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

In the Matter of the Accusation Against: Robert Adams Graham, M.D. Physician's and Surgeons Certificate No. A 32806 Respondent.	Case No. 800-2017-031578

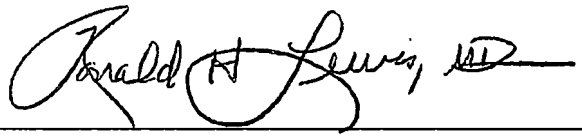
DECISION

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

This Decision shall become effective at 5:00 p.m. on February 26, 2021.

IT IS SO ORDERED: January 27, 2021.

MEDICAL BOARD OF CALIFORNIA



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

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
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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: **ROBERT ADAMS GRAHAM, M.D.** **728 E. Bullard Avenue, Suite 101** **Fresno, CA 93710** **Physician's and Surgeon's Certificate No. A 32806** Respondent.	Case No. 800-2017-031578 OAH No. 2020050338 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. 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 Lynette D. Hecker, Deputy Attorney General.

2. Robert Adams Graham, M.D. (Respondent) is represented in this proceeding by attorney Lawrence E. Wayte, Esq., whose address is: 7647 North Fresno Street, Fresno, CA 93720.

3. On or about August 21, 1978, the Board issued Physician's and Surgeon's Certificate No. A 32806 to Robert Adams Graham, 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. 800-2017-031578, and will expire on June 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-031578 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 6, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031578 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-031578. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-031578, if proven at an administrative hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case or factual basis with respect to the charges and allegations in Accusation No. 800-2017-031578, that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 32806 to disciplinary action, and Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-031578 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 32806 issued to Respondent Robert Adams Graham, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for two (2) years, to run consecutive to and taking effect immediately upon completion of the four (4) years imposed by the probationary order in case no. 800-2016-025845, on the same terms and conditions as set forth in the probationary order in case no. 800-2016-025845, which is attached as Exhibit B and incorporated here by reference as if fully set forth.

1. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-031578 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 his license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Lawrence E. Wayte, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/04/2020

ROBERT ADAMS GRAHAM, M.D.
Respondent

I have read and fully discussed with Respondent Robert Adams Graham, 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: Nov 4, 2020

LAWRENCE E. WAYTE, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: November 4, 2020

Respectfully submitted,

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

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-031578

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

In the Matter of the Accusation Against: **Robert Adams Graham, M.D.** **728 E. Bullard Avenue, Suite 101** **Fresno, CA 93710** **Physician's and Surgeon's Certificate No. A 32806,** Respondent.	Case No. 800-2017-031578 **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 August 21, 1978, the Medical Board issued Physician's and Surgeon's Certificate Number A 32806 to Robert Adams Graham, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 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 725 of the Code states, in pertinent part:

> (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, ...
>
> . . .
>
> (c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.
>
> (d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

5. This 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.

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:

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

. . .

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."

PERTINENT DRUGS AND DEFINITIONS

8. Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is

committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

9. A Controlled Substances Agreement is also known as a pain management contract or pain management agreement. A pain management agreement is recommended for patients on short-acting opioids at the time of the third visit; on long acting opioids; or expected to require more than three months of opioids. A pain management agreement outlines the responsibilities of the physician and patient during the time that controlled substances are prescribed. (Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain, November 2014.)

10. Morphine equivalent dose (MED) is an abbreviation used to evaluate the levels of opioids prescribed to a patient. The Centers for Disease Control recommends avoiding or carefully justifying any dosage greater than 90 MED/day.

11. Acetaminophen (Tylenol®) is a pain reliever and a fever reducer. It is used to treat many conditions including headache, muscle aches, arthritis, backache, toothaches, colds, and fevers. Acetaminophen is not a controlled substance.

12. Acetaminophen and codeine (Tylenol® with codeine, Tylenol 3®) is a combination of two medicines used to treat moderate to severe pain. Codeine is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of codeine. Codeine has a high potential for abuse. Codeine is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations.

13. Acetaminophen and hydrocodone bitartrate (Vicodin® and Norco®) is a combination of two medicines used to treat moderate to severe pain. Hydrocodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. Hydrocodone has a high potential for abuse. Hydrocodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1)

of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

14. Acetaminophen and oxycodone (Endocet®, Percocet®, Roxicet®) is a combination of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The Drug Enforcement Administration ("DEA") has identified opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 41.) Respiratory depression is the chief hazard from all opioid agonist preparations.

15. Alprazolam (Xanax®) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for abuse. Xanax is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

17. Butalbital (Fiorinal®) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Butalbital is a barbiturate which may be habit-forming. Tolerance, psychological dependence, and physical dependence may occur especially following prolonged use of high doses of barbiturates.

18. Carisoprodol (Soma®) is a muscle relaxant with a known potentiating effect on narcotics. It works by blocking pain sensations between the nerves and the brain. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed, it is used for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States. According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions." In December 2011, the Federal Drug Administration ("FDA") listed carisoprodol as a Schedule IV controlled substance (76 Fed.Reg. 77330 (Dec. 12, 2011).)

19. Clonazepam (Klonopin®, Clonopin®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Klonopin®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

20. Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,

subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

21. Hydromorphone (Dilaudid®) an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The DEA has identified hydromorphone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The FDA has issued black box warnings for Dilaudid® which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dialudid® with benzodiazepines or other central nervous system (CNS) depressants.

22. Fentanyl (Duragesic®) is an opioid medication that has a high potential for abuse. It is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl transdermal system is a means for conveyance of fentanyl to the patient via a patch that adheres to the skin, releasing the substance via absorption, over time. When properly prescribed and indicated fentanyl transdermal patches are indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long term opioid treatment and for which alternative treatment options are inadequate. The FDA has issued several black box warnings about fentanyl transdermal patches including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

23. Ketamine is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (g), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an analgesic that is most effective when used alongside a low-dose opioid. This is because, while it does have analgesic effects by itself, the doses required for adequate pain relief when it is used as the sole analgesic agent are considerably higher and far more likely to produce disorienting side effects. It may cause hallucinations. The short duration of effects promotes bingeing, tolerance can develop, and withdrawal symptoms (including anxiety, shaking, and palpitations) may be present in some daily users following cessation of use. The increase in recreational use prompted ketamine to be placed in Schedule III of the United States Controlled Substance Act in August 1999.

24. Methadone is an opioid medication that has a high potential for abuse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs. It may cause a prolonged QT interval (a rare heart problem that may cause irregular heartbeat, fainting, or sudden death).

25. Oxycodone (Oxaydo®, OxyCONTIN®, Oxyfast®, Roxicodon®, Xtampza ER®) is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. When properly prescribed and indicated, oxycodone is used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate. Respiratory depression is the chief hazard from all opioid agonist preparations. The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2

of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.)

26. Phentermine HCL (Lonamin®, Fastin®, Adipex®) an anorectic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated phentermine HCL is used as a short term adjunct in a regimen of weight reduction based on exercise, behavioral modification, and caloric restriction. According to the DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is frequently encountered on the illicit market.

27. Pregabalin (Lyrica®) is an antiepileptic drug, also called an anticonvulsant. It works by slowing down impulses in the brain that cause seizures. It also affects chemicals in the brain that send pain signals across the nervous system. It is a dangerous drug pursuant to Business and Professions Code section 4022. It is a Schedule V controlled substance and narcotic as defined by section 11058 of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.15 (e)(4) of Title 21 of the code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. When properly prescribed and indicated, pregabalin is used for, among other things, the treatment of neuropathic pain associated with spinal cord injury and/or the management of fibromyalgia or seizures. Caution must be exercised when prescribing pregabalin to patients with a history of depression, suicidal thoughts, drug and/or alcohol addiction.

28. Tapentadol hydrochloride (Nucynta®) is an opioid pain medication or narcotic that is used to treat moderate to severe pain. Tapentadol hydrochloride has a high potential for abuse. Tapentadol hydrochloride is a Schedule II controlled substance and narcotic as defined by both Health and Safety Code section 11055, subdivision (b)(l), and Section 1308.12(b)(l) of Title 21 of

the Code of Federal Regulations as well as a dangerous drug as defined in Business and Professions Code section 4022.

29. Tramadol (Ultram®) an opioid analgesic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Tramadol has the potential for abuse. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.

FACTUAL ALLEGATIONS

30. At all times relevant to the charges brought herein, Respondent worked as a sole practitioner in a clinic in Fresno, California. Each of the patients discussed below saw Respondent as their primary care physician.

Circumstances related to Patient A[1]

31. Patient A saw Respondent as her primary care physician for many years, since at least 2005. She was treated for a variety of medical conditions, including back pain, muscle spasm and peripheral neuropathy, trouble sleeping, headaches, and fibromyalgia. Her medical issues began with back problems and pain. Though she obtained back surgery, her pain was not relieved and instead worsened. Subsequently, her complaints regularly included low back pain radiating peripherally neuropathically which made her very unhappy and/or depressed, to the point of sometimes expressing suicidal ideations to Respondent. Patient A regularly complained to Respondent that almost every part of her body always hurts. Overtime, her back pain expanded beyond her lower back to include her thoracic spine. Though x-rays were taken, no particular abnormalities were found to substantiate the amount of pain complained of by Patient A.

32. On or about October 14, 2015, Respondent completed a brief evaluation of Patient A and refilled her prescriptions for medications: Tramadol, Dilaudid, and methadone for back pain; Soma for muscle spasms and peripheral neuropathy; and Valium for trouble sleeping and muscle spasms. Respondent realized that Patient A's addictive behavior was severe, but continued to prescribe both tramadol and Dilaudid, which are short-acting pain relievers, for Patient A because she insisted that she could not maintain her job as a hairdresser without all of the medication he

[1] Patients are referred to by letter to protect their privacy.

was prescribing for her at that time. On or about February 19, 2016, Patient A was seen by Respondent for having fallen on her right knee. Respondent took an x-ray of her knee and again refilled her medications.

33. On or about March 10, 2016, Patient A presented complaining of having difficulty obtaining her medication from her pharmacy. Respondent prescribed 180 tablets of Norco and refilled both her prescription of Valium and a previous prescription of oxycodone. On or about May 4, 2016, Patient A presented to Respondent requesting a change in medication, complaining that Lisinopril, which Respondent previously prescribed, was not working. Respondent noted that Patient A had back pain since a motor vehicle accident which occurred 16 years before, but that her neck, abdomen, and chest were normal on exam. Despite this, Patient A complained of a lot of pain. Patient A had stopped taking methadone. Respondent increased Patient A's Lisinopril from 5 mg to 20 mg, changed Patient A's prescription from Norco to Percocet, and terminated her oxycodone prescription. Respondent noted that Patient A was no longer taking methadone because the pharmacy would no longer dispense it to her. Despite complaints of withdrawal, Patient A still went to work and Respondent believed she was offsetting with Norco or Percocet.

34. Respondent did not see Patient A again until on or about August 1, 2016. Despite this, though Respondent only wanted Patient A to take a maximum of 4 Soma per day, he issued prescriptions for Patient A for 60 Soma which she filled on or about May 10, 2016, and for 120 Soma which she filled on or about May 25, 2016, June 24, 2016, July 7, 2016, and August 1, 2016. This allowed her to take up to 6 per day during those months.

35. On or about August 1, 2016, Patient A presented to Respondent for refills of Valium, Percocet, tramadol, Soma, and Norvasc. Respondent noted that Patient A had a new pain complaint related to injury to her right index finger. Respondent noted that she had degenerative arthritis and "lots of back pain." On or about August 23, 2016, Respondent noted that Patient A had run out of oxycodone and wanted Respondent to increase her prescription. Respondent declined and refilled her prescription at the level previously prescribed.

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36. On or about December 6, 2016, Patient A came in for refills and a nurse noted she was "shaky." However, Respondent spent little, if any, time with Patient A and merely ordered refills for her prescriptions of tramadol, Soma, Valium, and Percocet.

37. On or about January 9, 2017, Patient A presented to Respondent in follow-up to a recent hospital visit. She presented with complaints of passing out since the prior week, vertigo, blurred vision, gait disturbance, worsening headaches, some incontinence, memory loss, her chest was tired, and she had chest pain. Respondent noted Patient A had back surgery 4-5 years ago, has had facet epidural injections, and needs a total lumbar fusion. Patient A had been on vacation for three or four days. Respondent noted that Patient A had variable use of Percocet, taking up to as many as 10 per day, with Soma and a few Valium. Respondent confronted Patient A that her symptoms were drug caused and told her that she was using an excessive amount of her medications and that "vacation just about killed her." Despite this, Respondent ordered refills of her prescriptions for Soma, tramadol, Diazepam and Percocet at the same dosage he previously prescribed for Patient A.

38. On or about March 7, 2017, Patient A reported that only Percocet decreased her pain. Methadone or other opiates were not effective pain-relievers. On or about June 5, 2017, Patient A's medication use was going down and she no longer mentioned suicidal thoughts.

39. According to the CURES report, during the period of on or about December 16, 2015, through on or about August 5, 2017, Patient A filled the following prescriptions of controlled substances that were prescribed by Respondent:

Date Filled	Drug Name	Strength	Quantity
12/16/15	METHADONE HCL	10mg	300
12/16/15	CARISOPRODOL	350mg	120
12/16/15	DIAZEPAM	10mg	30
12/16/15	HYDROMORPHONE HCL	4mg	270
12/18/15	TRAMADOL HCL	50mg	240
1/14/16	CARISOPRODOL	350mg	120
1/14/16	TRAMADOL HCL	50mg	240
1/14/16	DIAZEPAM	10mg	30
1/20/16	METHADONE HCL	10mg	300
1/20/16	HYDROMORPHONE HCL	4mg	270

3/10/16	DIAZEPAM	10mg	60
3/10/16	ACETAMINOPHEN-HYDROCODONE BITARTRATE	325mg-10mg	180
3/10/16	CARISOPRODOL	350mg	120
3/15/16	TRAMADOL HCL	50mg	240
4/11/16	CARISOPRODOL	350mg	120
4/11/16	DIAZEPAM	10mg	30
4/11/16	ACETAMINOPHEN-HYDROCODONE BITARTRATE	325mg-10mg	150
5/4/16	TRAMADOL HCL	50mg	240
5/4/16	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	180
5/10/16	CARISOPRODOL	350mg	60
5/10/16	DIAZEPAM	10mg	60
5/25/16	CARISOPRODOL	350mg	60
6/3/16	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	180
6/9/16	DIAZEPAM	10mg	60
6/9/16	TRAMADOL HCL	50mg	240
6/24/16	CARISOPRODOL	350mg	120
7/6/16	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	180
7/7/16	DIAZEPAM	10mg	60
7/7/16	TRAMADOL HCL	50mg	240
7/7/16	CARISOPRODOL	350mg	120
8/1/16	OXYCODONE HCL	20mg	120
8/4/16	TRAMADOL HCL	50mg	240
8/4/16	DIAZEPAM	10mg	60
8/4/16	CARISOPRODOL	350mg	120
8/28/16	OXYCODONE HCL	20mg	120
8/30/16	METHADONE HCL	10mg	300
9/3/16	TRAMADOL HCL	50mg	240
9/3/16	CARISOPRODOL	350mg	120
9/3/16	DIAZEPAM	10mg	60
10/2/16	CARISOPRODOL	350mg	120
10/2/16	DIAZEPAM	10mg	60
10/2/16	TRAMADOL HCL	50mg	240
10/3/16	METHADONE HCL	10mg	300
10/6/16	OXYCODONE HCL	20mg	120
11/1/16	CARISOPRODOL	350mg	120
11/1/16	TRAMADOL HCL	50mg	240
11/1/16	DIAZEPAM	10mg	60
11/6/16	METHADONE HCL	10mg	300
12/6/16	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
12/6/16	DIAZEPAM	10mg	60
12/6/16	TRAMADOL HCL	50mg	240
12/6/16	CARISOPRODOL	350mg	120
1/5/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
1/5/17	DIAZEPAM	10mg	60
1/5/17	TRAMADOL HCL	50mg	240

1/5/17	CARISOPRODOL	350mg	120
2/2/17	DIAZEPAM	10mg	60
2/2/17	TRAMADOL HCL	50mg	240
2/2/17	CARISOPRODOL	350mg	120
2/7/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
3/6/17	DIAZEPAM	10mg	60
3/6/17	TRAMADOL HCL	50mg	240
3/6/17	CARISOPRODOL	350mg	120
3/7/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
4/1/17	DIAZEPAM	10mg	60
4/2/17	CARISOPRODOL	350mg	120
4/2/17	TRAMADOL HCL	50mg	240
4/7/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	3000
5/6/17	CARISOPRODOL	350mg	120
5/6/17	TRAMADOL HCL	50mg	240
5/6/17	DIAZEPAM	10mg	60
5/7/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
6/6/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
6/6/17	DIAZEPAM	10mg	60
6/6/17	CARISOPRODOL	350mg	120
6/6/17	TRAMADOL HCL	50mg	240
7/4/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
7/6/17	DIAZEPAM	10mg	60
7/6/17	CARISOPRODOL	350mg	120
7/6/17	TRAMADOL HCL	50mg	240
8/5/17	OXYCODONE HCL-ACETAMINOPHEN	325mg-10mg	300
8/5/17	DIAZEPAM	10mg	60
8/5/17	TRAMADOL HCL	50mg	240
8/5/17	CARISOPRODOL	350mg	120

40. In the visits noted in paragraphs 31 through 39, above, Patient A exhibited signs of medication misuse, abuse, or addiction. Patient A had severe addictive behavior such as: demanding more medication than should be taken; specifically requesting that Respondent prescribe Soma for her; taking more Soma (6 per day) than Respondent intended to prescribe (4 per day); running out of and requesting an increase of her oxycodone prescription; suicidal thoughts (prior to June 5, 2017); requesting refills and presenting as "shaky" to a nurse; presenting on another visit with complaints of vertigo, blurred vision, gait disturbance, and headaches; had at least one significant event with health consequences from use of an excessive amount of medications.

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41. Throughout treatment, Respondent provided Patient A with high-risk combinations of medications, including long and short acting narcotics along with benzodiazepines creating a high risk for respiratory depression. Additionally, Respondent prescribed Patient A Soma, which has barbiturate metabolites and is currently a controlled substance that, especially when mixed with other respiratory depressants, causes an additional risk for side-effects such as respiratory depression.

42. During the period of on or about December 16, 2015, through on or about June 5, 2017, Respondent prescribed Patient A five different narcotics including approximately: 540 tablets of hydrocodone 10 mg; 4,610 tablets of Tramadol 50 mg; 1,500 tablets of methadone 10 mg; 540 tablets of hydromorphone 4 mg; 3,180 tablets of oxycodone 10 mg; and 2401 tablets of oxycodone 20 mg. This is an approximate average of 219 MED per day, which is high. In addition, Respondent prescribed and Patient A used 2,340 tablets of Soma 350 mg concurrently with Diazepam.

Circumstances related to Patient B

43. Respondent began seeing Patient B, a heavyset woman with multiple sclerosis and degenerative changes, on or about July of 2007.[2] Subsequently, Patient B, had an unsuccessful knee surgery, which caused pain to the point of causing her to be wheelchair bound and necessitated eventual further surgical repair.

44. As of on or about September of 2015, Patient B's current medications included Tramadol, Xanax, Phentermine, oxycodone, and fentanyl. Respondent saw Patient B on or about September 3, 2015. Her exam was unremarkable aside from being miserable from knee pain for which Respondent prescribed oxycodone 30 mg, 4 times daily.

45. On or about October 5, 2015, Patient B saw Respondent and stated that the generic fentanyl was insufficient and ineffective for her pain. Respondent prescribed the brand name medication, Duragesic, for her. On that date, Respondent noted that Patient B had received 200

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

tablets[3] of oxycodone from a pharmacy, and would pick up the remaining 40 Respondent had ordered soon. On or about November 5, 2015, Patient B reported having weak spells, occasional inability to get out of bed, and that her feet sometimes turned purple.

46. On or about January 29, 2016, Respondent gave Patient B early refills of Duragesic patches and oxycodone. On or about July 12, 2016, Patient B presented to Respondent complaining of severe pain everywhere, coupled with being very fatigued. On or about December 20, 2016, Respondent noted Patient B was deteriorating and was depressed, but made no change to her medications.

47. On or about May 2, 2017, Patient B lost a fentanyl patch and Respondent authorized an early refill for her. On or about May 26, 2017, Respondent gave Patient B the choice to receive Xanax or Soma, but not both. Patient B chose Xanax and Respondent cancelled her prescription of Soma.

48. According to the CURES report, during the period of on or about May 17, 2016, through on or about July 26, 2017, Patient B filled the following prescriptions of controlled substances that were prescribed by Respondent:

Date Filled	Drug Name	Strength	Quantity
5/17/16	TRAMADOL HCL	50mg	120
5/19/16	CARISOPRODOL	350mg	90
5/19/16	OXYCODONE HCL	30mg	240
5/19/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	1
5/22/16	PHENTERMINE HCL	37.5mg	30
5/29/16	ALPRAZOLAM	2mg	120
6/15/16	TRAMADOL HCL	50mg	120
6/15/16	CARISOPRODOL	350mg	120
6/15/16	OXYCODONE HCL	30mg	240
6/15/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	1
6/25/16	ALPRAZOLAM	2mg	120
7/12/16	OXYCODONE HCL	30mg	240
7/12/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	1
7/12/16	TESTOSTERONE MICRONIZED	---	1
7/12/16	CARISOPRODOL	350mg	120

[3] Presumably Patient B received 200 tablets of oxycodone and would receive the remaining 40 tablets shortly, but Respondent's records are so illegible and scant, and his recollection so unclear, that it is uncertain as to which medication this was.

7/13/16	PHENTERMINE HCL	37.5mg	30
7/13/16	TRAMADOL HCL	50mg	120
7/21/16	KETAMINE HCL	---	13
7/22/16	ALPRAZOLAM	2mg	120
8/3/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	2
8/8/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
8/8/16	OXYCODONE HCL	30mg	240
8/15/16	CARISOPRODOL	350mg	120
8/19/16	ALPRAZOLAM	2mg	120
8/24/16	TRAMADOL HCL	50mg	100
9/4/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
9/4/16	OXYCODONE HCL	30mg	240
9/6/16	PHENTERMINE HCL	37.5mg	30
9/15/16	CARISOPRODOL	350mg	120
9/19/16	ALPRAZOLAM	2mg	120
9/20/16	TRAMADOL HCL	50mg	100
9/21/16	KETAMINE HCL	--	13
10/2/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
10/2/16	OXYCODONE HCL	30mg	240
10/12/16	CARISOPRODOL	350mg	120
10/12/16	TRAMADOL HCL	50mg	100
10/16/16	ALPRAZOLAM	2mg	120
10/18/16	KETAMINE HCL	--	13
10/29/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
10/29/16	OXYCODONE HCL	30mg	240
11/4/16	PHENTERMINE HCL	37.5mg	30
11/10/16	KETAMINE HCL	---	13
11/12/16	ALPRAZOLAM	2mg	120
11/25/16	OXYCODONE HCL	30mg	240
11/25/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
11/29/16	CARISOPRODOL	350mg	120
12/9/16	ALPRAZOLAM	2mg	120
12/9/16	TRAMADOL HCL	50mg	100
12/21/16	KETAMINE HCL	---	13
12/22/16	OXYCODONE HCL	30mg	240
12/22/16	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
12/26/16	CARISOPRODOL	350mg	120
1/2/17	TRAMADOL HCL	50mg	100
1/5/17	ALPRAZOLAM	2mg	120
1/12/17	KETAMINE HCL	--	27
1/18/17	OXYCODONE HCL	30mg	240
1/18/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
1/25/17	TRAMADOL HCL	50mg	120
2/2/17	ALPRAZOLAM	2mg	120
2/2/17	CARISOPRODOL	350mg	120
2/14/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	30
2/14/17	OXYCODONE HCL	30mg	240

2/22/17	TRAMADOL HCL	50mg	120
3/1/17	CARISOPRODOL	350mg	120
3/1/17	ALPRAZOLAM	2mg	120
3/7/17	NUCYNTA	100mg	30
3/13/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	30
3/13/17	OXYCODONE HCL	30mg	240
3/17/17	PHENTERMINE HCL	2mg	120
3/28/17	ALPRAZOLAM	2mg	120
3/28/17	TRAMADOL HCL	50mg	120
3/28/17	CARISOPRODOL	350mg	120
4/9/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	30
4/9/17	OXYCODONE HCL	30mg	240
5/2/17	OXYCODONE HCL	30mg	240
5/3/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	1
5/6/17	OXYCODONE HCL	30mg	240
5/6/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
5/13/17	PHENTERMINE HCL	37.5mg	30
5/21/17	ALPRAZOLAM	2mg	120
5/21/17	CARISOPRODOL	350mg	120
5/22/17	TRAMADOL HCL	50mg	120
6/2/17	OXYCODONE HCL	30mg	240
6/2/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
6/17/17	ALPRAZOLAM	2mg	120
6/29/17	OXYCODONE HCL	30mg	210
6/29/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10
7/14/17	ALPRAZOLAM	2mg	120
7/26/17	OXYCODONE HCL	30mg	150
7/26/17	FENTANYL TRANSDERMAL SYSTEM	100mcg/1hr	10

49. In the visits noted in paragraphs 43 through 48, above, Patient B exhibited concerning signs and symptoms for chronic controlled substances therapy including reporting weak spells, occasional inability to get out of bed, and that occasionally her feet turned purple. Patient B received early refills of Duragesic patches and oxycodone. Patient B told Respondent that she was very fatigued and Respondent noted that Patient B was deteriorating and depressed and repeatedly lost fentanyl patches.

50. Respondent provided Patient B with high-risk combinations of medications in the form of long and short acting narcotics along with benzodiazepines, which when taken in combination create a high risk for respiratory depression. Additionally, Respondent prescribed Patient B Soma, a medication that metabolizes to barbiturates and has a potentiating effect on narcotics.

51. Respondent prescribed Patient B controlled substances from at least on or about August 3, 2016, to on or about July 26, 2017. During this time Respondent prescribed for Patient B three different narcotics including approximately: fentanyl 100 mcg/hr., 142 patches; Tramadol 50 mg, 1080 tablets; Nucynta 100 mg, 30 tablets; and oxycodone 30 mg, 3264 tablets. This is an approximate average of 525 MED per day, which is very high. This level of MEDs placed Patient B at an unacceptably high risk for abuse, misuse, addiction, and overdose. Patient B was concurrently using a prescription from Respondent for Soma (that metabolizes to a barbiturate) 350 mg, 1080 tablets and alprazolam 2 mg, 1440 tablets. Additionally, Respondent prescribed for Patient B phentermine 37.5 mg, 120 tablets.

Circumstances related to Patient C

52. Respondent began seeing Patient C nearly two decades ago, primarily for back and knee pain as well as obesity. Respondent's long-term pain management plan consisted of counseling, support, and maintaining patient advocacy. Patient C's pain was ongoing and never showed improvement. Respondent did not have a pain management contract with Patient C, though he discussed the risks of long-term opiate use with her. However, Respondent did not monitor Patient C's use of controlled substances using urine toxicology screens.

53. On or about March 4, 2015, Respondent saw Patient C and noted she had an injection in her knee, which did not prove helpful. On or about April 15, 2015, Patient C called Respondent's office and indicated that the Cymbalta he had prescribed worked well for her pain. On or about February 10, 2016, Respondent continued Patient C's prescription for Norco for her to take 8 times a day. On or about September 1, 2016, Respondent started Patient C on Lyrica. On or about January 11, 2017, Respondent saw Patient C in follow-up to an ER visit after a near syncope (fainting) episode, and noted Patient C was having headaches and dizziness. On or about February 28, 2017, Respondent saw Patient C and noted that she fell a few months prior. On or about July 21, 2017, Respondent saw Patient C and noted her continuing complaint of pain from shoulder impingement.

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54. According to the CURES report, during the period of on or about August 2, 2016, through on or about July 24, 2017, Patient C filled the following prescriptions of controlled substances that were prescribed by Respondent:

Date Filled	Drug Name	Strength	Quantity
8/2/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
8/2/16	LYRICA	75mg	60
8/31/16	DIAZEPAM	10mg	60
9/2/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
9/2/16	TRAMADOL HCL	50mg	90
10/1/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
10/15/16	DIAZEPAM	10mg	60
10/28/16	TRAMADOL HCL	50mg	90
11/1/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
11/20/16	DIAZEPAM	10mg	60
12/1/16	TRAMADOL HCL	50mg	90
12/1/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
12/22/16	DIAZEPAM	10mg	60
12/29/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
12/30/16	TRAMADOL HCL	50mg	90
1/30/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
2/1/17	TRAMADOL HCL	50mg	90
2/3/17	DIAZEPAM	10mg	60
2/28/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
3/3/17	DIAZEPAM	10mg	60
3/8/17	TRAMADOL HCL	50mg	90
3/29/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
4/14/17	TRAMADOL HCL	50mg	90
4/14/17	DIAZEPAM	10mg	60
5/26/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240
5/30/17	DIAZEPAM	10mg	60
6/1/17	TRAMADOL HCL	50mg	90
6/25/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240

7/18/17	DIAZEPAM	10mg	60
7/24/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	240

55. In the visits noted in paragraphs 52 through 54, above, Respondent provided Patient C high-risk combinations of medications. Throughout treatment, Respondent prescribed Patient C long and short acting narcotics along with benzodiazepines, which when taken in combination, cause a high risk for respiratory depression.

56. The CURES reports show that Respondent prescribed Patient C controlled substances from at least on or about August 2, 2016 to on or about July 24, 2017. During this time Respondent prescribed her two narcotics: hydrocodone 10 mg, 2880 tablets and Tramadol 50 mg, 720 tablets. This is approximately an average of 91 MEDs per day, which is a high dose. Patient C was concurrently using diazepam, 630 tablets (benzodiazepine). Additionally, Respondent prescribed Lyrica 75 mg, 60 tablets (a non-narcotic schedule IV pain reliever).

Circumstances related to Patient D

57. Respondent began seeing Patient D in the 1980s. He treated Patient D for injuries sustained in a train accident that occurred 10-15 years ago, in which she suffered vertebral fractures. Respondent prescribed Norco three times per day and Klonopin for sleep and nerves. Respondent also treated Patient D for Parkinson's and migraines. Respondent has prescribed betablockers, Fiorinal, and either Soma or Xanax (the latter two which she occasionally used interchangeably) for Patient D. Patient D signed a pain contract in May of 2018, but no urine screening for drugs were completed.

58. On or about December 17, 2014, Respondent discontinued Patient D's Norco and prescribed Tylenol with codeine instead. On or about January 8, 2015, Respondent suspected possible neuropathy for a thigh problem Patient D presented with, and noted that her Norco prescription had not been filled. On or about April 19, 2016, Respondent was aware that Patient D was taking Xanax and Soma daily.

59. According to the CURES report, during the period of on or about September 14, 2016, through on or about July 24, 2017, Patient D filled the following prescriptions of controlled substances that were prescribed by Respondent:

Date Filled	Drug Name	Strength	Quantity	Days Supply
9/14/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
9/21/16	ALPRAZOLAM	0.5mg	30	15
11/10/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
11/30/16	CARISOPRODOL	350mg	60	30
11/30/16	ALPRAZOLAM	0.5mg	30	30
12/22/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
1/20/17	ALPRAZOLAM	0.5mg	30	30
2/2/17	CARISOPRODOL	350mg	60	30
2/20/17	ALPRAZOLAM	0.5mg	30	30
3/9/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
3/9/17	CARISOPRODOL	350mg	90	30
3/27/17	ALPRAZOLAM	0.5mg	30	30
4/7/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
4/24/17	ALPRAZOLAM	0.5mg	30	30
5/26/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
7/5/17	HYDROCODONE BITARTRATE-ACETAMINOPHEN	325mg-10mg	90	30
7/24/17	CARISOPRODOL	350mg	90	30

60. In the visits noted in paragraphs 57 through 59, above, Respondent provided Patient D high-risk combinations of medications. Throughout treatment, Respondent prescribed Patient D long and short acting narcotics along with benzodiazepines, which when taken in combination, cause a high risk for respiratory depression. Additionally, Respondent concurrently prescribed Soma, a muscle relaxant that metabolizes to a barbiturate, and which potentiates opiates.

61. The CURES reports show that Respondent prescribed Patient D controlled substances from at least on or about September 14, 2016 to on or about July 24, 2017. During this time she was prescribed hydrocodone 10mg, 630 tablets (a narcotic). This is an approximate average of 20 MED per day. Respondent concurrently prescribed Soma (carisoprodol/Class IV controlled substance that metabolizes to a barbiturate) 350mg, 300 tablets and alprazolam 0.5mg, 150 tablets (benzodiazepine).

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Circumstances related to Patient E

62. Respondent initially saw Patient E in or about July of 2004. In or about 2009, Patient E was in a motorcycle accident that caused head injury, low back pain, and neuropathy. The injuries from the motorcycle accident lead to Patient E's chronic pain, for which Respondent prescribed Norco.

63. On or about April 9, 2015, Patient E's foot was noted as better and Respondent did not increase his medication. On or about July 5, 2016, and again on or about October 4, 2016, Respondent wanted to decrease Patient E's Norco to 8 ½ per day. On or about February 2, 2017, Patient E requested an early refill of medication which Respondent denied. On or about April 4, 2017, Respondent decreased Patient E's Norco from 260 to "250-240." On or about April of 2018, Patient E signed a written pain contract. Patient E had an oral, but not a written pain contract prior to that date. Drug screening of Patient E was completed in or about April of 2018, but drug screens were not conducted at all prior to that date.

64. Respondent prescribed Patient E controlled substances from at least on or about January 6, 2016, to on or about April 4, 2017. During this time, Respondent prescribed approximately Norco 10mg, 1570 tablets, which is an approximate average of 34 MED per day. Patient E was concurrently using a benzodiazepine, Xanax 1 mg, approximately 180 tablets.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

65. Respondent's Physician's and Surgeon's Certificate No. A 32806 is subject to disciplinary action under section 2227, as defined by 2234, subdivision (b), in that he committed act(s) and/or omission(s) constituting gross negligence. The factual circumstances set forth above relating to Patient A, Patient B, Patient C, Patient D, and Patient E in paragraphs 30 through 64 are hereby incorporated by reference as if set forth fully herein. Additional circumstances are as follows:

Patient A

66. Respondent prescribed long-term narcotic therapy for Patient A's reported back pain, neuropathic pain, and insomnia despite lacking evidence to support chronic opioid therapy.

Respondent failed to use screening tools such as pain intensity and interference or Sheehan Disability Scale and failed to identify the potential benefits and risks of opioid therapy. Each such failure constitutes gross negligence.

67. Respondent failed to undertake any risk assessment/stratification for prescribing long-term, high dose (greater than 90 MEDs per day) use of controlled substances, such as use of various screening tools (PHQ-2, CAGE-AID, Opioid Risk Tool, SOAPP-R). Respondent also failed to fully evaluate potential risks of combined high dose opiate therapy (oxycodone, Tramadol, methadone, hydromorphone, and hydrocodone), or the risks when taken with other respiratory depressants such as benzodiazepines (diazepam) and Soma, a muscle relaxer with barbiturate metabolites. Each such failure constitutes gross negligence.

68. Respondent failed to specify measurable goals and objectives used to evaluate treatment progress. Respondent also failed to include an exit strategy for discontinuing opioid therapy, in the event the tapering or termination of opioid therapy became necessary. Each such failure constitutes gross negligence.

69. Respondent failed to discuss potential risks of long-term opioid use, combined opioid use, combined narcotic and benzodiazepine use, and combined narcotic, benzodiazepine and Soma use with Patient A, nor did he discuss potential side effects with Patient A. Respondent also failed to discuss the risk of impaired motor skills with concern for activities such as driving and the risk of misuse, dependence, addiction, and overdose with Patient A. Finally, Respondent failed to discuss the limited evidence of benefit of long-term opioid therapy with Patient A. Each such failure constitutes gross negligence.

70. Respondent failed to document evidence of Patient A's progress toward treatment objectives – failed to document decrease in pain; failed to discuss any improvement in Patient A's level of function and experience of side effects, and failed to discuss medication abuse or diversion, nor appropriate behavior and mood with Patient A. Each such failure constitutes gross negligence.

71. Respondent failed to place Patient A on a controlled substances contract. Each such failure constitutes gross negligence.

72. Respondent failed to investigate Patient A's medication use and failed to undertake any advised compliance monitoring such as drug testing, review of CURES Reports and/or conducting pill counting. Each such failure constitutes gross negligence.

Patient B

73. Despite minimal basis for chronic opioid therapy, Respondent prescribed long-term narcotic therapy for Patient B's reported musculo-skeletal pain. Further, Respondent failed to use screening tools such as pain intensity and interference or Sheehan Disability Scale and failed to identify the potential benefits and risks of opioid therapy. Each such failure constitutes gross negligence.

74. Respondent failed to undertake any risk assessment/stratification for prescribing long-term use of controlled substances, such as use of various screening tools (PHQ-2, CAGE-AID, Opioid Risk Tool, SOAPP-R) to Patient B. He also failed to fully evaluate potential risks for Patient B of combined opiate therapy (fentanyl, oxycodone, Tramadol) or the risks when taken with other respiratory depressants such as benzodiazepines (alprazolam) and Soma, a muscle relaxer with barbiturates metabolites. Each such failure constitutes gross negligence.

75. Respondent failed to specify measurable goals and objectives used to evaluate Patient B's treatment progress and failed to include an exit strategy for discontinuing opioid therapy, in the event the tapering or termination of opioid therapy became necessary. Each such failure constitutes gross negligence.

76. Respondent failed to discuss with Patient B the potential risks of long-term opioid use, combined opioid use (fentanyl, Tramadol and oxycodone) and combined narcotic and benzodiazepine use. Additionally, Respondent failed to discuss potential side effects of the medication he prescribed with Patient B and failed to discuss the risk of impaired motor-skills concerning activities such as driving as well as the risk of misuse, dependence, addiction, and overdose. Respondent also failed to discuss the limited evidence of benefit of long-term opioid therapy or the risks of use of prescription controlled substances with Patient B. Each such failure constitutes gross negligence.

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77. Respondent failed to conduct appropriate investigation and failed to undertake any advised compliance monitoring of Patient B such as drug testing, review of CURES Reports, and/or conducting pill counting. Each such failure constitutes gross negligence.

78. Respondent failed to document evidence of Patient B's progress toward treatment objectives, decreased pain, improvement in level of function, experience of side effects, medication abuse or diversion, or appropriate behavior and mood. Each such failure constitutes gross negligence.

79. Although Respondent placed Patient B on a controlled substances contract on or about in July of 2018, Patient B was not on a contract for over three years. Prescribing controlled substances to Patient B for over three years in the absence of such a contract constitutes gross negligence.

Patient C

80. Respondent failed to conduct a sufficient evaluation of Patient C for chronic opioid use. Respondent prescribed long-term narcotic therapy for Patient C's reported musculoskeletal pain based on little to no evidence to support chronic opioid therapy. Respondent did not establish a diagnosis of medical necessity to support long-term use of opioids for chronic, non-cancer pain. Respondent failed to use screening tools such as pain intensity and interference or Sheehan Disability Scale and failed to identify the potential benefits and risks of opioid therapy. Each such failure constitutes gross negligence.

81. Respondent failed to undertake any risk assessment/stratification for prescribing long-term use of controlled substances, such as PHQ-2, CAGE-AID, Opioid Risk Tool, and/or SOAPP-R. Respondent also failed to fully evaluate potential risks to Patient C of combining opiate therapy (Norco and Tramadol) with other respiratory depressants such as benzodiazepines (diazepam). Each such failure constitutes gross negligence.

82. Respondent failed to develop a treatment plan by specifying measurable goals and objectives to evaluate treatment progress in Patient C. Respondent also failed to include an exit strategy for discontinuing opioid therapy, in the event the tapering or termination of opioid therapy became necessary. Each such failure constitutes gross negligence.

83. Respondent failed to obtain adequate patient consent. Respondent failed to discuss potential side effects and risks of long-term opioid use, combined opioid use (Tramadol and Norco), and combined narcotic and benzodiazepine use (Tramadol/Norco and diazepam) with Patient C. Respondent failed to discuss the risk of impaired motor-skills for activities such as driving as well as the risk of misuse, dependence, and addiction. Respondent failed to discuss the limited evidence of benefit of long-term opioid therapy. Each such failure constitutes gross negligence.

84. Respondent failed to ensure appropriate compliance monitoring. Respondent failed to conduct an appropriate investigation and failed to undertake any advised compliance monitoring such as drug testing, review of CURES Reports, and/or conducting pill counting. Each such failure constitutes gross negligence.

85. Respondent continued Patient C on controlled substance therapy beyond an initial trial that was not based on outcomes such as making progress toward functional goals, presence and nature of side effects, pain status and a lack of evidence of patient misuse, abuse or diversion. Respondent failed to document evidence of patient's progress toward treatment objectives and any decrease in pain. Respondent failed to discuss improvement in level of function, side effects experienced, medication abuse or diversion, nor appropriate behavior and mood. Each such failure constitutes gross negligence.

86. Respondent failed to place Patient C on a controlled substances contract despite placing her on them for long-term use (greater than 90 days). Prescribing controlled substances to Patient C in the absence of such a contract constitutes gross negligence.

Patient D

87. Respondent failed to undertake any risk assessment/stratification for prescribing long-term use of controlled substances, such as use of various screening tools (PHQ-2, CAGE-AID, Opioid Risk Tool, SOAPP-R). He also failed to evaluate potential risks of combining opiate therapy (hydrocodone) with other respiratory depressants such as benzodiazepines (alprazolam) and Soma, a muscle relaxer that metabolizes to a barbiturate. Each such failure constitutes gross negligence.

88. Respondent failed to develop and specify measurable goals and objectives to evaluate Patient D's treatment progress. Respondent also failed to include an exit strategy for discontinuing opioid therapy, in the event the tapering or termination of opioid therapy became necessary. Each such failure constitutes gross negligence.

89. Respondent failed to discuss potential risks with Patient D of long-term opioid use, and combined use of a narcotic, benzodiazepine, and Soma, which metabolizes into a barbiturate. Respondent failed to discuss potential side effects of the medications he prescribed with Patient D and failed to discuss the risk of impaired motor skills for activities such as driving. Respondent also failed to discuss the risk of misuse, dependence, addiction, and overdose with Patient D. Finally, Respondent failed to discuss the limited evidence of benefit from long-term opioid therapy with Patient D. Each such failure constitutes gross negligence.

90. Respondent failed to conduct appropriate investigation. Respondent failed to undertake any efforts to ensure appropriate compliance monitoring of Patient D such as drug testing, review of CURES Reports, and/or conducting pill counting. Each such failure constitutes gross negligence.

91. Respondent failed to document evidence of Patient D's progress toward treatment objectives and failed to document any decrease in pain. Respondent failed to discuss or document improvement in Patient D's level of function. Respondent failed to discuss or document Patient D's experience of side effects and failed to discuss medication abuse or diversion as well as discuss or document appropriate behavior and mood. Each such failure constitutes gross negligence.

92. Respondent failed to have Patient D sign a pain contract, despite placing her on long-term use of controlled substances. Prescribing controlled substances to Patient D in the absence of such a contract constitutes gross negligence.

Patient E

93. Respondent failed to undertake any risk assessment/stratification for prescribing long-term use of controlled substances for Patient E, such as use of various screening tools (PHQ-2, CAGE-AID, Opioid Risk Tool, SOAPP-R), and failed to evaluate potential risks of combining

opiates (Norco) with other respiratory depressants such as benzodiazepines (Xanax). Each such failure constitutes gross negligence.

94. Respondent failed to develop measurable goals and objectives to evaluate Patient E's treatment progress. Respondent also failed to create an exit strategy for discontinuing Patient E's opioid therapy, in the event the tapering or termination of opioid therapy was necessary. Each such failure constitutes gross negligence.

95. Respondent failed to obtain Patient E's informed consent to the medication he prescribed. Specifically, Respondent failed to discuss the following with Patient E: potential risks of long-term opioid use and combined narcotic and benzodiazepine use; potential side effects of the medications prescribed; the risk of impaired motor skills for activities such as driving; the risk of misuse, dependence, addiction and overdose; and the limited evidence of benefit of long-term opioid therapy or the risks of use of prescription controlled substances. Each such failure constitutes gross negligence.

96. Respondent failed to ensure appropriate compliance monitoring of Patient E's medication use. Specifically, Respondent failed to conduct appropriate investigation and failed to utilize drug-testing, review of CURES Reports, and/or conduct pill counting. Each such failure constitutes gross negligence.

97. Respondent failed to engage in any ongoing assessment of Patient E's progress toward functional goals, presence and nature of side effects, pain status, and/or potential misuse, abuse, or diversion. Specifically, Respondent failed to discuss or document the following with Patient E: progress toward treatment objectives, including any decrease in pain; improvement in level of function; experience of side effects; medication abuse or diversion; nor evaluate Patient E's behavior and mood. Each such failure constitutes gross negligence.

98. Respondent failed to place Patient E on a controlled substances contract until on or about April of 2018. Prescribing controlled substances to Patient E in the absence of such a contract constitutes gross negligence.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

99. Respondent has subjected his Physician's and Surgeon's Certificate No. A 32806 to disciplinary action under section 2227, as defined by section 2234, subdivision (c), of the Code, in that he committed multiple acts and/or omissions constituting negligence. The circumstances are set forth in Paragraphs 30 through 98, which are hereby incorporated by reference as if fully set forth herein, are hereby alleged as separate and distinct acts of negligence. Additional circumstances are as follows:

100. Respondent prescribed Patient D long-term narcotic therapy for her reported musculoskeletal pain, despite the lack of basis to support a need for chronic opioid therapy. Respondent failed to use screening tools such as pain intensity and interference or Sheehan Disability Scale, failed to identify the potential benefits and risks of opioid therapy, and failed to review Patient D's CURES Report. Each such failure constitutes a separate and distinct act of negligence.

101. Respondent failed to conduct proper evaluation of Patient E for chronic opioid use. Specifically, Respondent prescribed long-term narcotic therapy for Patient E's reported chronic non-cancer pain with little to no evidence to support chronic opioid therapy. Respondent failed to use screening tools such as pain intensity and interference or Sheehan Disability Scale, failed to identify the potential benefits and risks of opioid therapy with Patient E, and failed to review a CURES Report in his treatment of Patient E. Each such failure constitutes a separate and distinct act of negligence.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

102. Respondent has subjected his Physician's and Surgeon's Certificate No. A 32806 to disciplinary action under section 2227, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E as more particularly alleged in paragraphs 30 through 101, which are hereby incorporated by reference as if fully set forth herein and are hereby

alleged as separate and distinct acts of negligence. Respondent's records regarding Patient A, Patient B, Patient C, Patient D, and Patient E above, are so illegible and lacking in content as to be rendered useless.

DISCIPLINARY CONSIDERATIONS

103. To determine the degree of discipline, if any, to be imposed on Respondent, Robert Adams Graham, M.D., Complainant alleges that on or about June 14, 2019, in a prior disciplinary action titled *In the Matter of the Accusation Against Robert Adams Graham, M.D. before the Medical Board of California*, in Case Number 800-2016-025845, Respondent's license was revoked. However, revocation was stayed and Respondent was placed on probation for four (4) years with standard terms and conditions for gross negligence, repeated negligent acts, aiding and abetting the unlicensed practice of medicine, and for a substantially related conviction. 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 32806, issued to Robert Adams Graham, M.D.;

2. Revoking, suspending or denying approval of Robert Adams Graham, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Robert Adams Graham, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: April 2, 2020

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

FR2019100831/95338163.docx

Exhibit B

Stipulated Settlement and Disciplinary Order
Re: Accusation No. 800-2016-025845

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

In the Matter of the Second Amended Accusation Against:	)	
Robert Adams Graham, M.D.	)	**Case No. 800-2016-025845**
Physician's and Surgeon's Certificate No. A 32806	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 14, 2019.

IT IS SO ORDERED: May 17, 2019.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
GLORIA CASTRO
Senior Assistant 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 Second Amended Accusation Against: **ROBERT ADAMS GRAHAM, M.D.** **728 E. Bullard Avenue, Suite 101** **Fresno, CA 93710** **Physician's and Surgeon's Certificate No. A 32806** Respondent.	Case No. 800-2016-025845 OAH No. 2018020003 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Steve Diehl, Supervising Deputy Attorney General.

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2. Respondent Robert Adams Graham, M.D. (Respondent) is represented in this proceeding by attorney Lawrence E. Wayte, Esq., whose address is: 7647 North Fresno Street Fresno, CA 93720.

3. On or about August 21, 1978, the Board issued Physician's and Surgeon's Certificate No. A 32806 to Robert Adams Graham, 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 Second Amended Accusation No. 800-2016-025845, and will expire on June 30, 2020, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 800-2016-025845 was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation.

5. A copy of Second Amended Accusation No. 800-2016-025845 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 800-2016-025845. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Second Amended Accusation No. 800-2016-025845, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Second Amended 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 Second Amended Accusation, and that Respondent hereby gives up his right to contest those charges. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Second Amended Accusation No. 800-2016-025845 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

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

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 32806 issued to Respondent Robert Adams Graham, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 20 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

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

Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

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

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices

are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

This condition shall be in effect for the first three (3) years of probation, and will expire thereafter, unless the practice monitor recommends continued monitoring.

5. PROHIBITED PRACTICE. During probation, Respondent is prohibited from acting as Medical Director of any medical spa or facility where cosmetic treatments are performed. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from acting as Medical Director of any medical spa or facility where cosmetic treatments are performed. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the

date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Second Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If

Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,

or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Lawrence E. Wayte, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/31/2019

ROBERT ADAMS GRAHAM, M.D.
Respondent

I have read and fully discussed with Respondent Robert Adams Graham, 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: Jan 31, 2019

LAWRENCE E. WAYTE, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 2/6/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
GLORIA CASTRO
Senior Assistant Attorney General

STEVE DIEHL
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 800-2016-025845

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

In the Matter of the Second Amended Accusation Against: **ROBERT ADAMS GRAHAM, M.D.** 728 E. Bullard Avenue, Suite 101 Fresno, CA 93710 Physician's and Surgeon's Certificate No. A 32806, Respondent.	Case No. 800-2016-025845 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 21, 1978, the Medical Board issued Physician's and Surgeon's Certificate Number A 32806 to Robert Adams Graham, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

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JURISDICTION

3. This Second Amended Accusation, which supersedes the First Amended Accusation filed on December 3, 2018, in the above entitled matter, is brought before the Board under the authority of the following laws. All section references are to the Business and Professions 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."

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5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

6. Section 2236 of the Code states:

"(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

"(b) The district attorney, city attorney, or other prosecuting agency shall notify the Division of Medical Quality of the pendency of an action against a licensee charging a felony or misdemeanor immediately upon obtaining information that the defendant is a licensee. The notice shall identify the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall also notify the clerk of the court in which the action is pending that the defendant is a licensee, and the clerk shall record prominently in the file that the defendant holds a license as a physician and surgeon.

"(c) The clerk of the court in which a licensee is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the board. The division may inquire into the circumstances surrounding the commission of a crime in order to fix the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred."

7. Section 2052 of the Code states:

"(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other

provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

"(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

"(c) The remedy provided in this section shall not preclude any other remedy provided by law."

8. Title 16, Section 1379 of the California Code of Regulations states:

"A physician and surgeon or a podiatrist who collaborates in the development of standardized procedures for registered nurses shall comply with Title 16 California Administrative Code Sections 1470 through 1474 governing development and use of standardized procedures."

9. Title 16, Section 1474 of the California Code of Regulations states:

"Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing:

"(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

"(b) Each standardized procedure shall:

"(1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.

"(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

"(3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

"(4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

"(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

"(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

"(7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.

"(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

"(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

"(10) Specify patient record keeping requirements.

"(11) Provide for a method of periodic review of the standardized procedures."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he engaged in an act or acts amounting to gross negligence.

Circumstances related to Rebekah DeMoss, R.N., are as follows:

11. Between July, 2011, and November 4, 2014, Rebekah DeMoss, R.N., provided cosmetic treatments to hundreds of patients without physician supervision. These treatments included Botox anti-wrinkle treatments, and Juvederm injectable facial filler treatments. Both of these treatments are available by prescription only. These treatments were provided to patients at spas and private homes, under the name "ZLB Rejuvenation." Nurse DeMoss employed Respondent as Medical Director of ZLB Rejuvenation, for which he was paid $500 per month. During the time that Respondent was Medical Director of ZLB Rejuvenation, he did not perform any examinations of patients who received cosmetic treatments performed by DeMoss, and he did not review any patient medical records related to cosmetic treatments performed by DeMoss. Respondent allowed DeMoss to order medications using his name and medical license. Respondent was unaware of when, what, or how much medication DeMoss ordered, or where she

ordered it from. Respondent had no standardized protocols in place governing the care DeMoss provided, and Respondent was unaware of what, if any, prior training DeMoss had in performing cosmetic treatments.

12. Registered Nurses may perform cosmetic treatments under the supervision of a physician. When prescription drugs or devices are to be used, a prior physical examination by a physician is required. Once the examination is performed, the physician can delegate the procedure to the nurse, pursuant to standardized procedures that dictate when the physician should be contacted regarding a patient's condition. The physician must be immediately reachable and able to assist in the management of the patient's care.

13. On or about November 3, 2014, patient S.E. presented to DeMoss for a Botox treatment of wrinkles in the glabellar area and chin as well as a browlift. Respondent was not present and provided no prior physical examination. DeMoss provided the requested treatment while under observation by an undercover investigator.

14. Patient P.E. presented to DeMoss for Juvederm and Botox treatments on four occasions: April 27, 2013; November 29, 2013; June 6, 2014; and September 9, 2014. DeMoss failed to document a medical history, and Respondent failed to perform a prior physical examination. Respondent never reviewed this patient's chart.

15. Patient S.H. presented to DeMoss on nine occasions between November 25, 2012, and October 7, 2014, for Botox and/or Juvederm treatments. DeMoss never documented a medical history, and Respondent never documented a prior physical examination. Respondent never reviewed this patient's chart.

16. Patient C.H. presented to DeMoss on three occasions: December 4, 2013; March 24, 2013; and September 12, 2014, for Botox and/or Juvederm treatments. Respondent never documented a prior physical examination of this patient. Respondent never reviewed this patient's chart.

17. Patient R.S. presented to DeMoss on ten occasions between July 23, 2011, and November 4, 2014, for Botox and/or Juvederm treatments. DeMoss never documented a medical

history, and Respondent never documented a prior physical examination. Respondent never reviewed this patient's chart.

18. Respondent committed gross negligence in allowing a registered nurse, whom he had agreed to supervise, to evaluate and treat patients with Botox and Juvederm without a prior physical examination.

Circumstances related to Julie Guyette, N.P., are as follows:

19. On or about July 10, 2013, the Board of Registered Nursing initiated an investigation regarding allegations that Julie Guyette, N.P., a licensee of that Board, was recklessly prescribing narcotic medications. Julie Guyette, N.P., worked at the North Fresno Family Health clinic in Fresno, California. Respondent was her supervising physician.

20. On or about October 22, 2013, an undercover investigator using the fictitious name "Kristina Rios" presented to Julie Guyette, N.P. The investigator told Guyette that she had not been sleeping well for the past three to four months, and that the problem was worsening. Guyette completed a brief physical examination of the investigator, and discussed the reasons for insomnia and indicated that the inability to sleep is a symptom of depression. Guyette asked the investigator questions about her employment status, marital status, children, and support system. Guyette told the investigator she could provide sample medications that would help her with sleep and assist with depression and anxiety. Guyette provided the investigator with ten individually packaged Lunesta[1] 3 mg tablets, and three packages containing Viibyrd[2] tablets.

21. On or about November 13, 2013, an undercover investigator using the fictitious name "Michael Williams" presented to Julie Guyette, N.P. The investigator told Guyette that he had not been sleeping well for the past four months. The investigator stated that he could sleep better

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[1] Lunesta (eszopiclone) is a sedative medication used to treat insomnia. It is a Schedule IV controlled substance.

[2] Viibyrd (vilazodone) is a serotinergic antidepressant. It is not a scheduled controlled substance, but is available only by prescription.

when he drank alcoholic beverages or took Vicodin[3], and described drinking six beers per night. Guyette completed a brief physical examination and discussed causes of insomnia. The investigator stated that he had tried Ambien and Lunesta, and that neither worked for him. Guyette stated that an older sleep agent may work, and suggested that the investigator do blood work and have a sleep study performed. The investigator refused blood work or a sleep study. Guyette then issued a prescription for thirty temazepam[4] tablets.

22. On or about October 14, 2014, an undercover investigator using the fictitious name "Julian Padron" presented to Julie Guyette, N.P. The investigator told a medical assistant that he was being seen for anxiety related to fear of flying. Guyette asked the investigator questions related to allergies to medications, surgeries, family health history, and which pharmacy he utilized. The investigator told Guyette he had been taking Vicodin to help him with sleep, and stated that the Vicodin was not prescribed and that he obtained it from coworkers. The investigator stated that he was taking the Vicodin for anxiety, and that he didn't like the side effects of other medications like Ambien. Guyette asked the investigator if he had tried Valium, and the investigator said he had not. Guyette issued a prescription for thirty Vicodin and thirty Valium. Guyette did not document any indication for the Vicodin prescription other than "anxiety." The investigator returned to Guyette on two additional separate occasions, each time obtaining additional prescriptions of Vicodin for "anxiety."

23. In each of the above encounters with undercover investigators, Julie Guyette, N.P., failed to document any formal pain inventory or assessment, any review of prior records, any access of the CURES[5] Patient Activity Report, or any review of the patient cases with Respondent, who was her supervising physician. Guyette failed to document any pain or controlled substance contracts with the patients. Respondent never saw any of the three fictitious patients, and he never documented any review of the prescriptions Guyette issued.

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[3] Vicodin is a preparation of the opiate hydrocodone and acetaminophen.

[4] Temazepam is a benzodiazepine sedative used to treat insomnia. It is a Schedule IV controlled substance.

[5] Controlled Substance Utilization Review and Evaluation System.

24. Initially, upon assuming supervisory responsibility for Guyette, Respondent did not establish any standardized procedures or protocols at the office. Respondent later provided Guyette with the 2011 edition of Ferri's Clinical Advisor handbook to Guyette to assist her in medical decision making. Initially, Respondent did not review any patient charts, and later only reviewed charts that Guyette had questions about.

25. The standard of care for supervision of a nurse practitioner requires that the furnishing or ordering of drugs or devices by a nurse practitioner occur under physician supervision. Such supervision includes collaboration on the development of a standardized procedure, approval of the standardized procedure, and availability by telephone at the time the patient is being examined by the nurse practitioner. The standard of care requires that the standardized procedure comply with Title 16, Section 1474 of the California Code of Regulations, which is incorporated here by reference as if fully set forth.

26. Respondent committed gross negligence in his supervision of Julie Guyette, N.P., in that he failed to establish and adhere to a standardized procedure for the furnishing or ordering of drugs or devices.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated acts of negligence. The circumstances are set forth in paragraphs 11 through 26, above, which are incorporated here by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Aiding/Abetting Unlicensed Practice)

28. Respondent is subject to disciplinary action under section 2234, subdivision (a), and section 2052, subdivision (b) in that he aided and abetted the unlicensed practice of medicine. The circumstances are set forth in paragraphs 11 through 26, above, which are incorporated here by reference as if fully set forth.

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FOURTH CAUSE FOR DISCIPLINE

(Substantially Related Conviction)

29. Respondent is subject to disciplinary action under section 2236 in that he suffered a misdemeanor conviction substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are set forth in paragraphs 11 through 18, above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

30. On or about August 31, 2016, in the Superior Court of California for the County of Fresno, in an action entitled "The People of the State of California vs. Rebekah Suzanne Demoss and Robert Adams Graham," case number F16905392, a felony complaint was filed alleging inter alia that on or about October 1, 2014, through November 30, 2014, Respondent committed a violation of Business and Professions Code section 2052, subdivision (b), a felony, aiding and abetting the unlicensed practice of medicine.

31. On or about December 18, 2018, in the Superior Court of California for the County of Fresno, in an action entitled "The People of the State of California vs. Rebekah Suzanne Demoss and Robert Adams Graham," case number F16905392, Respondent entered a plea of no contest to an amended single misdemeanor count of violating Business and Professions Code section 2052, subdivision (b), aiding and abetting unlicensed practice of medicine. Respondent was sentenced to one year of bench probation with various terms and conditions.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 32806, issued to Robert Adams Graham, M.D.;

2. Revoking, suspending or denying approval of Robert Adams Graham, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Robert Adams Graham, 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: February 20, 2019

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

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