting treatment goals and objectives, which constitutes an extreme departure from
6 the standard of care.

7 c. After Respondent stopped prescribing benzodiazepines in September 2012 to Patient
8 A because of his struggles with alcohol, Respondent later prescribed a benzodiazepine without
9 documenting a medical indication and without a further warning to the patient about the risks.

10 d. During the course of treatment, Respondent did not document having any discussion
11 with Patient A about the risks of overdose and death with taking the combination of prescribed
12 medications such as methadone, gabapentin, Ambien, and benzodiazepines.

13 e. During the course of treatment, Respondent failed to document counselling Patient A
14 on the risks of his medication profile in combination with his use of alcohol, particularly the
15 dangers of a potential overdose and death.

16 f. Respondent prescribed different sleep medications, such as benzodiazepines,
17 Gabapentin and Ambien, without documenting any discussion with the patient about sleep
18 hygiene or about other non-prescription drug-type treatments. Respondent also failed to clearly
19 document the medical indication for the prescribing of the different sleep medications, whether
20 the medications were being prescribed for sleep or for chronic pain.

21 g. When Respondent became aware that Patient A was receiving prescription
22 medications, controlled substances, from another physician, Respondent failed to appropriately
23 respond, such as with closer monitoring.

24 h. During the course of treatment, when Respondent became aware that the patient was
25 craving or actually consuming alcohol while taking the combination of prescribed controlled
26 substances with synergistic sedating properties, Respondent did not perform random toxicology
27 testing for alcohol prior to prescribing more opioids and benzodiazepines.

28

1 i. Although Respondent referred Patient A to psychiatry, Respondent did not discuss or
2 appear to consider prescribing antidepressants to Patient A.

3 j. At the last visit in July 2013, Respondent prescribed a high dose of Methadone
4 despite the patient reporting that he had recently received controlled substances from another
5 physician and without consulting the CURES. Respondent also prescribed Methadone even
6 though the patient reported that it caused him nausea.

7 k. In 2013, Respondent did not consult the CURES database to monitor Patient A's
8 receipt of controlled substances prescriptions.

9 l. During at least 2013, Respondent continued to prescribe controlled substances
10 without adequate follow-up.

11 m. There was no copy of a pain management agreement in Patient A's medical records.

12 n. Respondent often did not timely write her entries in Patient A's medical records.

13 o. During the course of treatment, Respondent did not obtain objective measurements to
14 determine whether Patient A was consuming alcohol, such as a toxicology or a liver function test.
15 Respondent also did not provide treatment recommendations or referrals for alcohol cessation,
16 such as referral to a substance abuse treatment specialist or to AA.

17 p. In March 2013, Respondent stopped prescribing gabapentin without documenting an
18 explanation or a medical indication for her treatment plan.

19 **SECOND CAUSE FOR DISCIPLINE**

20 **(Unprofessional Conduct: Failure to Maintain Adequate Medical Records (Patient A))**

21 40. Respondent is subject to disciplinary action for unprofessional under section 2266 for
22 failing to maintain adequate and accurate records for Patient A. Paragraphs 18 through 39 are
23 incorporated herein by reference as if fully set forth.

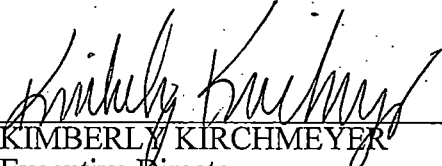
24 **PRAYER**

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

27 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 86620,
28 issued to Jennifer Ann Wilson, M.D.;

- 1 2. Revoking, suspending or denying approval of Jennifer Ann Wilson, M.D.'s authority
2 to supervise physician assistants and advanced practice nurses;
3 3. Ordering Jennifer Ann Wilson, M.D., if placed on probation, to pay the Board the
4 costs of probation monitoring; and
5 4. Taking such other and further action as deemed necessary and proper.

6
7 DATED: January 11, 2019


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

8
9
10
11 SF2018201631