

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

In the Matter of the Accusation
Against:

Kalpana Amarendra Phadnis, M.D.

Physician's and Surgeon's
Certificate No. A120572

Respondent

Case No. 800-2019-057135


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 May 26, 2021.

IT IS SO ORDERED: April 26, 2021.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D., Chair
Panel B

1 XAVIER BECERRA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
3 JOHN S. GATSCHET
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8 *Attorneys for Complainant*

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

14 In the Matter of the Accusation Against:
15 **KALPANA AMARENDRA PHADNIS, M.D.**
2081 Bronze Star Dr
16 Woodland, CA. 95776-5423
17 Physician's and Surgeon's Certificate No. A
120572
18 Respondent.
19

Case No. 800-2019-057135

OAH No. 2020050732

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

23 **PARTIES**

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

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1 cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully
2 document in the patient's chart that the patient or the patient's primary caregiver was so
3 informed. Nothing in this condition prohibits Respondent from providing the patient or the
4 patient's primary caregiver information about the possible medical benefits resulting from the use
5 of marijuana.

6 This restriction shall be deemed fully satisfied upon the Board's receipt and acceptance of a
7 certificate of completion from a Board approved prescribing practices course. A prescribing
8 practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the
9 effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted
10 towards the fulfillment of this condition if the course would have been approved by the Board or
11 its designee had the course been taken after the effective date of this Decision.

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

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

24 3. EDUCATION COURSE. Within 60 calendar days of the effective date of this
25 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
26 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
27 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
28 correcting any areas of deficient practice or knowledge and shall be Category I certified. The

1 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
2 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
3 completion of each course, the Board or its designee may administer an examination to test
4 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
5 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

20 Respondent shall submit a certification of successful completion to the Board or its
21 designee not later than 15 calendar days after successfully completing the course, or not later than
22 15 calendar days after the effective date of the Decision, whichever is later.

23 5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
24 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
25 advance by the Board or its designee. Respondent shall provide the approved course provider
26 with any information and documents that the approved course provider may deem pertinent.
27 Respondent shall participate in and successfully complete the classroom component of the course
28 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully

1 complete any other component of the course within one (1) year of enrollment. The medical
2 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
3 Medical Education (CME) requirements for renewal of licensure.

4 A medical record keeping course taken after the acts that gave rise to the charges in the
5 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
6 or its designee, be accepted towards the fulfillment of this condition if the course would have
7 been approved by the Board or its designee had the course been taken after the effective date of
8 this Decision.

9 Respondent shall submit a certification of successful completion to the Board or its
10 designee not later than 15 calendar days after successfully completing the course, or not later than
11 15 calendar days after the effective date of the Decision, whichever is later.

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

21 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
22 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
23 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
24 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role
25 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
26 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
27 signed statement for approval by the Board or its designee.

28 Within 60 calendar days of the effective date of this Decision, and continuing throughout

1 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall
2 make all records available for immediate inspection and copying on the premises by the monitor
3 at all times during business hours and shall retain the records for the entire term of probation.

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

9 The monitor(s) shall submit a quarterly written report to the Board or its designee which
10 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
11 are within the standards of practice of medicine, and whether Respondent is practicing medicine
12 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
13 that the monitor submits the quarterly written reports to the Board or its designee within 10
14 calendar days after the end of the preceding quarter.

15 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
16 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
17 name and qualifications of a replacement monitor who will be assuming that responsibility within
18 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
19 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
20 notification from the Board or its designee to cease the practice of medicine within three (3)
21 calendar days after being so notified. Respondent shall cease the practice of medicine until a
22 replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

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

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

18 10. GENERAL PROBATION REQUIREMENTS.

19 Compliance with Probation Unit

20 Respondent shall comply with the Board's probation unit.

21 Address Changes

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

27 Place of Practice

28 Respondent shall not engage in the practice of medicine in Respondent's or patient's place

1 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
2 facility.

3 License Renewal

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

6 Travel or Residence Outside California

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

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

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

16 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
17 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
18 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
19 defined as any period of time Respondent is not practicing medicine as defined in Business and
20 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
21 patient care, clinical activity or teaching, or other activity as approved by the Board. If
22 Respondent resides in California and is considered to be in non-practice, Respondent shall
23 comply with all terms and conditions of probation. All time spent in an intensive training
24 program which has been approved by the Board or its designee shall not be considered non-
25 practice and does not relieve Respondent from complying with all the terms and conditions of
26 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
27 on probation with the medical licensing authority of that state or jurisdiction shall not be
28 considered non-practice. A Board-ordered suspension of practice shall not be considered as a

1 period of non-practice.

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

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

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

9 Periods of non-practice for a Respondent residing outside of California will relieve
10 Respondent of the responsibility to comply with the probationary terms and conditions with the
11 exception of this condition and the following terms and conditions of probation: Obey All Laws;
12 General Probation Requirements; and Quarterly Declarations.

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

17 14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
18 of probation is a violation of probation. If Respondent violates probation in any respect, the
19 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
20 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
21 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
22 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
23 the matter is final.

24 15. LICENSE SURRENDER. Following the effective date of this Decision, if
25 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
26 the terms and conditions of probation, Respondent may request to surrender his or her license.
27 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
28 determining whether or not to grant the request, or to take any other action deemed appropriate

1 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
2 shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its
3 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
4 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
5 application shall be treated as a petition for reinstatement of a revoked certificate.

6 16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
7 with probation monitoring each and every year of probation, as designated by the Board, which
8 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
9 California and delivered to the Board or its designee no later than January 31 of each calendar
10 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, John Quincy Brown III. 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: 01/11/2021 K A Phadnis
KALPANA AMARENDRA PHADNIS, M.D.
Respondent

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

DATED: Jan 11, 2021 [Signature]
JOHN QUINCY BROWN III
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

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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Exhibit A

1 XAVIER BECERRA
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2 STEVE DIEHL
Supervising Deputy Attorney General
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Deputy Attorney General
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8 *Attorneys for Complainant*

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

In the Matter of the Accusation Against:	Case No. 800-2019-057135
Kalpana Amarendra Phadnis, M.D. 2081 Bronze Star Dr. Woodland, CA 95776-5423	ACCUSATION
Physician's and Surgeon's Certificate No. A 120572,	
Respondent.	

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PARTIES

- Christine J. Lally ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").
- On or about March 16, 2012, the Medical Board issued Physician's and Surgeon's Certificate Number A 120572 to Kalpana Amarendra Phadnis, 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 November 30, 2021, unless renewed.

JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code ("Code") unless otherwise
4 indicated.

5 4. Section 2227 of the Code provides that a licensee who is found guilty under the
6 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
7 one year, placed on probation and required to pay the costs of probation monitoring, or such other
8 action taken in relation to discipline as the Board deems proper.

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

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

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

15 (b) Gross negligence.

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

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

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

28 ...

6. Section 2266 of the Code, states in pertinent part:

 The failure of a physician and surgeon to maintain adequate and accurate records
relating to the provision of services to their patients constitutes unprofessional conduct.

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1 **PERTINENT DRUG DEFINITIONS**

2 7. Hydromorphone hydrochloride – Generic name for the drug Dilaudid.

3 Hydromorphone hydrochloride (“hcl”) is a potent opioid agonist that has a high potential for
4 abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting
5 medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance
6 pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a
7 dangerous drug pursuant to California Business and Professions Code section 4022, and is a
8 Schedule II controlled substance pursuant to California Health and Safety Code section 11055
9 subdivision (b).

10 8. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid.

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

16 9. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and

17 Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination
18 product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a
19 Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section
20 1308.12.¹ Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business
21 and Professions Code section 4022 and is a Schedule II controlled substance pursuant to
22 California Health and Safety Code section 11055, subdivision (b).

23 10. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain

24 medication used to treat moderate to moderately severe pain. Effective August 18, 2014,
25 tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of
26

27
28 ¹ 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).

1 Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and
2 Professions Code section 4022.

3 11. Alprazolam – Generic name for Xanax. Alprazolam is a benzodiazepine that is
4 commonly used in short-term management to treat anxiety disorders, panic disorders, and anxiety
5 caused by depression. Alprazolam can increase the risk of respiratory depression when taken in
6 combination with opiate and opioid medications. Alprazolam is a Schedule IV controlled
7 substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule
8 IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a
9 dangerous drug pursuant to Business and Professions Code section 4022.

10 12. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety
11 medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia.
12 Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title
13 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety
14 Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
15 Code section 4022.

16 FACTUAL ALLEGATIONS

17 13. Respondent is a family practice physician in Woodland, California. On November
18 26, 2013, Patient A² presented at Respondent's clinic to establish new care. According to the
19 history of present illness documented in the medical record, Patient A presented with, "a history
20 of MS³, RA⁴, hypertension, CAD⁵, neuropathy, DM⁶, PAD⁷, hypothyroidism, hyperlipidemia,
21 shingles twice in the past, narcolepsy, chronic pain. She also uses 2 L of oxygen at night by nasal
22 cannula." The medical record documented that another physician in Colusa, California, was
23 previously both Patient A's primary care physician, and had also provided chronic pain
24 management care. According to Respondent, the prior physician's clinic was, "shut down by the

25 ² Patient's name has been omitted to protect confidentiality. All witnesses will be fully
26 identified in discovery.

27 ³ Multiple sclerosis

28 ⁴ Rheumatoid arthritis

⁵ Coronary artery disease

⁶ Diabetes mellitus

⁷ Peripheral artery disease

1 narcotics squad and so the patient has transferred care here.” According to the progress note,
2 Patient A’s medical records from the other physician’s clinic were not available. Respondent
3 documented that Patient A requested refills of some of her medications.

4 14. On November 26, 2013, medical records documented that a PHQ-9⁸ questionnaire
5 was completed and Patient A presented with a score of 17, indicating a moderately severe
6 problem with depression. Respondent documented that Patient A was currently taking
7 hydromorphone, methadone, and tramadol for pain. Respondent documented that Patient A was
8 also taking alprazolam for anxiety. Respondent documented a brief physical examination but
9 failed to document the physical issues that generated Patient A’s pain, failed to specify what
10 physical functions were altered by pain, and failed to state how Patient A’s past chronic pain
11 treatments had affected her physical function. Respondent also failed to document in Patient A’s
12 medical history whether non-opioid treatments and/or low dose opioid treatments had failed in
13 treating Patient A’s pain. Respondent failed to document whether Patient A had a history of
14 substance abuse. According to Patient A’s certified pharmacy profile, Dr. L had prescribed and
15 Patient A had received a three-month supply of methadone and hydromorphone on October 29,
16 2013.⁹ Assuming Patient A was taking a daily dose of 4 tablets of 10 mg methadone, 7 tablets of
17 8 mg hydromorphone, 1 tablet of 100 mg tramadol, and 3 mg of alprazolam, under the prior
18 physician’s care, Patient A had a daily MED¹⁰ of 554 in combination with benzodiazepines.

19 15. Respondent documented in Patient A’s treatment plan for chronic pain that Patient A
20 would bring all of her medication bottles at her next visit in two weeks and that Respondent
21 would get Patient A’s “medication history from Davison drug house in Colusa.” Respondent
22 prescribed Patient A 30 tablets of 100 mg tramadol and a 30 tablets of 1 mg alprazolam, but did
23 nor prescribe hydromorphone or methadone. Respondent did not order any medical imaging, nor

24
25 ⁸ The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and
measuring the severity of depression.

26 ⁹ 360 tablets of 10 mg. methadone, 630 tablets of 8 mg. hydromorphone.

27 ¹⁰ 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
28 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.

1 did she have Patient A provide a urine drug test. Respondent did not have Patient A sign a
2 controlled drug agreement on November 26, 2013.

3 16. Respondent next saw Patient A on December 10, 2013, in her clinic for a two-week
4 follow-up. Respondent documented under history of physical illness that Patient A was there for
5 follow-up regarding diabetes, hyperlipidemia, and chronic pain. Respondent documented Patient
6 A's chronic pain as follows that:

7 "she is on Diluadid 8 mg 4 tablets daily along with methadone 10 mg 4 tablets daily for
8 chronic pain. She is complaining of 10/10 pain today because she has run out of
9 medications. She is requesting a refill of her pain medications. She has not established
care with pain management."

10 Respondent also documented that Patient A suffered from coronary artery disease, narcolepsy,
11 rheumatoid arthritis, and was a current every day smoker. Respondent documented that she did a
12 minimal general physical examination but failed to document the physical issues that generated
13 Patient A's pain, failed to specify what physical functions were altered by chronic pain, and failed
14 to state how Patient A's past chronic pain treatments had affected her physical function.

15 Respondent did not have Patient A sign a controlled drug agreement on December 10, 2013.

16 Respondent also did not perform and/or document performing an EKG¹¹ and did not document
17 that she provided Patient A with a specific informed consent regarding the dangers of prescribing
18 methadone to a patient with a known history of cardiac disease. While Respondent documented
19 that she ordered a drug abuse screen in Patient A's medical records, the first urine drug screen
20 result actually documented in Patient A's chart is dated December 22, 2014.

21 17. Respondent documented in Patient A's plan for chronic pain therapy that she would
22 refill Patient A's methadone and Dilaudid and make a referral to pain management to establish
23 care. Assuming Patient A took the prescriptions as Respondent prescribed, Patient A was taking
24 a daily prescription of 4 tablets of 10 mg methadone, 4 tablets of 8 mg hydromorphone, and 1
25 tablet of 100 mg tramadol, for chronic pain while also taking 1 tablet of 2 mg alprazolam for
26

27 _____
28 ¹¹ Electrocardiogram

1 anxiety.¹² Respondent documented that Patient A would receive a referral to pain management
2 and that she would be contacted within 3 to 5 business days.

3 18. On December 23, 2013, Patient A was admitted to Enloe Medical Center in Chico,
4 California for symptoms related to a cardiac event after being transferred from the Colusa
5 Hospital emergency department. That same day Patient A underwent a quintuple bypass of her
6 heart vessels. Patient A's methadone prescription was stopped following the hospital admission
7 for the cardiac event. Respondent next saw Patient A on January 13, 2014, in office. Respondent
8 documented Patient A's hospital admission from December 23, 2013, and noted that Patient A
9 was in severe pain due to her recent surgery and her chronic pain conditions. Respondent noted
10 that Patient A's chronic pain was a result of three abdominal hernias, which were operated on
11 multiple times. Respondent noted that Patient A had 10 surgeries over ten years. Respondent
12 noted that Patient A was out of all of her pain medications and that a referral to pain management
13 was still pending authorization.

14 19. On January 13, 2014, Respondent began prescribing a monthly total of 120 tablets of
15 8 mg hydromorphone, which if taken as prescribed would mean Patient A was taking 32 mg per
16 day.¹³ Patient A had received 30 tablets of 1 mg alprazolam and 30 tablets of 2 mg alprazolam on
17 January 9, 2014, from a prior prescription from Respondent. Respondent discontinued both
18 methadone and tramadol. Respondent documented that she would order a urine toxology screen
19 at the next visit but, as noted above, the first urine drug screen did not occur until December 22,
20 2014. On January 13, 2014, Respondent had Patient A enter a controlled substances agreement
21 with Respondent. Respondent failed to document a comprehensive physical examination related
22 to Patient A's chronic pain issues.

23 20. On February 4, 2014, Respondent next saw Patient A in her clinic. Respondent
24 refilled Patient A's hydromorphone and noted that the pain management referral was still pending
25 and that the patient was waiting for an appointment. Respondent noted that the office would need
26 to follow-up on Patient A's pain management referral. On March 4, 2014, Respondent next saw

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28 ¹² An MED of 458 in combination with a benzodiazepine.

¹³ An MED of 128 in combination with a benzodiazepine.

1 Patient A in clinic. Respondent documented that Patient A's pain was not controlled on
2 hydromorphone and that Patient A reported that she had a lot anxiety despite being on 2 tablets of
3 1 mg alprazolam. Respondent documented again that the referral to pain management was still
4 pending. Respondent noted that Patient A stated she had severe pain in her right leg all the way
5 down to her foot, and stated that, "her leg feels like a dead weight." Respondent documented a
6 brief physical examination and that Patient A was in moderate distress due to pain, but failed to
7 specifically document Patient A's sources of pain or a more complete physical examination
8 geared to chronic pain. Respondent documented under the treatment plan that Patient A would
9 continue to be prescribed 32 mg of hydromorphone per day and would be prescribed 20 mg of
10 hydrocodone with acetaminophen for breakthrough pain.¹⁴ Respondent also documented that she
11 continued Patient A on 2 tablets of 1 mg alprazolam per day but that Patient A could take a third
12 pill of alprazolam if she felt her anxiety was not controlled. On March 27, 2020, at an
13 investigative interview with the Board, Respondent was asked why she managed Patient A's
14 chronic pain with two short-acting opiates, Dilaudid and Norco. Respondent stated, "(w)ell, I do
15 not have experience in pain management and I would – I would not be (inaudible) if I needed to
16 transition the patient on such high doses of opiates (inaudible) –uh—that is not within my –uh—
17 you know (inaudible) and I don't think (inaudible) to that competently."

18 21. On April 4, 2014, Respondent next saw Patient A in clinic. Respondent documented
19 Patient A was taking 3 tablets of 1 mg alprazolam per day and that Patient A's anxiety was under
20 improved control. Respondent also documented that Patient A was having shooting pain from her
21 right groin to her right toe. Respondent documented that Patient A's referral to pain management
22 was still pending. Respondent documented that Patient A reported that the Norco prescription for
23 breakthrough pain was, "not adequate to control her pain." Respondent noted that Patient A
24 remained on hydromorphone. Respondent refilled Patient A's 60-tablet prescription for 5/325 mg
25 hydrocodone with acetaminophen and her 120-tablet prescription for 8 mg hydromorphone.
26 Respondent also prescribed 60 tablets of 50 mg Lyrica to Patient A.¹⁵

27 ¹⁴ An MED of 148.

28 ¹⁵ Lyrica, generically known as pregabalin, is a Schedule V controlled substance designed to treat neuropathic pain.

1 22. On May 2, 2014, Respondent next saw Patient A in clinic. Respondent documented
2 that Patient A reported that her pain was not well controlled and that she was taking 4 to 6 tablets
3 of 5/325 mg Norco per day. Respondent documented that she increased Patient A's Lyrica to 50
4 mg tablet three times daily, and that she advised Patient A to not take more than four Norco
5 tablets per day. Respondent continued Patient A on hydromorphone and Norco. Respondent also
6 continued Patient A on 3 tablets of 1 mg alprazolam.¹⁶

7 23. On May 30, 2014, Respondent next saw Patient A in clinic for chronic pain and
8 anxiety. Respondent documented that Patient A stated that her pain was reasonably well
9 controlled but that the Patient wanted to change from 5/325 mg Norco tablets to stronger 10/325
10 mg Norco tablets in order reduce her Tylenol intake. Respondent documented that 3 tablets of 1
11 mg alprazolam kept Patient A's anxiety well controlled. Respondent documented a brief physical
12 exam and noted that Patient A was alert and oriented and not in distress. However, Respondent
13 did not document a more comprehensive physical examination of Patient A's chronic pain
14 complaints. Respondent documented in the treatment plan that she was now prescribing 90
15 tablets of 10/325 mg hydrocodone with acetaminophen and continuing Patient A's 90 tablet
16 prescription of 1 mg alprazolam and 120 tablet prescription of 8 mg hydromorphone.¹⁷ Despite
17 documenting that Patient A's pain was "reasonably well controlled," Respondent failed to
18 document why she was increasing Patient A's MED from 148 to 158.

19 24. Between June 27, 2014, and October 22, 2014, Respondent prescribed
20 hydromorphone, hydrocodone with acetaminophen, and alprazolam to Patient A. On or about
21 October 22, 2014, Respondent increased Patient A's hydrocodone with acetaminophen
22 prescription to 120 tablets of 10/325 mg per month. Respondent noted that she had discontinued
23 Lyrica due to cost and had started Patient A on gabapentin and that she was increasing Norco.
24 Between October 22, 2014, and March 30, 2017, on a recurring monthly basis, Respondent

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27 ¹⁶ Respondent incorrectly documented the benzodiazepine as lorazepam (Ativan) in
Patient A's chart rather than the alprazolam which was actually prescribed.

28 ¹⁷ MED of 158 in combination with a benzodiazepine.

1 prescribed 120 tablets of 10/325 mg Norco, 120 tablets of 8 mg hydromorphone, and 90 tablets of
2 1 mg alprazolam to Patient A.¹⁸

3 25. A review of the progress notes between October 22, 2014, and March 30, 2017,
4 shows that Respondent documented a treatment plan from visit to visit but did not set forth any
5 objectives for Patient A to reach while on chronic pain therapy. Between October 22, 2014, and
6 March 30, 2017, Respondent often documented that Patient A's pain was 10/10 and that the
7 medications were not effective, yet there was no change in Patient A's chronic pain therapy.
8 Respondent often documented that she referred Patient A to a pain specialist for chronic therapy
9 management but there was never any follow-up with this referral, and Patient A was not seen by a
10 pain specialist during that period of time. Similarly, a review of the progress notes between
11 October 22, 2014, and March 30, 2017, reveals a lack of documentation of Patient A's progress
12 on controlled substances. Respondent failed to document a change in Patient A's chronic pain
13 treatment plan despite Patient A being either unable and/or unwilling to go to see a pain
14 management specialist. Finally, between October 22, 2014, and March 30, 2017, Respondent
15 failed to document any comprehensive physical examination findings or medical imaging that
16 would have supported the continued prescribing of controlled substances.

17 26. Between June 27, 2014, and March 30, 2017, Respondent did not document whether
18 she ever suspected that Patient A was abusing her pain management therapy despite an indication
19 that Patient A was at risk of abuse. For example, on June 2, 2014, Patient A was admitted to
20 Enloe Medical Center following a fall in her garage when she tried to feed her cat. According to
21 the hospitalization summary from the hospital stay, Patient A's presentation was consistent with
22 narcotic abuse in terms of hypotension, respiratory acidosis, and improvement in the conditions
23 with time in the hospital. It was noted that on June 3, 2014, Patient A left Enloe Medical Center
24 against medical advice while pending an MRI¹⁹ to rule out other neurological defects because
25 Patient A wanted to take "all her pain medications at her usual dose." The physician at Enloe
26 Medical Center stated that prior to Patient A leaving against medical advice, she advised Patient

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28 ¹⁸ MED of 168 in combination with a benzodiazepine.

¹⁹ Magnetic resonance imaging.

1 A that she should only take her pain medications at reasonable dosages or she would be at risk of
2 sedation and hypotension. The discharge summary from Enloe Medical Center is located in
3 Respondent's medical chart and dated July 7, 2014. Despite this record from Enloe Medical
4 Center, Respondent continued to prescribe controlled substances to Patient A.

5 27. On April 3, 2017, a podiatrist saw Patient A regarding concerns with ulcers plantar
6 and posterior to both heels. The podiatrist debrided Patient A's heels. On April 17, 2017, a
7 physician assistant that is supervised by Respondent saw Patient A in clinic. At that time, Patient
8 A had last received 120 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 8
9 mg hydromorphone, and 90 tablets of 1 mg alprazolam on March 30, 2017, from Respondent.
10 The physician assistant noted that Patient A presented with complaints of bilateral foot pain and
11 that her pain level was 10 out of 10. The physician assistant noted that Patient A was extremely
12 defensive when confronted with the fact that she smoked 6-10 cigarettes per day, and told the
13 physician assistant to "stop this shit" in reference to the physician assistant telling her to quit
14 smoking. The physician assistant documented in regards to Patient A's chronic pain therapy that
15 Patient A stated, "(s)he's been on Dilaudid for over 15 years and feels that her body is somewhat
16 immune to this because it does not help her pain."

17 28. In the treatment plan, the physician assistant documented that Patient A was in severe
18 pain and that because she had been taking her medications every four hours, that she was due to
19 run out of her controlled medications in a few days. The physician assistant noted that Patient A
20 was not due for a refill of her pain medication until April 27 or April 29, at least 10 days later.
21 The physician assistant noted that Patient A wanted a referral to pain management (despite
22 Respondent documenting that she had referred Patient A to pain management over the last two
23 and half years of progress notes) and she wanted a refill or increase of her chronic pain
24 medications. The physician assistant stated she was unable to increase Patient A's chronic pain
25 medications and that she would speak with Respondent about the medication regimen.
26 Respondent counter-signed the physician assistant's note on April 23, 2017.

27 29. On April 20, 2017, Respondent prescribed and Patient A received 90 tablets of 1 mg
28 alprazolam and 84 tablets of 8 mg hydromorphone. This represented an early refill of Patient A's

1 medications. Respondent failed to author a progress note in the medical record that set forth the
2 reason or basis for this early refill. Respondent next prescribed to Patient A on May 5, 2017.
3 Respondent failed to verify that Patient A had run out of opioid medication prior to issuing new
4 prescriptions. Assuming that Patient A had in fact run out of all opioid medication by April 20,
5 2017, 84 tablets of hydromorphone over 15 days would mean that Patient A was now taking at
6 least five pills of 8 mg hydromorphone a day, but could take as many as six pills per day.²⁰

7 30. On May 3, 2017, Patient A presented at Enloe Medical Center. According to the
8 history of present illness, Patient A had fallen on the afternoon of May 2, 2017, and her caregiver
9 had found her in a confused mental state. According to the Enloe Medical Center note, her
10 caregiver brought Patient A to the hospital but the caregiver dropped Patient A off at the hospital
11 and left. According to the Enloe Medical Center note, Patient A was confused and unable to
12 provide any information whatsoever; specifically, her answer to most of the questions was, "I
13 have heel problems." The note mentioned that Patient A had previously been admitted to Enloe
14 Medical Center in June 2014 and mentioned Patient A's history of excessive narcotic use. In the
15 assessment and plan, the physician at Enloe Medical Center noted that Patient A had "Acute
16 encephalopathy and quite likely opiate and benzodiazepine related, I will hold those. In fact, I
17 will hold all patient's outpatient medications, as patient is drowsy. She will be on bowel rest until
18 she is more awake and prove that she can eat and swallow." The note from Enloe Medical Center
19 also mentioned that Patient A would be placed on "p.r.n. Narcan²¹" and that she was somewhat
20 hypotensive. On the bottom of the Enloe Medical Center note, there was writing which indicated
21 the report was for Respondent's clinic and the note was stamped May 3, 2017, in the upper right
22 hand corner of the chart.

23 31. On May 5, 2017, Respondent prescribed and Patient A received a 28-day supply of
24 controlled substances which included 112 tablets of 10/325 mg hydrocodone with acetaminophen
25 and 168 tablets of 8 mg hydromorphone. Assuming these medications were taken as prescribed,

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27 ²⁰ Five pills of 8 mg hydromorphone per day as an MED of 160. Six pills of 8 mg
hydromorphone has an MED of 192. This was in combination with a benzodiazepine.

28 ²¹ Naloxone, sold under the brand name Narcan

1 Patient A would be taking 4 tablets of 10/325 mg hydrocodone with acetaminophen and 6 tablets
2 of 8 m. hydromorphone in combination with three tablets of 1 mg alprazolam per day.²² There is
3 no documentation in Patient A's medical record that explains why the prescriptions were
4 dispensed to Patient A on May 5, 2017.

5 32. On May 9, 2017, Respondent next saw Patient A in clinic for follow-up. Respondent
6 documented that Enloe Medical Center had recently admitted Patient A for concerns of confusion
7 and difficulty in arousal by her caregiver. Respondent documented that Patient A's narcotic
8 prescriptions were withheld while she was in the hospital and that Patient A had left the hospital
9 "AGAINST MEDICAL ADVICE" the next day. Respondent did not document why she
10 provided Patient A an early refill of controlled substances on April 20, 2017. Respondent noted
11 that Patient A's diabetes was uncontrolled. Respondent noted that Patient A was taking 6 tablets
12 of 8 mg hydromorphone daily and 3-4 tablets of 10/325 mg Norco daily as well as 3 tablets of 1
13 mg alprazolam daily. Respondent noted that Patient A reported that Norco does not really help
14 much with her pain control. Respondent noted that Patient A was noncompliant with her Lyrica
15 prescription, only taking 100 mg daily when she should have been taking 150 mg daily. Under
16 the treatment plan, Respondent documented that Patient A had drowsiness/difficulty in arousal
17 and attributed that to either controlled drug prescriptions or her uncontrolled diabetes. Under the
18 treatment plan for chronic pain, Respondent documented that she would discontinue Norco and
19 advised Patient A to "use only" 6 tablets of 8 mg hydromorphone daily. Respondent noted that,
20 "[p]atient unwilling to reduce the dose of Dilaudid." Respondent documented that she discussed,
21 "[s]top Norco" with Patient A but there is no documentation on what would happen to the 112
22 tablets of 10/325 mg hydrocodone with acetaminophen that had been dispensed to Patient A only
23 four days earlier. Respondent also reduced Patient A's prescription of alprazolam to 1 mg tablet
24 taken twice daily.

25 33. Between May 10, 2017, and July 10, 2017, Respondent did not see Patient A in clinic
26 for chronic pain management. On May 24, 2017, an individual in Respondent's practice authored
27 a progress note which stated that Patient A's diabetes was out of control, and that her medication

28 ²² MED of 232 in combination with a benzodiazepine.

1 was non-compliant. According to the May 24, 2017, progress note, Patient A had been
2 hospitalized twice in 2017 and had been to the emergency room three times in 2017. The May
3 24, 2017, progress note documented that Respondent was updated regarding Patient A's current
4 status. On May 25, 2017, Patient A received a prescription of 90 tablets of 1 mg alprazolam from
5 Respondent, despite Respondent reducing the prescription to two pills daily on May 9, 2017. On
6 June 2, 2017, Patient A received a prescription of 168 tablets of 8 mg hydromorphone. On June
7 19, 2017, a telephone note was entered in Patient A's medical record regarding follow-up with
8 medication compliance. According to the telephone note, Patient A had cancelled follow-up
9 appointments with Respondent on June 5, 2017, June 7, 2017, and June 14, 2017. According to
10 the telephone note, Patient A stated she cancelled the appointments because she was "feeling
11 good" and that it was difficult to travel to Respondent's clinic. According to the note, Patient A
12 agreed to schedule a follow-up visit with Respondent in June. Patient A never attended a follow-
13 up visit with Respondent in June 2017.

14 34. On July 6, 2017, a telephone call was documented with Patient A's caregiver who
15 stated that Patient A was not doing well. According to Patient A's caregiver, Respondent was
16 sleeping most of the time and was bed bound. According to the Patient's caregiver, when she last
17 took Patient A to the emergency department, the caregiver had been informed that Patient A was
18 over-medicated. According to Patient A's caregiver, she was providing Lyrica, hydromorphone,
19 and alprazolam twice daily to Patient A instead of three times a day. Finally, Patient A's
20 caregiver noted that she would work hard to have Patient A attend a July 11, 2017, appointment
21 with Respondent. On June 30, 2017, Patient A received a prescription of 90 tablets of 1 mg
22 alprazolam from Respondent, despite Respondent having previously reduced the prescription to
23 two pills daily on May 9, 2017.

24 35. On July 11, 2017, Respondent next saw Patient A in clinic for follow-up regarding
25 her diabetes and chronic pain management. Respondent documented that Patient A was on
26 Dilaudid and was using six 8 mg tablets a day. Respondent documented that Patient A was
27 getting over sedated and difficult to arouse. Respondent noted that she had Patient A's caregiver
28 previously give Patient A two Dilaudid tablets in the morning and two tablets in the afternoon and

1 that Patient A was more alert and interactive. Respondent noted that Patient A reported her pain
2 was not controlled on four tablets of 8 mg Dilaudid and she requested that her dose of Dilaudid be
3 increased. Respondent documented that Patient A was receiving two tablets of 1 mg alprazolam
4 daily and that was working for her. This statement was not supported by the pharmacy records,
5 which showed that Patient A was still receiving three tablets of 1 mg alprazolam daily.

6 Respondent noted that Patient reported she was more depressed since her husband passed away.
7 Respondent documented under the treatment plan that she wanted Patient A to continue to use 2
8 tablets of 8 mg Dilaudid twice daily, plus use an additional tablet midday if her pain was worse.
9 Respondent documented that she would continue Patient A on two tablets of 1 mg alprazolam.
10 Respondent provided Patient A with a prescription for 140 tablets of 8 mg hydromorphone and
11 Patient A received the prescription on July 12, 2017.

12 36. Following this visit with Respondent, Patient A was hospitalized in early August
13 2017 and it was determined that she would be transferred to hospice care. Respondent did not
14 prescribe controlled substances to Patient A following the July 11, 2017, appointment. Patient A
15 died on October 25, 2017, from multiple health complications. Between November 16, 2013, and
16 July 12, 2017, Respondent only had Patient A provide two urine toxicology screens, which were
17 collected on December 22, 2014, and March 20, 2015, respectively. The December 22, 2014, test
18 was negative for hydrocodone and hydromorphone despite Patient A receiving a prescription
19 from Respondent for 120 tablets of 10/325 mg hydrocodone with acetaminophen and 120 tablets
20 of 8 mg hydromorphone on November 26, 2014. The December 22, 2014, test was positive for
21 alprazolam. The March 20, 2015, test was positive for hydrocodone, hydromorphone and
22 alprazolam.

23 37. Between November 16, 2013, and July 12, 2017, Patient A often reported that her
24 pain was uncontrolled and ten out of ten despite being on high dose opioids. During that time,
25 Respondent failed to evaluate and/or document evaluating whether or not Patient A was abusing
26 her controlled pain medication. Between April 17, 2017, and July 12, 2017, Patient A required
27 more and more opioids and continued to have intolerable pain. Between November 16, 2013, and
28 July 12, 2017, Respondent failed to consider and/or document considering a referral of Patient A

1 to a substance abuse program. Between November 16, 2013, and July 12, 2017, aside from
2 stopping methadone in early 2014 following Patient A's cardiac event, Respondent failed to
3 consider and/or document considering whether she should reduce Patient A's opioid dosages.
4 Between November 16, 2013, and July 12, 2017, despite Respondent repeatedly stating that
5 Patient A would be referred to a pain management specialist, Respondent failed to follow through
6 and/or document following through and ensure that Patient A was actually seen by a pain
7 management specialist. Between November 16, 2013, and July 12, 2017, Respondent did not
8 consider and/or document considering terminating Patient A as a patient for violating the pain
9 contract.

10 **FIRST CAUSE FOR DISCIPLINE**

11 **(Gross Negligence)**

12 38. Respondent's license is subject to disciplinary action under section 2234, subdivision
13 (b), of the Code, in that she committed gross negligence during the care and treatment of Patient
14 A. The circumstances are set forth in paragraphs 13 through 37, and those paragraphs are
15 incorporated by reference as if fully set forth herein. Additional circumstances are as follows:

16 39. Respondent's license is subject to disciplinary action because she committed gross
17 negligence during the care and treatment of Patient A in the following distinct and separate ways:

18 a. By improperly prescribing high dose opioids from January 2015 to July 2017
19 without documenting a comprehensive treatment plan for chronic pain management which set
20 forth goals and objectives for treatment and without performing a periodic review of that
21 treatment plan when it became apparent that Patient A was unable and/or unwilling to go to a pain
22 management specialist.

23 b. By continuing to prescribe high dose opioids over a three-year period between
24 January 2014 and July 2017 in conjunction with benzodiazepines to Patient A without obtaining
25 any prior records, any new evaluations, any new pain management consultations or transfer
26 Patient A's chronic pain therapy to a specialist;

27 c. By improperly prescribing a high morphine equivalent dose of opioids on
28 December 10, 2013, to Patient A, which included methadone, without doing an independent

1 evaluation of Patient A's chronic pain, without ordering appropriate medical imaging, without
2 following through on appropriate pain management referrals, without documenting a separate
3 informed consent for methadone, and without ordering an EKG;

4 d. By failing to consider and/or document considering whether Patient A was
5 suffering from abuse disorder between November 16, 2013, and July 12, 2017, while Respondent
6 continued to prescribe high dose opioids to Patient A;

7 e. By failing to consider and/or document considering whether Patient A was
8 suffering from hyperalgesia between November 16, 2013, and July 12, 2017, and either reduce
9 Patient A's opioid prescriptions and/or refer her to a substance abuse program; and

10 f. By improperly continuing to prescribing high dose opioids to Patient A despite
11 repeated hospital documentation which indicated that Patient A was somnolent and had
12 repeatedly fallen in her residence.

13 **SECOND CAUSE FOR DISCIPLINE**

14 **(Repeated Negligent Acts)**

15 40. Respondent's license is subject to disciplinary action under Section 2234, subdivision
16 (c), of the Code in that she committed repeated negligent acts during the care and treatment of
17 Patient A. The circumstances are set forth in paragraphs 13 through 39, which are incorporated
18 by reference as if fully set forth herein. Each of the instances of gross negligence are also
19 considered separate and distinct negligent acts. Additional negligent acts are as follows:

20 a. By failing to order and/or document ordering Patient A to undergo urine drug
21 testing more than twice over a three and a half year period between November 16, 2013, and July
22 12, 2017.

23 **THIRD CAUSE FOR DISCIPLINE**

24 **(Inadequate and Inaccurate Medical Records)**

25 41. Respondent's license is subject to disciplinary action under Section 2266 of the Code
26 in that she kept inaccurate and inadequate medical records during her care and treatment of
27 Patient A. The circumstances are set forth in paragraphs 13 through 40, which are incorporated
28 by reference as if fully set forth herein.

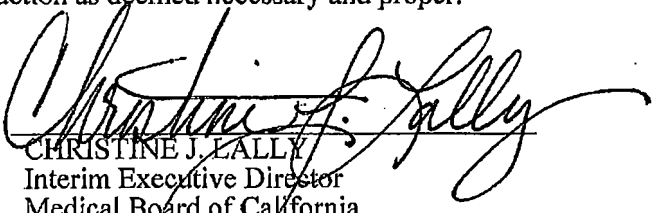
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 120572, issued to Kalpana Amarendra Phadnis, M.D.;
2. Revoking, suspending or denying approval of Kalpana Amarendra Phadnis, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Kalpana Amarendra Phadnis, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: ~~APR 09 2020~~


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

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