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

In the Matter of the First Amended Accusation Against: Jack Wayne Finch, M.D. Physician's and Surgeon's License No. G68377 Respondent	Case No. 800-2018-042679

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 April 22, 2021.

IT IS SO ORDERED: March 23, 2021.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **JACK WAYNE FINCH, M.D.** 2888 Eureka Way, Ste. 201 Redding, CA 96001 Physician's and Surgeon's Certificate No. G 68377, Respondent.	Case No. 800-2018-042679 OAH No. 2020070091 **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 John S. Gatschet, Deputy Attorney General.

2. Respondent Jack Wayne Finch, M.D. ("Respondent") is represented in this proceeding by attorney Philip H. Heithecker, whose address is:

Law Office of Philip Heithecker
1560 Humboldt Rd., Ste. 1
Chico, CA, 95928

On or about April 16, 1990, the Board issued Physician's and Surgeon's Certificate No. G 68377 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in the First Amended Accusation No. 800-2018-042679, and will expire on March 31, 2022, unless renewed.

JURISDICTION

3. First Amended Accusation No. 800-2018-042679 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on June 8, 2020. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

4. A copy of the First Amended Accusation No. 800-2018-042679 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation No. 800-2018-042679. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First 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.

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

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in the First Amended Accusation No. 800-2018-042679, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in the First Amended Accusation No. 800-2018-042679, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 68377 to disciplinary action.

10. ACKNOWLEDGMENT Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

11. Respondent 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 the First Amended Accusation No. 800-2018-042679 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding and/or any other licensing and/or administrative proceeding involving Respondent in the State of California. Upon adoption of this Decision and Order by the Board, this paragraph shall be fully incorporated as part of the terms and conditions of the Disciplinary Order below.

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.

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. G 68377 issued to Respondent Jack Wayne Finch, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. PATIENT DISCLOSURE. Before a patient's first visit following the effective date of this order and while the respondent is on probation, the respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes the respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on the respondent by the board, the board's telephone number, and an explanation of how the patient can find further information on the respondent's probation on the respondent's profile page on the board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure

and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct treatment relationship with the patient.

2. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act in Schedule II, except for those drugs listed in Schedule(s) III-V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

This restriction shall be deemed fully satisfied upon the Board's receipt and acceptance of a

certificate of completion from a Board approved prescribing practices course. A prescribing practices course taken after the acts that gave rise to the charges in the original 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 the Decision.

3. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

4. 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 40 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 65 hours of CME of which 40 hours were in satisfaction of this condition.

5. 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 original 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.

6. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping 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 medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the original 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.

7. 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(s), 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(s) and First Amended Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), First Amended Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and First Amended Accusation(s), 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.

The parties agree that this term and condition, requiring the monitoring of the Respondent's Practice, shall expire eighteen (18) months after the effective date of the Decision and Order. Upon the expiration of this term and condition, the Respondent shall be relieved from the requirements to have a practice monitor. The remaining conditions of the Decision and Order shall remain in full force and effect following expiration of the practice monitor requirement.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the

Respondent shall provide a true copy of this Decision and the First 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.

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

10. 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.

11. 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.

12. 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, subdivision (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.

13. 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.

14. 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's 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; and, Quarterly Declarations.

15. 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.

16. 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.

17. 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.

18. 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.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Philip H. Heithecker. 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: 1/22/21

JACK WAYNE FINCH, M.D.
Respondent

I have read and fully discussed with Respondent Jack Wayne Finch, 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: 1.22.21

PHILIP H. HEITHECKER
Attorney for Respondent

ENDORSEMENT

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

DATED: 1-27-21

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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First Amended Accusation Stipulation Finch Patient Disclosure.docx

Exhibit A

First Amended Accusation No. 800-2018-042679

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Jack Wayne Finch, M.D.** 2888 Eureka Way, Ste. 201 Redding, CA 96001 Physician's and Surgeon's Certificate No. G 68377, Respondent.	Case No. 800-2018-042679 **FIRST AMENDED** **ACCUSATION**

PARTIES

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

2. On or about April 16, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number G 68377 to Jack Wayne Finch, 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 March 31, 2022, unless renewed.

JURISDICTION

3. This First Amended 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:

(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, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

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

(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. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

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

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

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

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

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

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

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

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

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

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

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

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

6. Section 2234 of the Code, states:

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.

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7. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

8. 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.

DEFINITIONS

9. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

10. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting semi-synthetic opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055 subdivision (b).

11. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b). Prior to October 6, 2014,

Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

12. Morphine sulfate – Generic name for the drugs MSIR ("instant release") and MSER also known as MS Contin ("extended release"). Morphine sulfate is an opiate analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone is a short-acting medication used to treat severe pain. Hydromorphone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

15. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a transdermal patch, buprenorphine is used to treat chronic pain. Buprenorphine is a Schedule III

controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

16. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). 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.

17. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Alprazolam – Generic name for Xanax. Alprazolam is a member of the benzodiazepine family and is a short-acting medication commonly used for the short-term management of anxiety disorders, specifically panic disorder or generalized anxiety disorder. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant designed for short-term relief. On January 11, 2012, carisoprodol was classified as a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

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FACTUAL ALLEGATIONS[1]

Patient B

20. On March 19, 2012[2], and April 18, 2012, Patient B[3] was seen by a rheumatologist, a specialist in the study of rheumatism, arthritis, and other joint disorders, in Redding, CA. The rheumatologist's progress notes are incorporated into Respondent's medical file that was kept on Patient B. The rheumatologist's March 19, 2012, progress note documented that Patient B had mild tenderness of the left shoulder and right heal tenderness from a spur. The rheumatologist documented that Patient B was receiving a daily pain management prescription of two tablets of 10/325 mg. hydrocodone with acetaminophen. The MED[4] on that prescription was 20 mg. The rheumatologist noted that Patient B did not have classic arthropathy of hemochromatosis, calcium deposits in the second-phalangeal joints, and this was confirmed by an April 13, 2012, hand x-ray, which was normal. The rheumatologist documented that Patient B stated he had some lower back pain but the back exam was documented as normal. The rheumatologist documented that Patient B could benefit from stretching exercises, physical therapy, wearing custom orthotics, and nonsteroidal medications in addition to his hydrocodone prescription. The rheumatologist noted that Patient B became agitated when the rheumatologist suggested the use of nonsteroidal medications because Patient B thought that the rheumatologist was suggesting the use of those medications instead of hydrocodone. On April 18, 2012, the rheumatologist documented that Patient B reported that he continued to have some right heal pain and joint pain but the physical examinations were normal. The rheumatologist continued Patient B's hydrocodone prescription of two tablets of 10/325 mg. hydrocodone daily.

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[1] As contained in the Accusation that was filed with the Board on February 25, 2020.

[2] As for Patients B and D, conduct occurring before March 1, 2013, is for reference only and is not serving as an independent basis for disciplinary action. However, conduct occurring before March 1, 2013, may be used to explain or support disciplinary action for conduct occurring after March 1, 2013.

[3] All patients and witnesses will be fully identified in discovery. Patients will be identified by numeric pseudonyms to protect confidentiality.

[4] Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day. http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17.

21. On August 16, 2012, Respondent saw Patient B to establish care and to take over his treatment for hemochromatosis from the rheumatologist. Throughout Patient B's care, Respondent documented Patient B's medical records by making handwritten entries on pre-printed templates. On August 16, 2012, Patient B filled out a new patient health questionnaire where he documented that Patient B works in education, smokes 1/2 packet of cigarettes daily, does not drink alcohol, and exercises regularly. Patient B denied a history of present drug use but admitted to using psychedelic mushrooms a few times in college. Patient B noted that he had a history of depression. Patient B documented that he had arthralgia, plantar fasciitis, and biceps tendonitis. Patient B noted that he was taking 325 mg. of aspirin three times daily and had been taking 10/325 mg. hydrocodone with acetaminophen twice a day. He noted that he had been in an accident on August 8, 2012, and his hydrocodone dosage had been increased by a physician at a Medical Clinic to four times a day. Patient B noted that he had an allergy to alprazolam, which caused him increased anxiety.

22. Respondent documented that Patient B reported fatigue, malaise, myalgia, joint pain, L-spine pain, and headaches. Respondent documented Patient B's weight, height and a relatively normal examination. Respondent did not document a pain score, nor did he document a musculoskeletal or spine examination. Respondent circled Patient B's foot on a pre-printed male diagram but didn't note the specific issue on the diagram. Respondent continued Patient B's 10/325 mg. hydrocodone with acetaminophen prescription four times daily[5], prescribed a Flexor patch, and referred to physical therapy.

23. On September 13, 2012, Respondent saw Patient B in clinic for a medication refill of hydrocodone with acetaminophen. Respondent refilled Patient B's prescription for 120 tablets of 10/325 mg. hydrocodone with acetaminophen and prescribed thirty tablets of 10 mg. diazepam for insomnia. On October 30, 2012, Respondent changed Patient B's diazepam prescription to three tablets of 5 mg. daily.

24. On December 12, 2012, Respondent saw Patient B in clinic and documented that Patient B reported he had ran out medications due to a flood and that he had been in a fight with a

[5] MED of 40 mg.

student. Respondent documented that Patient B was going through medication withdrawals and had been placed on Suboxone by a pain clinic. Respondent documented that Patient B wanted to discontinue Suboxone. Respondent documented that Patient B was anxious and circled the patient diagrams in the chart on the lower back and chest. Respondent restarted Patient B on 10/325 mg. hydrocodone with acetaminophen four times daily, 5 mg. of diazepam three times daily, and started Lyrica. Respondent saw Patient B on March 7, 2013, and continued him on hydrocodone with acetaminophen, diazepam, and Lyrica.

25. On August 8, 2013, Respondent saw Patient B in clinic and documented that Patient B reported being off narcotics during the summer and had "total body pain always." Despite Patient B reportedly being off narcotics during the summer, Respondent noted that Patient B was taking hydrocodone with acetaminophen as needed. Respondent failed to document a pain score, and failed to document a musculoskeletal examination. Respondent didn't circle any areas on the patient diagrams to indicate pain. Respondent prescribed 60 tablets of 20 mg. OxyContin to be taken twice daily.[6] Respondent did not document if he was aware that Patient B had received buprenorphine and phenobarbital prescriptions on or about June 12, 2013.

26. On August 22, 2013, Respondent saw Patient B in clinic, continued OxyContin and added hydrocodone with acetaminophen. On January 29, 2014, Respondent saw Patient B in clinic, continued 20 mg. tablets of oxycodone twice daily, 10/325 mg. tablets of hydrocodone with acetaminophen four times daily, and added diazepam three times daily for work related stress.[7] On April 14, 2014, Respondent saw Patient B in clinic and for the first time documented a pain score of six out of ten in Patient B's chart. Respondent documented that Patient B was anxious, and crying, but did not document a musculoskeletal examination and did not circle any areas of pain on the patient diagrams. Respondent added 90 tablets of 10 mg. oxycodone to be taken three times daily to Patient B's existing prescriptions.[8] Respondent did not document any other prescriptions at that time in Patient B's chart. On April 28, 2014, Respondent documented that Patient B had a pain level of nine out of ten despite previously increasing his opiate pain

[6] MED of 60 mg.
[7] MED of 100 mg.
[8] MED of 145 mg.

medications. On May 20, 2014, Respondent failed to document a pain score in Patient B's chart, and failed to document whether pain treatment was working for Patient B. Respondent refilled Patient B's OxyContin, oxycodone, and Norco prescriptions.

27. On June 14, 2014, a pharmacist sent Respondent a letter with a CURES[9] report attached. The pharmacist stated that Patient B's mother had come to the pharmacy to fill a prescription for 60 tablets of 10/325 mg. hydrocodone with acetaminophen from another physician. According to the pharmacist, Patient B's mother didn't want "her insurance or the doctor under her son's pain contract" to know he was getting a script from a different doctor at a different pharmacy. The pharmacist stated he ran a CURES report and discovered that Patient B was getting multiple opioids/opiates from Respondent. The CURES report documented that Respondent had prescribed and Patient B had received 90 tablets of 10 mg. diazepam on April 4, 2014, 120 tablets of 1 mg. alprazolam on April 14, 2014, 90 tablets of 10 mg. oxycodone, on April 14, 2014, 120 tablets of hydrocodone with acetaminophen on April 18, 2014, and 60 tablets of 20 mg. OxyContin on April 28, 2014. These prescriptions represent an opioid/opiate MED of 145 with two separate benzodiazepines. As noted about, on August 16, 2012, Patient B had previously reported that alprazolam caused him increased anxiety. Despite seeing Patient B on April 14, 2014, April 28, 2014, and May 20, 2014, Respondent failed to document in Patient B's chart that he was prescribing Patient B two separate benzodiazepines while he was also prescribing opiate/opioid pain medication. Respondent documented that he reviewed the pharmacist's note on June 16, 2014.

28. On June 20, 2014, Respondent saw Patient B in clinic. Respondent documented that he discussed the clinic visit where Patient B had received a prescription from another physician with Patient B, discussed Patient B's knee x-rays, which revealed no findings, and documented a pain score of five out of ten. Respondent documented that Patient B had left knee joint pain under musculoskeletal examination and noted swelling on the pre-printed patient diagram. Respondent did not document any consequences for Patient B related to him receiving

[9] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice, which tracks all controlled drug prescriptions that are dispensed in the State of California.

prescriptions from another physician while receiving pain management therapy from Respondent. In fact, Respondent increased Patient B's OxyContin prescription to two 40 mg. tablets daily and six 10/325 mg. tablets of hydrocodone with acetaminophen. Respondent was now prescribing an MED of 180 to Patient B.

29. On July 3, 2014, Respondent next saw Patient B in clinic for follow-up on his right knee. Respondent documented that an MRI was clear. Respondent then documented that Patient B reported knee pain and back pain. Respondent did not document a pain score, nor did he document a musculoskeletal examination. Respondent did document that Patient B had a 75 percent reduction in swelling in his knee. Respondent diagnosed an acute knee dislocation. Respondent did not document whether he recommended any non-controlled substance therapy for Patient B's knee. Respondent prescribed 100 mg. tablet of morphine sulfate twice daily and 4 mg. tablet of hydromorphone four times daily to Patient B. Respondent was now prescribing an MED of 264 to Patient B. On July 17, 2014, Respondent saw Patient B in clinic and lowered the morphine sulfate prescription and increased the hydromorphone prescription for an MED of 248. Respondent didn't document a pain score and didn't document a musculoskeletal examination. Respondent did document that Patient B had mild knee swelling and pain issues with his feet on the pre-printed diagram.

30. Respondent continued to see Patient B on a regular basis in clinic on August 7, 2014, September 3, 2014, and October 1, 2014, for follow-up and medication refills. Respondent lowered Patient B's morphine sulfate prescription during that time, and documented joint pain in Patient B's lower back, knees and ankles. Respondent failed to document a pain score. On October 23, 2014, Respondent saw Patient B in clinic and documented a chief complaint of a fall, which had occurred ten days prior due to a wet floor. Respondent documented that Patient B fell hard on his left kneecap. Respondent documented that he was now prescribing 100 mg of morphine sulfate two times a day and 6 tablets of 8 mg. Dilaudid per day which equals a morphine equivalent dose of 392 mg.

31. Respondent saw Patient B in clinic on November 21, 2014. Respondent changed Patient B's prescription and prescribed 5 tablets of 30 mg. oxycodone per day instead of

morphine and prescribed 5 tablets of 8 mg. Dilaudid for a morphine equivalent dose of 385 mg. Respondent failed to document why he discontinued morphine. Respondent next saw Patient B in clinic on December 3, 2014. Respondent documented that Patient B reported that his medication, specifically the oxycodone, caused him to throw up and noted that Patient B had then taken 30 mg. of methadone from his mother. Respondent also documented that Patient B wanted to change Xanax to Valium. Respondent had Patient B sign a document entitled "Opiate/Pain Management Agreement." Respondent also had Patient B provide a urine sample. On December 17, 2014, the urine test showed that Patient B was positive for methadone, Dilaudid, morphine, alprazolam, lorazepam, and oxycodone. Respondent failed to document in the December 3, 2014, note whether he clearly stated future consequences for Patient B if he took medication from other sources. Respondent next saw Patient B on December 22, 2014, in clinic. Respondent did not document whether he discussed the results of the December 3, 2014, urine test with Patient B despite the inconsistent results of lorazepam, which the patient was not prescribed, and the presence of four opiates: methadone, Dilaudid, morphine and oxycodone.

32. Between December 22, 2014, and February 12, 2016, Respondent rapidly increased Patient B's morphine equivalent dose and made significant medication changes without documenting a clear rationale in Patient B's treatment plan. For example, on February 4, 2015, Respondent documented that Patient B needed his medications early because of job stress and a panic attack. Respondent documented that Patient B had quit work two weeks earlier and wanted to start methadone. At the time, Respondent was prescribing Patient B 420 mg. of morphine sulfate (3 tablets of 100 mg. morphine sulfate and 4 tablets of 30 mg. morphine sulfate), 10 mg. of diazepam, and 4 mg. of alprazolam. Respondent did not document whether he had discussed the risks and benefits of prescribing opiates in combination with multiple benzodiazepines. Respondent discontinued Patient B's morphine prescription and began him on a prescription of 12 tablets of 10 mg. methadone daily. The prescription of 120 mg. methadone daily represented a possible morphine equivalent dose as high as 1440 mg. due to the long half-life of methadone. At the Respondent's subject interview with the Board on August 21, 2018, Respondent stated that he made the medication change to help Patient B with the cost of medications and that he didn't

count morphine equivalents but selected the methadone dosage based on "clinical experience." Respondent didn't document discussing any of the risks and benefits of placing Patient B on methadone in Patient B's chart.

33. On February 26, 2015, Respondent again saw Patient B in clinic. Despite prescribing a 30-day prescription of methadone on February 4, 2015, to Patient B, Respondent documented that he was seeing Patient B for a medication refill. Respondent documented that Patient B reported that methadone was not giving good pain control but that it was affordable. Respondent then documented that Patient B had a diagnosis of fibromyalgia but did not document a corresponding examination. Respondent went back to prescribing 420 mg. of morphine sulfate daily (three 100 mg. tablets and four 30 mg. tablets) to Patient B. Despite Patient B's prior misuse of opiates/opioids in the past, Respondent did not document what, if anything, was supposed to be done with the remainder of Patient B's methadone prescription. Between February 26, 2015, and June 12, 2016, Respondent prescribed alprazolam, diazepam, lorazepam, carisoprodol, morphine sulfate, Dilaudid, oxycodone, and OxyContin in combination to Patient B.

34. On February 12, 2016, Respondent prescribed three tablets of 200 mg. morphine sulfate and 5 tablets of 30 mg. oxycodone for a morphine equivalent dose of 825 mg. Respondent continued to prescribe lorazepam and diazepam to Patient B in combination with high dose opiates/opioids. Respondent documented that Patient B was having left knee pain and myalgia. Respondent next saw Patient B in clinic on March 10, 2016. Respondent documented that Patient B's pain was increasing despite the high dose of opiates prescribed on February 12, 2016. Respondent documented that Patient B reported that oxycodone was not working well but that morphine sulfate was working well. Respondent discontinued Patient B's oxycodone prescription and prescribed 6 tablets of 8 mg. Dilaudid per day in combination with morphine sulfate. Respondent continued to prescribe 2 mg. of lorazepam and 10 mg. of diazepam to Patient B.

35. On April 11, 2016, Respondent next saw Patient B in clinic. Respondent documented Patient B's current medications as morphine sulfate, lorazepam, and "Dillatted"(sic) but omitted diazepam. Respondent noted that Patient B was present for a medication refill and that he wished to be prescribed methadone, as he, "has used before." Starting on April 11, 2016, and on an on-

going basis until June 2018, Respondent began prescribing 360 tablets of 10 mg. methadone per month to Patient B. In addition to the methadone prescriptions during that time, Respondent often prescribed either a daily prescription of 6 tablets of 8 mg. Dilaudid or a daily prescription of six to eight tablets of 30 mg. oxycodone to Patient B. Between April 2016 and June 2018, Patient B's morphine equivalent doses varied between as low as 552 mg. and as high as 1710 mg.

36. On April 17, 2017, during the period that Respondent was prescribing high dose methadone to Patient B, a urine drug tests showed the presence of methadone, marijuana, and clonazepam. The April 17, 2017, drug test was negative for oxycodone. Patient B filled 240 tablets of oxycodone on March 20, 2017, filled clonazepam on March 25, 2017, and filled methadone on April 3, 2017. Respondent wrote on the urine drug screen result that Patient B "Needs re √." Respondent next saw Patient B in clinic on May 17, 2017. While Respondent documented that Patient B's back pain had increased, Respondent failed to document whether he discussed the inconsistent urine drug screen result with Patient B and failed to incorporate the inconsistent result into Patient B's treatment plan. Respondent prescribed a daily prescription of 64 mg. of Dilaudid, 120 mg. of methadone, 30 mg. of diazepam, and 4 mg. of clonazepam to Patient B, which calculated as a morphine equivalent dose of as high as 1696 mg.

37. In late December 2017 and early January 2018, Patient B filled the following prescriptions from Respondent: a 30-day prescription for 240 tablets of 8 mg. Dilaudid on December 9, 2017; a 30-day prescription for 60 tablets of 1 mg. clonazepam on December 9, 2017; a 30-day prescription of 360 tablets of 10 mg. methadone on December 27, 2017; a 30-day prescription of 240 tablets of 30 mg. oxycodone on January 8, 2018; and a 30-day prescription of 60 tablets of .5 mg. lorazepam on January 8, 2018. Respondent had Patient B submit to a urine drug test on January 9, 2018. The drug test was both positive and consistent for methadone, marijuana, and clonazepam. However, the January 9, 2018, drug test indicated a number of inconsistencies including being negative for oxycodone and hydromorphone despite Patient B filling those prescriptions before the test sample was obtained. Respondent next saw Patient B in clinic on February 1, 2018, and failed to document an explanation regarding these irregularities in the urine drug testing.

38. On or about April 20, 2018, Respondent documented that Patient B came to clinic with a written plan to reduce his use of medications to, "keep pharmacy happy." At the time, Patient B's morphine equivalent dose as calculated by his pharmacist was 736 mg. per day. Respondent began a tapering plan for Patient B over the next year. On or about February 11, 2019, Respondent had Patient B sign a new pain contract. For example by April 2, 2019, Respondent documented that the plan was to have Patient B on 30 mg. oxycodone four times daily and 15 mg. of morphine four times daily. This prescription represented an morphine equivalent dose of 240 mg. per day. On April 2, 2019, Respondent did not document a pain score, did not document a comprehensive examination of Patient B's pain, and mentioned in Patient B's chart that Patient B complained of increased pain but that Lyrica was helping. Respondent added his usual comment that the "4 A[10]'s addressed and stable."

Patient D

39. On or about February 10, 2012, Respondent began providing treatment to Patient D. Patient D's medical history noted that she was single, living with one child, a one pack a day smoker, never drank alcohol, never used recreational drugs, she was disabled, and that she was unemployed. Patient D reported that she was taking six tablets of 10/325 mg.[11] hydrocodone with acetaminophen a day for pain.[12] Patient D also reported that she suffered from rheumatoid arthritis, depression, anxiety, having pain from a residual joint injury, was presently without active disease and was seeing a rheumatologist. Respondent documented that Patient D had lower back pain and sciatica for two years and suffered from tension headaches. Respondent documented a normal examination by placing circles over normal pre-printed diagrams in the template chart. Respondent prescribed a daily prescription of 4 tablets of 10/325 mg. hydrocodone with acetaminophen, 60 mg. propranol and 90 mg. of Cymbalta. Respondent saw Patient D in clinic on March 5, 2012, March 27, 2012, and April 18, 2012. According to the clinic notes on May 14, 2012, Respondent had begun prescribing methadone to Patient D in

[10] Analgesia, Activities of Daily Living, Adverse Side Effects, and Aberrant Drug Taking.
[11] MED of 60 mg.
[12] Patient D was also taking 60 mg. Cymbalta for depression, 500 mg. Naprosyn, 20 mg. BID of Prilosec, and a "headache med."

addition to Norco. On March 5, 2012, Respondent noted that Patient D complained of left sciatica pain with hand and left leg numbness and he diagnosed her with peripheral neuropathy. On March 26, 2012, a L-spine X-ray indicated that Patient D had some scoliosis and mild disc narrowing at L4/5 and L5/S1 with face hypertrophy. On March 27, 2012, Respondent prescribed Flexeril and stopped Robaxin. This prescription was later switched to Soma.

40. On May 14, 2012, Respondent saw Patient D in clinic for a medication refill. He noted that she had a pain score of 1-3 out of 10 while on methadone. Respondent did not document a full physical examination. Respondent prescribed 60 tablets of methadone 10 mg. and 120 tablets of 10/325 mg. hydrocodone with acetaminophen. At that time, assuming those prescriptions were taken on a daily basis over thirty days, Patient D's morphine equivalent dosage was 120 mg. Respondent rapidly escalated Patient D's prescription of methadone. On July 26, 2012, Respondent increased Patient D's prescription to 90 tablets of methadone 10 mg. and 120 tablets of 10/325 mg. hydrocodone with acetaminophen. At that time, assuming those prescriptions were taken on a daily basis over thirty days, Patient D's morphine equivalent dosage was 280 mg. On September 14, 2012, Respondent increased Patient D's prescription to 120 tablets of 10 mg. methadone and 120 tablets of 10 mg. hydrocodone with acetaminophen. At that time, assuming these prescriptions were taken on a daily basis over thirty days, Patient D's morphine equivalent dosage was 360 mg. While respondent documented that Patient D had some pain and tenderness during this rapid pain medication increase, Respondent failed to document performing a full physical examination or pain scores, which would have supported such a medication increase. On September 20, 2012, a UGI endoscopy showed the presence of gastroparesis and Reglan was added to Patient D's medication. On November 6, 2012, Respondent prescribed Seroquel but failed to document a supporting reason.

41. On November 18, 2012, Respondent documented Patient D as suffering from fibromyalgia but failed to provide any supporting documentation. On February 8, 2013, Patient D's C-Spine X-rays were normal. Also on February 8, 2013, Patient's MRI of her lumbar spine disc showed multi-level degenerative disc disease and facet hypertrophy, with focal central and paracentral disc protrusions (with annular tears) at L4/5 and L5/S1 with possible existing nerve

root contact. On January 22, 2013, Respondent was still prescribing a monthly prescription of 120 tablets of 10 mg. methadone and 120 tablets of 10 mg. hydrocodone with acetaminophen. On February 13, 2013, Respondent noted that he refilled Soma as part of Patient D's prescriptions, in addition to methadone and hydrocodone with acetaminophen. On March 27, 2013, Respondent documented that Patient D was present for a sinus infection, and refills. The history and physical mentioned that Patient D was on methadone, Norco, Soma, and Seroquil. Respondent documented that the patient had discontinued Lyrica because it was not providing relief. Respondent documented that Patient D had, "ran out of meds." Respondent documented that Patient D reported joint pain, myalgia and L-Spine pain. Respondent increased Patient D's prescriptions to 6 tablets of 10 mg. methadone, 6 tablets of 10/325 mg. hydrocodone with acetaminophen, 6 tablets of 350 mg. Soma, and 30 mg. of Seroquel. Respondent would eventually increase Patient's Seroquel dosage to 90 mg. daily and eventually diagnose her as bi-polar. Based on Respondent's prescriptions, Patient D's morphine equivalent dosage was now 660 mg. in combination with 2100 mg. of carisoprodol. Despite this large increase in Patient D's prescription, Respondent failed to document a comprehensive physical and instead just drew a circle over a diagram of a patient's back and a line down a diagram of a patient's leg. Respondent did not document a pain score.

42. Between the March 2013 visit and May 1, 2014, Respondent provided on-going treatment to Patient D. By May 1, 2014, Respondent was prescribing 300 tablets of 10 mg. methadone, 120 tablets of 10/325 hydrocodone with acetaminophen, and 120 tablets of carisoprodol per month to Patient D. Assuming Patient D was taking these medications as prescribed; Patient D's morphine equivalent dosage was now 1240 mg. while in combination with 1400 mg. of carisoprodol. On May 27, 2014, Respondent prescribed 300 tablets of methadone to Patient D early within 26 days of the previous prescription; Patient D could have taken as many as 11.5 10 mg. tablets of methadone per day during that time. Between May 1, 2014, and January 4, 2018, Respondent continued to keep Patient D on a prescription of 10 tablets of 10 mg. methadone per day. Respondent began tapering Patient D in January 2018 and by May 29, 2018, Respondent was only prescribing 6 tablets of 10 mg. methadone per day to Patient D.

43. Between May 1, 2014, and January 8, 2018, on multiple occasions, Respondent documented that Patient D presented troubling issues while taking her pain medication. For example on July 16, 2014, Respondent documented that Patient D was poorly compliant with med dosages. On December 31, 2014, Respondent documented that Patient D was "out of meds" at her medication refill appointment. On January 28, 2015, Respondent documented that Patient D's "pain control always a problem in winter and consistently runs out early..." Respondent also documented issues with Patient D's pain management regime. For example on December 3, 2014, Patient D provided a urine sample that showed the presence of a presumptive positive immunoassay and negative result for benzodiazepines. Respondent failed to make mention of the December 3, 2014, inconsistent result in Patient D's chart on December 21, 2014, and whether the urine result should be investigated further. On May 26, 2016, Patient D provided an inconsistent urine sample that was negative for the presence of hydrocodone and carisoprodol. Respondent had prescribed and Patient D had received 120 tablets of 10/325 mg. hydrocodone with acetaminophen on May 2, 2016, and 120 tablets of 350 mg. carisoprodol on May 4, 2016. On June 22, 2015, Respondent documented seeing Patient D in clinic for a medicine refill but failed to incorporate the result of the May 26, 2016, urine drug test into Patient D's treatment plan and investigate whether Patient D was diverting medication. On January 3, 2018, Patient D provided a urine drug sample that was negative for the presence of carisoprodol and positive for marijuana. On February 2, 2018, Respondent documented seeing Patient D in clinic for a medicine refill but failed to incorporate the result of the January 3, 2018, urine drug test into Patient D's treatment plan and investigated whether Patient D was diverting medication.

44. Between May 1, 2014, and April 2015, despite having Patient D on a high morphine equivalent dose of 1240 mg. in combination with Soma, Respondent often failed to record pain scores between visits. Respondent consistently began documenting pain scores in April 2015. Between May 1, 2014, and January 8, 2018, Respondent failed to document long-term plans for pain management, in particular whether tapering medication was appropriate. Between May 1, 2014, and January 8, 2018, Respondent failed to refer Patient D to a pain management specialist. Between May 1, 2014, and January 8, 2018, Respondent failed to provide definite documentation

for diagnoses of peripheral neuropathy, fibromyalgia, or bi-polar disease. Between May 1, 2014, and January 8, 2018, Respondent failed to take into account his own documentation that Patient D was having issue with medication compliance and perform a periodic review to determine if Patient D's medications should be tapered. Between May 1, 2014, and January 8, 2018, Respondent failed to document whether he discussed the possible serious interactions of the multiple medications she was being prescribed including the combinations of methadone, Seroquel, Soma, and marijuana, which can lead to increased sedation. In addition, there is no evidence that Respondent adequately discussed with Patient D the risk of cardiac toxicity that was posed by prescribing methadone and Seroquel at the same time.

45. On September 11, 2018, Respondent switched Patient D from methadone to 60 mg. of morphine sulfate, four times daily, for a morphine equivalent dose of 240 mg. and continued Soma. On September 18, 2018, Respondent documented that Patient D was having trouble weaning off methadone. On October 3, 2018, Respondent documented that morphine was not helping and restarted her on methadone but at a much lower dosage. For example on January 2, 2019, Respondent prescribed 60 tablets of 10 mg. methadone, 60 tablets of 10 mg. oxycodone and 120 tablets of 350 mg. carisoprodol. If taken as prescribed over a one-month period, Patient D's morphine equivalent dose had been reduced to 110 mg. in combination with Soma. Respondent also documented that Patient D declined Narcan. Respondent continued to provide treatment to Patient D until May 2019 and continued to lower her morphine equivalent dosages. However in May 2019, Patient D ceased receiving treatment from Respondent and instead chose to go to the methadone clinic where she could receive five pills daily of 10 mg. methadone which gave her enough pain relief to take care of her daughter.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

46. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patients B and D. The circumstances are as follows:

47. Complainant realleges paragraphs 20 through 45, and those paragraphs are incorporated by reference as if fully set forth herein.

48. Respondent's license is subject to disciplinary action because he committed gross negligence during the care and treatment of Patients B and D in the following distinct and separate ways:

a. By improperly prescribing excessive opiates to Patient B, including but not limited to initiating a prescription of methadone at an initial level of 120 mg. per day;

b. By failing to adequately document Patient B's medical records while prescribing controlled substances including: failing to perform and/or document performing a history and physical that supported the initiation of Patient B's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient B was on opioid therapy which would have included possible treatment concerns; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient B's chronic pain therapy goals and objectives, including incorporating his past history of Suboxone treatment; and,

c. By failing to adequately document Patient D's medical records while prescribing controlled substances including: failing to perform and/or document performing a history and physical that supported the initiation of Patient D's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient D was on opioid therapy which would have included possible treatment concerns; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient D's chronic pain therapy goals and objectives.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligence)

49. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts during the care and treatment of Patients B and D. The circumstances are as follows:

50. Complainant realleges paragraphs 20 through 45, and those paragraphs are incorporated by reference as if fully set forth herein.

51. Respondent committed the following negligent acts during the care and treatment of Patients B and D:

a) By improperly prescribing excessive opiates to Patient B, including but not limited to initiating a prescription of methadone at an initial level of 120 mg. per day;

b) By regularly prescribing benzodiazepines to Patient B in combination with long-term opiate therapy, which can lead to a risk of increased sedation;

c) By failing to adequately document Patient B's medical records while prescribing controlled substances including: failing to perform and/or document performing a history and physical that supported the initiation of Patient B's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient B was on opioid therapy which would have included possible treatment concerns; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient B's chronic pain therapy goals and objectives, including his past history of Suboxone treatment;

d) By failing to address multiple irregularities in Patient B's urine drug screens that were inconsistent with Patient B's pain management therapy;

e) By improperly prescribing excessive opiates to Patient D;

f) By improperly prescribing multiple dangerous combinations of controlled medications to Patient B, including but not limited to combining methadone, Seroquel, marijuana, and carisoprodol, which can lead to a risk of increased sedation; and,

g) By failing to adequately document Patient D's medical records while prescribing controlled substances including: failing to perform and/or document performing a history and physical that supported the initiation of Patient D's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient D was on opioid therapy which would have included possible treatment concerns; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient D's chronic pain therapy goals and objectives.

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THIRD CAUSE FOR DISCIPLINE

(Prescribing without a Prior Examination and Medical Indication)

52. Respondent's license is subject to disciplinary action under section 2242 of the Code in that he prescribed controlled substances to Patients B and D without completion of a prior examination and without medical indication. The circumstances are as follows:

53. Complainant realleges paragraphs 20 through 45, and those paragraphs are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

54. Respondent's license is subject to disciplinary action under section 725 of the Code in that he repeatedly provided excessive prescriptions to Patients B and D. The circumstances are as follows:

55. Complainant realleges paragraphs 20 through 45, and those paragraphs are incorporated by reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Record Keeping)

56. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he kept inaccurate and incomplete medical records during the treatment of Patients B and D. The circumstances are as follows:

57. Complainant realleges paragraphs 20 through 45, and those paragraphs are incorporated by reference as if fully set forth herein.

ADDITIONAL FACTUAL ALLEGATIONS

58. On or about May 17, 2010,[13] the Respondent saw Patient A in his clinic to establish care for chronic pain management. Patient A presented as obese, with a mental health disorder, arthritis, and as a one-and-a-half pack a day smoker. Patient A stated that she was taking four

[13] As for Patients A and C, conduct occurring before July 1, 2013, is for reference only and is not serving as an independent basis for disciplinary action. However, conduct occurring before July 1, 2013, may be used to explain or support disciplinary action for conduct occurring after July 1, 2013.

tablets of 30 mg. oxycodone, ten tablets of 10/325 mg. hydrocodone with acetaminophen, five tablets of 350 mg. carisoprodol, two tablets of 2 mg. alprazolam each day.[14] Patient A listed her health problems as including chronic back and hip pain, swelling and numbness in her hands, constant allergies, depression and anxiety. Respondent's documented medical history for Patient A listed low back pain, degenerative disc disease, degenerative joint disease, myalgias, and concerns regarding heart palpitations. Respondent documented a normal physical examination, which included him circling on her pre-printed chart that she had normal musculoskeletal, neurological and psychological examinations. Respondent did not perform a urine drug screen, did not have Patient A sign a pain management contract and did not document a comprehensive chronic pain management treatment plan.

59. Between May 17, 2010, and July 1, 2013, Respondent saw Patient A on a monthly basis. During that time, she remained on chronic pain management therapy and by January 17, 2011, Respondent was prescribing eight tablets of 40 mg. oxymorphone extended release[15] for an MED of 960 per day. Respondent only prescribed oxymorphone on one occasion and returned Patient A to oxycodone. On or about November 23, 2010, Respondent had Patient A provide a basic urine toxicology screen for morphine, hydrocodone, codeine and heroin. Despite Patient A being on oxycodone, the urine drug test did not specifically test for oxycodone. The urine toxicology screen did test for benzodiazepines and despite Respondent prescribing alprazolam, Patient A tested negative. On or about August 21, 2012, Patient A had a CT scan of her head, which was negative. On or about December 18, 2012, Patient A had a MRI of her lumbar spine, which showed the following: a 4 mm disc protrusion at L3/4 resulting in stenosis of the right neural foramen; fact arthropathy from L3 to S1, 2 mm of slippage of the L4 vertebra on L5 due to this arthopathy; and a small annular fissure of the L4/5 disc posteriorly on the right. On or about April 11, 2013, an orthopedist who specialized in spine care saw Patient A. The orthopedist documented a thorough history and physical regarding Patient A's chronic pain therapy, which

[14] MED of 280 in combination with a sedative and muscle relaxant.

[15] Marketed under the brand name Opana, Oxymorphone was voluntarily removed from the market in July 2017 by its manufacturer at the request of the FDA due to drug safety concerns.

was the first time a thorough history and physical was actually placed in Respondent's chart for Patient A. The orthopedist documented that he recommended the following: that Patient A's opioids should be tapered; that Patient A stated she would need detoxification to get off her opioid medications; that steroid injections should be considered for Patient A; and that she needed cognitive behavioral therapy.

60. On or about July 18, 2013, Respondent prescribed three hundred and sixty tablets of 30 mg. oxycodone HCL, one hundred and twenty tablets of 10/325 mg. oxycodone with acetaminophen, one hundred and twenty tablets of 2 mg. alprazolam, and one hundred and twenty tablets of 325 mg. carisoprodol to Patient A.[16] On or about August 15, 2013, Respondent prescribed three hundred tablets of 30 mg. oxycodone HCL, one hundred tablets of 10/325 mg. oxycodone with acetaminophen, one hundred and twenty tablets of 2 mg. alprazolam, and one hundred and twenty tablets of 325 mg. carisoprodol to Patient A.[17] On or about January 3, 2014, a urine drug screen showed the presence of alprazolam. According to records, Respondent continued that prescription, more or less, until December 2014 when he discontinued the prescription for 10/325 mg. oxycodone with acetaminophen. Respondent entered into a pain contract with Patient A on or about December 1, 2014. On December 1, 2014, Respondent also had Patient A provide a more expanded drug screen, which showed the presence of oxycodone, alprazolam, and carisoprodol.

61. On or about January 27, 2015, Respondent prescribed one hundred and twenty tablets of 350 mg. carisoprodol, one hundred and twenty tablets of 2 mg. alprazolam, and three hundred and sixty tablets of 30 mg. oxycodone to Patient A.[18] In March 2015 Respondent lowered the prescription to three hundred and fifty tablets of 30 mg. oxycodone but the other prescriptions remained the same for carisoprodol and alprazolam. Between March 2015 and March 2016 on a monthly basis, Respondent continued to prescribe three hundred and fifty to three hundred and

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[16] If taken over thirty days, this prescription had an MED of 600 in combination with a sedative and muscle relaxer.

[17] If taken over thirty days, this prescription had an MED of 510 in combination with a sedative and muscle relaxer.

[18] If taken over thirty days, this prescription had an MED of 540 in combination with a sedative and muscle relaxer.

sixty tablets of 30 mg. oxycodone HCL, one hundred and twenty tablets of 2 mg. alprazolam, one hundred and tablets of 350 mg. carisoprodol. A L-spine series performed on or about September 23, 2015, now showed an 11 mm slippage of L4 on L5 and a possible L4/5 pars interarticularis fracture. An MRI of the L-Spine on or about December 14, 2015, showed no fractures but showed increased neural foraminol narrowing at three levels compared to the imaging done on or about December 18, 2012.

62. On or about April 28, 2016, Respondent began prescribing three hundred tablets of 30 mg. oxycodone HCL and one hundred and twenty 2 mg. tablets of alprazolam to Patient A.[19] Respondent discontinued Carisoprodol and continued this prescription on a recurring monthly basis until September 2017. On or about July 27, 2016, a psychologist treated Patient A and diagnosed Patient A with a severe depressive disorder, PTSD, and lethargy. The psychologist noted that Patient A was preoccupied with hopeless thoughts, and that the care of two of her grandchildren (living with her) were her reason for living. On or about April 7, 2017, Patient A provided a urine drug screen result, which was negative for alprazolam despite having filled one hundred and twenty tablet prescriptions for 2 mg. alprazolam on both March 8, 2017, and April 7, 2017. On or about October 4, 2017, the Respondent began tapering Patient A's controlled medications be reducing the monthly prescriptions of both oxycodone and alprazolam. For example, by May 18, 2018, Respondent was only prescribing 90 tablets of 1 mg. alprazolam and by June 5, 2018, prescribing only 60 tablets of 30 mg. oxycodone to Patient A. During the period of tapering there continued to be inconsistent urine drug screens. For example on or about January 10, 2018, a urine drug screen was again negative for alprazolam despite Patient A receiving refills on or about both December 22, 2017, and January 19, 2018, for one hundred and twenty tablet prescriptions of 2 mg. alprazolam. On or about May 10, 2018, a urine drug screen of Patient A was consistent for alprazolam but negative for oxycodone despite Patient A receiving a refill of ninety tablets of 30 mg. oxycodone on both April 9, 2018, and May 8, 2018.

[19] If taken over thirty days, this prescription had an MED of 450 in combination with a sedative.

63. According to the medical note documented on October 4, 2017, Respondent indicated that Patient A had increased pain in her neck but failed to document the source of pain. The Respondent documented that he intended to prescribe Oxycontin but this prescription was never filled due to cost. Despite Respondent seeing Patient A on a monthly basis between July 2013 and March 29, 2019, Respondent's medical documentation was minimal at best. Respondent usually documented Patient A examinations by drawing a circle on the lower back area of a pre-preprinted diagram with comments which occasionally stated, "decreased ADL[20]s" and "no signs of withdrawal." Respondent inconsistently documented Patient A's pain scores from progress note to progress note. Throughout Patient A's chronic pain management care, Respondent only documented cursory medical histories, and the treatment plans were often mere medication refills. Between July 2013 and March 29, 2019, Respondent failed to document detailed assessments and long term chronic pain treatment plans with specific goals related to Patient A's care. Between July 2013 and March 29, 2019, Respondent failed to address repeated inconsistencies in Patient A's urine drug screen results. Between July 2013 and October 2017, Respondent failed to acknowledge the April 11, 2013, note from the orthopedist in which the orthopedist recommended that Patient A's medications should be tapered and he continued to simply continue high dose opioid treatment in combination with sedatives and muscle relaxers. Between July 2016 and October 2017, Respondent failed to acknowledge the psychologist's findings regarding Patient A's depression and the risks that her mental status poses while he continued to simply continue high dose opioid treatment in combination with sedatives and muscle relaxers.

Patient C

64. On or about February 22, 2008, Patient C presented in Respondent's clinic for a medication refill. At that time, Patient C was taking 8 tablets of 10/325 mg. hydrocodone with acetaminophen to treat a nine-year history of lower back pain. Respondent documented that Patient C had no prior history of back surgery, had received a prior back MRI, had a right sciatica, and had left leg swelling. According to the records, Patient C had no history of alcohol, smoking or illicit drug use. Respondent also documented that Patient C suffered from fatigue

[20] Activities of Daily Living.

while on Neurontin, methadone didn't work, and that she had no history of taking muscle relaxers. Respondent did not document a pain score and the physical examination was entirely normal with nothing marked on the pre-printed medical diagrams to indicate the presence of pain. Between February 22, 2008, and July 1, 2013, Respondent repeatedly prescribed controlled substances to Patient C. For example, by December 17, 2010, Respondent was prescribing 640 mg. of oxycodone per day[21] in combination with Ambien to Patient C. Respondent began prescribing Xanax to Patient C on or about Jaunary 11, 2011. On or about June 3, 2008, Respondent documented that Patient C lost her medication in an ambulance. On or about September 27, 2010, Respondent documented that Patient C suffered from sleep apnea. On or about September 15, 2012, Respondent documented receiving records from a pharmacy, which indicated that there were "DA agents" and "diversion" and that Patient C could no longer have early refills of medications from respondent. According to the pharmacy records, Patient C had early refills of Respondent's prescriptions for 30 mg. oxycodone on August 6, 2012, August 24, 2012, and September 14, 2012. For example, between August 6, 2012, and November 14, 2012, as a result of Respondent's prescriptions and early refills, Patient C was ingesting a morphine equivalent dose of 960 mg. in combination with a prescription for carisoprodol.

65. On or about July 25, 2013, Respondent prescribed one hundred and twenty tablets of 100 mg. morphine sulfate, two hundred and forty tablets of 30 mg. oxycodone HCL, one hundred and twenty tablets of 350 mg. carisoprodol, and one hundred and twenty tablets of 1 mg. alprazolam to Patient C.[22] Respondent repeated this prescription on a monthly basis until September 2013. Throughout the end of 2013 and 2014, Respondent continued to prescribe to Patient C but on a much more sporadic basis. On or about December 17, 2014, Patient C provided a urine drug screen that was consistent with Respondent's prescriptions. On or about September 2015 Respondent began prescribing one hundred and twenty tablets of 100 mg. morphine sulfate, one hundred and twenty tablets of 350 mg. carisoprodol, and one hundred and twenty tablets of 1 mg. alprazolam to Patient C.[23] By and large, Respondent continued this group

[21] MED of 960.
[22] MED of 660 in combination with a sedative and muscle relaxer.
[23] MED of 300 in combination with a sedative and muscle relaxer.

of prescriptions until June 2016. On June 16, 2016, Patient C provided an inconsistent urine drug screen that was positive for codeine and low amounts of buprenorphine. The Respondent was not prescribing codeine or buprenorphine to Patient C at the time of the inconsistent result. On or about July 2016, Respondent again began prescribing two hundred and forty tablets of 30 mg. oxycodone HCL, one hundred and twenty tablets of 100 mg. morphine sulfate, one hundred and twenty tablets of 350 mg. carisoprodol on a monthly basis until April 2018.[24] On March 13, 2017, Patient C provided an inconsistent urine drug screen as it was positive for alcohol and smoking nicotine.

66. According to the medical records, the Respondent began to taper Patient C off her controlled medications in April 2018. The Respondent's medication tapering was in response to various medical guidelines and insurance pressures. On May 18, 2018, the Respondent documented that Patient C had been off pain medication for one week without any withdrawal symptoms, that she was taking carisoprodol for sleep and Excedrin for pain relief. On September 25, 2018, a pharmacy faxed a note to Respondent that documented Patient C was receiving an MED of 380 and that Respondent should not have Patient C on an MED over 120 unless she was seen by a pain specialist. Respondent continued to prescribe opiates in amounts over an MED of 120 to Patient C. On February 5, 2019, the Respondent documented that Patient C had been visited by DEA agents and received a letter from the Federal Department of Justice. On or about February 9, 2019, Respondent lowered Patient C's medication to two tablets of 60 mg. morphine sulfate ER, and three tablets of 30 mg. morphine sulfate IR per day[25]. On February 5, 2019, Respondent also discontinued Patient C's alprazolam prescription. Between July 2013 and February 5, 2019, Respondent never referred Patient C to a pain specialist. In early 2019, Respondent did not prescribe or document prescribing Narcan[26] to Patient C despite still keeping her on an MED well over 90.

67. Between July 2013 and February 5, 2019, the Respondent failed to perform and failed to document performing a complete history and physical for Patient C. During that period of

[24] MED of 660 in combination with a sedative and muscle relaxer.
[25] MED of 310.
[26] A medication used to treat drug overdose.

time, the Respondent documented only a few pain scores and only occasionally circled the pre-printed diagrams to show he had examined Patient C. Between July 2013 and February 5, 2019, the Respondent failed to make detailed assessments of whether Patient C was benefitting from chronic pain management and the Respondent failed to document a treatment plan with goals and objectives. The Respondent relied on x-rays performed in 2008 and failed to order any additional advanced imaging between July 2013 and February 5, 2019, to justify continued chronic pain management treatment. Between July 2013 and February 5, 2019, the Respondent failed to document whether he believed Patient C was engaging in drug diversion when she never suffered withdrawal symptoms despite running out of medications.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

68. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patients A and C. The circumstances are as follows:

69. Complainant realleges paragraphs 58 through 67, and those paragraphs are incorporated by reference as if fully set forth herein.

70. Respondent's license is subject to disciplinary action because he committed gross negligence during the care and treatment of Patients A and C in the following distinct and separate ways:

a. By repeatedly prescribing high dose opioids over an MED of 120 between July 2013 and March 29, 2019, to Patient A;

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b. By failing to adequately document Patient A's medical records while prescribing controlled substances including but not limited to: continuing to prescribe controlled substances to Patient A between July 2013 and March 29, 2019, despite failing to perform and/or document performing a history and physical that supported the initiation of Patient A's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient A was on opioid therapy which would have included possible treatment concerns; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient A's chronic pain therapy goals and objectives;

c. By repeatedly prescribing high dose opioids over an MED of 120 between July 2013 and February 5, 2019 to Patient C; and,

d. By failing to adequately document Patient C's medical records while prescribing controlled substances including but not limited to: continuing to prescribe controlled substances to Patient C between July 2013 and February 5, 2019, despite failing to perform and/or document performing a history and physical that supported the initiation of Patient C's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient C was on opioid therapy which would have included possible treatment concerns; failing to refer Patient C to a pain specialist; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient C's chronic pain therapy goals and objectives.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligence)

71. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts during the care and treatment of Patients A and C. The circumstances are as follows:

72. Complainant realleges paragraphs 58 through 67, and those paragraphs are incorporated by reference as if fully set forth herein.

73. Respondent committed the following negligent acts during the care and treatment of Patients A and C:

a) By improperly prescribing excessive opiates to Patient A;

b) By regularly prescribing benzodiazepines and carisoprodol to Patient A in combination with long-term opiate therapy, which can lead to a risk of increased sedation;

c) By failing to adequately document Patient A's medical records while prescribing controlled substances including, but not limited to: continuing to prescribe controlled substances to Patient A between July 2013 and March 29, 2019, despite failing to perform and/or document performing a history and physical that supported the initiation of Patient A's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient A was on opioid therapy which would have included possible treatment concerns; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient A's chronic pain therapy goals and objectives, including his past history of Suboxone treatment;

d) By failing to address multiple irregularities in Patient A's urine drug screens that were inconsistent with Patient A's pain management therapy;

e) By improperly prescribing excessive opiates to Patient C;

f) By regularly prescribing benzodiazepines and carisoprodol to Patient C in combination with long-term opiate therapy, which can lead to a risk of increased sedation;

g) By failing to adequately document Patient C's medical records while prescribing controlled substances including, but not limited to: continuing to prescribe controlled substances to Patient C between July 2013 and February 5, 2019, despite failing to perform and/or document performing a history and physical that supported the initiation of Patient C's chronic pain therapy; failing to perform and/or document performing detailed assessments while Patient C was on opioid therapy which would have included possible treatment concerns; failing to refer Patient C to any specialists in chronic pain management; and failing to develop and/or document developing a comprehensive treatment plan that set forth Patient C's chronic pain therapy goals and objectives; and,

h) By failing to address multiple irregularities in Patient C's urine drug screens that were inconsistent with Patient C's pain management therapy.

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EIGHTH CAUSE FOR DISCIPLINE

(Prescribing without a Prior Examination and Medical Indication)

74. Respondent's license is subject to disciplinary action under section 2242 of the Code in that he prescribed controlled substances to Patients A and C without completion of a prior examination and without medical indication. The circumstances are as follows:

75. Complainant realleges paragraphs 58 through 67, and those paragraphs are incorporated by reference as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

76. Respondent's license is subject to disciplinary action under section 725 of the Code in that he repeatedly provided excessive prescriptions to Patients A and C. The circumstances are as follows:

77. Complainant realleges paragraphs 58 through 67, and those paragraphs are incorporated by reference as if fully set forth herein.

TENTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Record Keeping)

78. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he kept inaccurate and incomplete medical records during the treatment of Patients A and C. The circumstances are as follows:

79. Complainant realleges paragraphs 58 through 67, and those paragraphs are incorporated by reference as if fully set forth herein.

Business and Professions Code section 2228.1

As more fully discussed above, Respondent's excessive prescribing of opioids/opiates in combination with other sedatives caused specific harm to Patients A, B, C and D, for purposes of Business and Professions Code section 2228.1 by exposing them to a very high risk of drug abuse, risk of addiction, risk of respiratory suppression and risk of death.

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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 G 68377, issued to Jack Wayne Finch, M.D.;

2. Revoking, suspending or denying approval of Jack Wayne Finch, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jack Wayne Finch, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Jack Wayne Finch, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and,

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

DATED: JUNE 29, 2020

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

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