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

In the Matter of the Accusation Against: Richard J. Winkle, M.D. Physician's and Surgeon's Certificate No. G 8441 Respondent.	Case No. 800-2018-041723

DECISION

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

This Decision shall become effective at 5:00 p.m. on JUN 0 2 2021.

IT IS SO ORDERED MAY 2 6 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

MATTHEW RODRIQUEZ
Acting Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
Deputy Attorney General
State Bar No. 295656
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9455
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **RICHARD J. WINKLE, M.D.** **11741 Valley View Street** **Cypress, CA 90630** **Physician's and Surgeon's Certificate No. G 8441,** Respondent.	Case No. 800-2018-041723 **STIPULATED SURRENDER OF LICENSE 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 Matthew Rodriquez, Acting Attorney General of the State of California, by Christine A. Rhee, Deputy Attorney General.

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2. Richard J. Winkle, M.D. (Respondent) is represented in this proceeding by attorney Nicholas D. Jurkowitz, Esq., whose address is: 1990 South Bundy Drive, Suite 777, Los Angeles, CA 90025.

3. On or about March 7, 1963, the Board issued Physician's and Surgeon's Certificate No. G 8441 to Richard J. Winkle, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-041723 and will expire on July 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-041723 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 2, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2018-041723 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-041723. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License 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 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. Having had the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2018-041723, agrees that he has thereby subjected his license to disciplinary action, and hereby surrenders his Physician's and Surgeon's Certificate No. G 8441 for the Board's formal acceptance.

9. Respondent agrees that if he ever petitions for reinstatement of his license, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations in Accusation No. 800-2018-041723 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Pursuant to Business and Professions Code section 2224, subdivision (b), the Executive Director of the Board has been delegated the authority to adopt or reject a stipulation for surrender of a Physician's and Surgeon's Certificate.

12. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved by the Executive Director on behalf of the Board. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it

shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion, and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

13. The Executive Director shall have a reasonable period of time in which to consider and act upon this stipulation after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director considers and acts upon it.

ADDITIONAL PROVISIONS

14. This Stipulated Surrender and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-listed matter.

15. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 8441, issued to Respondent Richard J. Winkle, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

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2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2018-041723 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2018-041723 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 4/15/21

RICHARD J. WINKLE, M.D.
Respondent

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I have read and fully discussed with Respondent Richard J. Winkle, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: April 16, 2021

NICHOLAS D. JURKOWITZ, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

MATTHEW RODRIQUEZ
Acting Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Respondent Richard J. Winkle, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: _____

NICHOLAS D. JURKOWITZ, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: April 26, 2021

Respectfully submitted,

MATTHEW RODRIQUEZ
Acting Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-041723

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
Deputy Attorney General
State Bar No. 295656
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9455
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **RICHARD J. WINKLE, M.D.** **11741 Valley View Street** **Cypress, CA 90630** **Physician's and Surgeon's Certificate No. G 8441,** Respondent.	Case No. 800-2018-041723 **ACCUSATION**

PARTIES

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

2. On or about March 7, 1963, the Medical Board issued Physician's and Surgeon's Certificate No. G 8441 to Richard J. Winkle, M.D. (Respondent). Physician's and Surgeon's Certificate No. G 8441 was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

5. Section 2228.1 of the Code states, in pertinent part:

> (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:
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> ...
>
> (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.

...

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

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

...

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

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

...

(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.

...

7. Section 2266 of the Code states that 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.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G 8441 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, C, and D,[1] as more particularly alleged hereafter:

Patient A

9. Respondent treated Patient A, a woman born in 1936, as her primary care physician from approximately 2011 through 2018. In an interview with Board investigators, Respondent said that he believed that Patient A had initially been prescribed Xanax[2] by a neurologist or psychiatrist, and that he would renew the prescriptions.

[1] Names of the patients have been omitted to protect the patients' privacy.
[2] Xanax, brand name for alprazolam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

10. In a note dated on or about November 11, 2002,[3] Patient A reported that she was currently taking Zoloft.[4] There was no additional psychiatric history documented.

11. At a visit on or about March 3, 2014, Respondent documented that Patient A, then 77-years old, was recovering from an acute back injury. He also documented that Patient A had spondylolisthesis, degenerative disc disease, and osteoarthritis, and that she was receiving physiotherapy to good effect. Patient A's documented current medications included Vicoprofen[5] and Xanax.

12. According to CURES,[6] between on or about July 5, 2011 and May 7, 2015, Respondent prescribed Patient A an average of 3 to 6 mg of Xanax per day. During this time period, Respondent failed to document the rationale for increasing and decreasing Patient A's Xanax dose or any re-assessment of symptoms or management.

13. According to CURES, on or about January 2, 2015, Patient A filled a prescription written by Respondent for liquid hydrocodone bitartrate-homatropine.[7] This prescription was not documented in the medical records.

14. According to CURES, from on or about April 30, 2014 through March 15, 2018, Patient A filled approximately 17 prescriptions for Ambien[8] that were written by Respondent. Other than noting some of the prescriptions in a medication log, Respondent failed to document the rationale for giving these prescriptions to Patient A, any ongoing monitoring, and the reasons

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[3] Conduct occurring more than seven (7) years from the filing date of this Accusation or more than three (3) years from notification to the Board is for informational purposes only and is not alleged as a basis for disciplinary action.

[4] Zoloft, brand name for sertraline, is a selective serotonin reuptake inhibitor (SSRI) and an anti-depressant.

[5] Vicoprofen, brand name for hydrocodone and ibuprofen. Hydrocodone is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

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

[7] Hydrocodone bitartrate-homatropine, brand name Hycodan, is an opiate used for pain relief.

[8] Ambien, brand name for zolpidem, is a sedative hypnotic commonly used to treat insomnia, and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

why the dose was increased on or about January 4, 2016 and decreased on or about March 15, 2018.

15. On or about April 30, 2014, Patient A reported that her back was feeling better, and that she did not need further therapy.

16. On or about September 4, 2014, Patient A returned to the office to recheck her medications. Respondent failed to document any objective findings, assessment, or plan.

17. On or about October 28, 2014, Patient A returned to the office and complained of feeling tired and "hazy." Respondent failed to document any objective findings, assessment, or plan.

18. On or about November 13, 2014, Patient A returned to the office to follow up on her depression. In this progress note, Patient A's listed medications were Prozac[9] and Xanax. Respondent failed to document any objective findings, assessment, or plan.

19. On or about February 6, 2015, Patient A returned to the office. During this visit, she made bizarre statements about talking to the police about a chest wall scar and complained of a buzzing in her head. A medical assistant noted, "Pt seems a little unstable today."

20. On or about March 6, 2015, Patient A returned to the office. She complained of anxiety and wanted to speak to a physician about her insomnia. The handwritten notes under the "Assessment" section of the note is illegible, and there is no plan listed.

21. On or about March 19, 2015, Patient A returned to the office and reported that she was having "light" panic attacks. There is no legible assessment or plan listed.

22. On or about March 27, 2015, Patient A returned to the office. She reported having shortness of breath after leaving the emergency department of a hospital the day prior.

23. On or about April 9, 2015, Patient A returned to the office and reported that her "sleeping pills" had been stolen. No other details about the stolen sleeping pills are documented.

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[9] Prozac, brand name for fluoxetine, is a SSRI and an anti-depressant. Respondent never mentioned depression in previous notes.

24. On or about April 15, 2015, Patient A returned to the office and complained of shaking all over, panic, and shortness of breath. Respondent appeared to write "anxiety," but omitted any plan or treatment.

25. At a visit on or about April 20, 2015, Patient A reported feeling better. Respondent's written assessment was Generalized Anxiety Disorder and depression.

26. On or about May 7, 2015, Patient A returned to the office for a medication management visit. Other than listing her medications, there are no other notes about their efficacy or any adjustments.

27. On or about May 12, 2015, Patient A returned to the office and said she wanted to stop taking Xanax. She also said she was seeing a psychiatrist the following week. There were no notes documenting any assessment or plan, including any instructions for Patient A to wean off her medication.

28. On or about May 18, 2015, Patient A returned to the office to follow up on her anxiety. There are no objective findings, assessments, or plan documented.

29. According to CURES, on or about May 23, 2015, Patient A filled a prescription written by Respondent for 30 tablets of 5 mg zolpidem tartrate. This prescription was not documented in Respondent's medical records.

30. On or about May 26, 2015, Patient A returned to the office for another follow up visit for her anxiety. The progress note documents that Patient A was taking diphenhydramine[10] at night. There are no other notes documenting Patient A's anxiety or any treatment plan.

31. On or about May 29, 2015 and June 9, 2015, Patient A returned to the office to follow up on her depression and/or anxiety. There are no documented objective findings, assessment, or plan relating to Patient A's depression and/or anxiety.

32. According to CURES, on or about June 12, 2015, Patient A filled a prescription written by another treatment provider, H.S., M.D., for 30 tablets of 5 mg zolpidem tartrate. On or about June 15, 2015, Patient A filled a prescription written by H.S. for 30 tablets of 1 mg alprazolam.

[10] Dyphenhydramine, brand name Benedryl, is an antihistamine.

33. On or about June 23, 2015, Patient A returned to the office to recheck her depression and anxiety. Respondent noted that Patient A's Xanax prescription was "ordered by psych only" and to "cancel my Rx."

34. On or about June 25, 2015, Patient A was evaluated by a neurologist, B.B., D.O., for shaking and anxiety, and a report was faxed to Respondent's office on or about the same day. B.B. concluded that Patient A may have "memory and cognitive dysfunction related to her underlying and undertreated depression and anxiety." B.B. also noted that Patient A had run out of her Xanax medications early, and gave her a prescription for 15 more tablets.

35. According to CURES, on or about July 1, 2015 and July 28, 2015, Patient A filled prescriptions written by H.S., M.D., each for 60 tablets of 1 mg alprazolam. On or about July 9, 2015, Patient A filled another prescription written by H.S. for 30 tablets of 5 mg zolpidem tartrate.

36. On or about July 30, 2015, Patient A returned to the office. Patient A reported that she had gone to the Whittier Hospital for chest pain and that she was feeling better. The only documentation in the note was a list of Patient A's current medications and some lab results.

37. According to CURES, on or about July 31, 2015, Patient A filled a prescription written by Respondent for 15 tablets of 5 mg zolpidem tartrate. This prescription was not documented in Respondent's medical records. On or about August 18, 2015, Patient A filled a prescription written by Respondent for 30 tablets of 5 mg zolpidem tartrate.

38. According to CURES, on or about August 26, 2015 and October 7, 2015, Patient A filled prescriptions written by H.S., M.D., for 60 tablets of 1 mg alprazolam each. On or about September 18, 2015 and October 21, 2015, Patient A filled prescriptions written by H.S. for 30 tablets of 5 mg zolpidem tartrate each.

39. On or about September 2, 2015, Patient A returned to Respondent's office and complained of insomnia and trembling. The note also states that Patient A saw a psychiatrist on August 26, and per the psychiatrist, Respondent's office was not to give Patient A prescriptions for alprazolam.

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40. According to CURES, on or about November 11, 2015, Patient A filled a prescription written by Respondent for 30 tablets of 1 mg alprazolam. There is no documentation in the records explaining why Respondent gave Patient A a prescription for Xanax despite her treating psychiatrist's instructions.

41. According to CURES, from on or about November 30, 2015 through December 8, 2016, Respondent continued to prescribe between 1 to 3 mg of alprazolam and 5 to 10 mg of zolpidem tartrate per day to Patient A. Again, there is no documentation in the records explaining why Respondent restarted Patient A on Xanax.

42. On or about August 2, 2016, Patient A returned to the office for a comprehensive physical exam. Other than listing Xanax and zolpidem as Patient A's medications, there is no documented assessment or related ongoing monitoring.

43. According to CURES, from on or about December 20, 2016 through March 15, 2018, Respondent continued to prescribe between 1 to 4 mg of alprazolam per day to Patient A.

44. On or about June 15, 2017 and June 21, 2017, Patient A returned to the office and complained of difficulty breathing and or chest pressure. Other than noting Patient A's medications including Prozac and Xanax, Respondent did not document any mental health exam, assessment, or plan.

45. On or about August 3, 2017, Patient A returned to the office and requested a referral to a psychiatrist. At a follow up visit on or about August 17, 2017, it was noted that Patient A received the authorization for this referral and was notified.

46. On or about November 3, 2017, Patient A returned to the office and complained of anxiety. She was given a prescription for Prozac and assessed for constipation.

47. On or about November 17, 2017, Patient A returned to the office for a medication management appointment. She told Respondent she wanted to try Paxil.[11] Respondent wrote "no" and increased Patient A's Prozac to 40 mg per day.

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[11] Paxil, brand name or paroxetine, is a SSRI and an anti-depressant used to treat depression and anxiety.

48. On or about December 1, 2017, Patient A returned to the office. Respondent wrote "chronic anxiety" but failed to document any subjective or objective findings or plan.

49. On or about January 12, 2018, Patient A returned to the office for a Xanax refill. According to the progress note, she was given a prescription for 15 pills.

50. On or about March 2, 2018, Patient A returned to the office. She recounted that she went to the hospital two weeks prior for anxiety, and that her current symptoms included nausea. She was given a prescription for Zofran.[12]

51. On or about March 23, 2018, Patient A returned to the office and complained of depression after stopping Xanax. There is no documentation in this note identifying any specific symptoms, related assessment or plan.

52. On or about April 16, 2018, Patient A went to the hospital for insomnia. She reported being nearly out of her medication, despite getting 30 tablets of 5 mg zolpidem tartrate on or about April 9, 2018. She was given a prescription of 15 tablets of zolpidem tartrate, and a copy of the hospital records were sent to Respondent.

53. On or about April 18, 2018, Patient A returned to the office and reported that she had gone to the hospital for a buzzing in her head. She was given a prescription for Ambien.

54. On or about May 3, 2018, Patient A returned to the office and complained of insomnia, shaking, lightheadedness, chest pain, and difficulty breathing and walking. Patient A was given a referral for home health services for tachycardia and acute anxiety. Patient A's pulse was measured at 123 beats per minute. According to the progress note, Patient A was given a prescription for Valium.[13] On or about the same day, Patient A submitted to a drug screen which tested positive for benzodiazepines. Zolpidem was not one of the tested substances.

55. On or about May 5, 2018, Respondent documented a referral request for a psychiatrist, noting that Patient A had major depressive disorder, recurrent.

56. On or about June 18, 2018, Patient A went to the hospital for intermittent chest pressure for the past few weeks. Her EKG was unremarkable and there was no evidence of

[12] Zofran, brand name for ondansetron, is an anti-emetic.

[13] Valium, brand name for diazepam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

pulmonary embolism, aneurysm or dissection. She was assessed for intermittent dysphagia, and a copy of the hospital record was sent to Respondent's office.

57. On or about August 1, 2018, Patient A returned to the office and reported that she needed transportation to go to the psychiatrist.

58. Respondent committed gross negligence in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent failed to conduct an appropriate examination before prescribing controlled substance medications;

b. Respondent failed to document a justifiable treatment plan, discussion of treatment goals, and regular pain and functional assessments;

c. Respondent failed to document an appropriate history and physical exam prior to prescribing or refilling controlled substance medications, legible and/or adequate progress notes, or a discussion of the major potential risks of the controlled substances;

d. Respondent failed to perform and document the appropriate necessary monitoring when prescribing controlled substance medications on a frequent basis; and

e. Respondent prescribed Patient A controlled substance medications in excessive amounts and combinations.

Patient B

59. Respondent treated Patient B, a woman born in 1938, as her primary care physician from approximately 2015 to 2019. In an interview with Board investigators, Respondent said that Patient B's medical problems included low back pain, insomnia, and hyperlipidemia. He said that the nurse practitioner in his office started Patient B on Vicodin[14] and flurazepam.[15]

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[14] Vicodin and Norco are the brand names for hydrocodone and acetaminophen.

[15] Flurazepam, brand name Dalmane, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

60. On or about March 27, 2014, Patient B went to the office for a medication management visit. Her documented current medications were Vicoprofen, flurazepam, meloxicam,[16] and simvastatin.[17]

61. On or about June 30, 2014, Patient B returned to the office and complained of right shoulder pain. Respondent ordered an x-ray and physical therapy.

62. On or about July 15, 2014, Patient B returned to the office and complained of back pain radiating towards the left leg and anxiety. According to this progress note, Patient B went to the hospital on July 11, 2014 for a bleeding ulcer. Respondent's assessment included bleeding gastric ulcer, constipation, and "LS DD" (possibly lumbosacral degenerative disease).

63. On or about August 14, 2014, Patient B returned to the office for a comprehensive physical exam. Respondent failed to document any subjective or objective findings related to Patient A's pain or anxiety.

64. On or about March 30, 2015, Patient B returned to the office to follow up on her low back pain. Respondent's handwritten notes are illegible.

65. On or about April 2, 2015, Patient B returned to the office. Patient B's current listed medications were Norco, Pyridium,[18] flurazepam, simvastatin, and Macrobid.[19]

66. According to CURES, from on or about April 27, 2016 through April 10, 2019, Patient A filled prescriptions written by Respondent for an average of 30 mg of flurazepam and up to 3 tablets of 325-10 mg Norco per day.

67. On or about September 6, 2016 and October 7, 2016, Patient B returned to the office for a comprehensive physical exam. Respondent failed to document any subjective or objective findings, assessments, or plan related to Patient B's pain or anxiety.

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[16] Meloxicam, brand name Mobic, is a non-steroidal anti-inflammatory drug often used to treat osteoarthritis.

[17] Simvastatin, brand name Zocor, is a status used to treat high cholesterol.

[18] Pyridium, brand name for phenazopyridine, is an analgesic to treat urinary tract infections.

[19] Macrobid, brand name for nitrofurantoin, is an antibiotic.

68. On or about December 13, 2016, Patient B returned to the office and complained of pain shooting down her right arm. There is no documented physical exam, objective findings other than vital signs and cholesterol labs, assessment, or plan.

69. On or about April 24, 2017, Patient B returned to the clinic for a medication check. Insomnia was noted as one of her medical problems, although no other information about Patient B's symptoms, Respondent's assessment, or any ongoing monitoring was documented.

70. On or about July 1, 2017, Patient B returned to the office and complained of a lack of appetite, stomach pain, leg pain, and black stools. Respondent's handwritten notes are illegible.

71. On a progress note dated on or about July 3, 2017, it was noted that Patient B was in the hospital. No other information was provided.

72. On or about July 25, 2017, Patient B returned to the office and complained of throbbing calves. No other information about Respondent's assessment or plan was documented.

73. On or about September 29, 2017, Patient B returned to the office for the removal of stitches. The handwritten note states "see EMR." Respondent's medical records do not include any electronic medical records for this visit.

74. On or about February 10, 2018, Patient B returned to the office for a medication management visit. Other than listing Patient B's current medications and her oxygen saturation and pulse, no other notes are documented.

75. On or about March 13, 2018, Patient B signed a medication monitoring patient agreement in which she agreed to take her medications as instructed, not sell her medications or share it with others, would use only one pharmacy to get her medications, and would submit to urine drug screens and pill counting.

76. On or about December 28, 2018, Patient B returned to the office for medication refills. Patient B reported pain in her left shoulder caused by moving a washing machine. Other than noting that the pain was felt when Patient B's arm was rotated and lifted and was measured 8 out of 10, there are no other objective findings, assessment, or plan on the handwritten note. A typed note using electronic medical records authored by N.S., a nurse practitioner can be found in Patient B's medical records. According to the electronic medical records, Patient B had a history

of chronic low back pain with osteoarthritis for the past 12 years, and she was taking Norco for pain relief. The note also referenced a 2016 x-ray indicating dextroscoliosis and extensive degenerative disc disease, and that Patient B had tried epidural injections in the past with no relief.

77. On or about January 29, 2019, Patient B returned to the office and continued to complain about pain in her left shoulder. Patient B reported having the pain for approximately six months. Other than notes documenting vital signs, no other objective findings, assessment, or plan were documented.

78. On or about April 2, 2019, Patient B returned to the office for a medication management visit. According to a medication log in the records, on or about this date, Patient B was given a new prescription for zolpidem while flurazepam appears to have been discontinued. Respondent failed to document the reasons why he was giving Patient B a new prescription and discontinuing another.

79. According to a medication log in the records, from on or about May 3, 2019 through July 17, 2019, Respondent continued to give Patient B prescriptions for zolpidem and Norco.

80. On or about May 3, 2019, Patient B returned to the office and reported that her pharmacy ran out of zolpidem and flurazepam. Respondent failed to note why he had switched Patient B to zolpidem and discontinued flurazepam.

81. On or about September 6, 2019, Patient B submitted various self-assessment tools, which revealed she was at medium risk for somatic symptom severity and opioid risk.

82. On or about September 6, 2019, Patient B submitted to a drug screen. The sample was positive for opiates and negative for benzodiazepines.

83. On or about January 13, 2020, Patient B submitted to another drug screen. This sample was also positive for opiates and negative for benzodiazepines.

84. Respondent committed gross negligence in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent failed to conduct an appropriate examination before prescribing controlled substance medications;

b. Respondent failed to document a justifiable treatment plan, discussion of treatment goals, and regular pain and functional assessments;

c. Respondent failed to document an appropriate history and physical exam prior to prescribing or refilling controlled substance medications, legible and/or adequate progress notes, or a discussion of the major potential risks of the controlled substances;

d. Respondent failed to perform and document the appropriate necessary monitoring when prescribing controlled substance medications on a frequent basis; and

e. Respondent prescribed Patient B controlled substance medications in excessive amounts and combinations.

Patient C

85. In an interview with Board investigators, Respondent said that he treated Patient C, a male patient born in 1957, starting in 2014. Respondent's records for Patient C include a print out from CURES dated October 31, 2011 for prescriptions filled from July 31, 2011 through October 31, 2011. This CURES report shows that Patient C filled prescriptions written by Respondent for Norco and diazepam.

86. A medication log in Respondent's records shows prescriptions being given to Patient C as early as October 25, 2013. Through the end of 2013, Respondent gave Patient C prescriptions for hydrocodone, carisoprodol,[20] and diazepam. Patient C was taking up to 3 tablets of 5-500 mg hydrocodone, 30 mg of diazepam, and 1,050 mg of carisoprodol per day.

87. On or about March 7, 2014, Patient C was seen in Respondent's office for a medication management visit. He reported that his current medications were diazepam, Vicodin, and Lotrel.[21]

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[20] Carisoprodol, brand name Soma, is a muscle relaxant. The combination of opiates, benzodiazepines, and carisoprodol is associated with abuse, misuse, and diversion.

[21] Lotrel is a medication used to treat hypertension.

88. On or about April 24, 2014, Patient C returned to the office and complained of body aches, cough, raspy throat, and joint pain. Demerol[22] is documented, possibly indicating that Patient C received a Demerol injection.

89. On or about July 31, 2015, Patient C was admitted to the hospital for mid-chest pain. Patient C reported having a hiatal hernia and chronic low back pain. Tests ruled out a cardiac event, and Patient C was discharged on or about the same day.

90. On or about June 20, 2014, Patient C returned to the office for medication refills. Again, it appears from the records that Patient C received a Demerol injection. No subjective or objective findings, assessments, or plan was documented.

91. On or about August 21, 2014, Patient C returned to the office for a medication management visit. Again, it appears from the records that Patient C received a Demerol injection. No subjective or objective findings, assessments, or plan was documented.

92. On or about October 13, 2014, Patient C returned to the office for a medication management visit. Again, it appears from the records that Patient C received a Demerol injection, albeit at a lower dose, 25 mg rather than 50 mg. Patient C complained of low back pain, shortness of breath, and tiredness. No assessment or plan was documented.

93. According to Respondent's records, on or about November 18, 2014, December 18, 2014, and January 19, 2015, Patient C returned to the office and received Demerol injections. No assessment or plan was documented for any of these visits.

94. On or about February 26, 2015, Patient C returned to the office for a medication management visit. Patient C reported that he had been in the hospital for an infected left knee on January 30, 2015. Patient C received a 50 mg Demerol injection at this visit. No assessment or plan was documented.

95. On or about March 31, 2015 and April 28, 2015, Patient C returned to the office for a medication management visit. At each visit, Patient C received a 50 mg Demerol injection. No assessment or plan was documented.

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[22] Demerol, brand name for meperidine, is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

96. On or about May 29, 2015, Patient C returned to the office and reported that he had fallen. Patient C complained of pain in his left side and left wrist. Patient C received another 50 mg Demerol injection. No assessment or plan was documented.

97. On or about July 3, 2015 and October 9, 2015, Patient C returned to the office for a medication management visit and received a Demerol injection. No assessment or plan was documented.

98. On or about November 25, 2015, Patient C was admitted to the hospital for vertigo.

99. According to CURES, on or about December 12, 2015, Patient C filled a prescription written by Respondent for 90 tablets of 325-10 mg Norco, increasing the dose from 325-5 mg tablets. Respondent failed to document the reasons why he increased the dose of this medication.

100. On or about January 12, 2016 and March 17, 2016, Patient C returned to the office and received Demerol injections. No assessment or plan was documented for either visit.

101. On or about April 5, 2016, Patient C returned to the office for a medication management visit. Patient C complained of right knee pain which had been going on for approximately five months. Patient C received a 35 mg Demerol injection. No assessment or plan was documented.

102. On or about May 9, 2016, Patient C returned to the office for medication refills. Respondent documented that Patient C was to take 3 tablets of Norco per day, 3 tablets of Soma per day as needed, and an illegible amount of diazepam per day for anxiety. Respondent's notes appear to indicate that Patient C's back had a decreased range of motion.

103. According to Respondent's records, Patient C failed to appear for an appointment on or about August 15, 2016. Patient C next returned to the office on or about January 12, 2017. According to CURES, during this time period, Patient C filled approximately 10 prescriptions from other treatment providers for Norco and diazepam.

104. On or about January 12, 2017, Patient C returned to the office and saw Respondent for a medication management visit. In the progress note, Norco 10-325 was noted, and CURES shows that Patient C filled a prescription written by Respondent on or about the same day for Norco at that strength. Respondent failed to document why he increased Patient C's Norco dose.

105. Respondent committed gross negligence in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent failed to conduct an appropriate examination before prescribing controlled substance medications;

b. Respondent failed to document a justifiable treatment plan, discussion of treatment goals, and regular pain and functional assessments;

c. Respondent failed to document an appropriate history and physical exam prior to prescribing or refilling controlled substance medications, legible and/or adequate progress notes, or a discussion of the major potential risks of the controlled substances;

d. Respondent failed to perform and document the appropriate necessary monitoring when prescribing controlled substance medications on a frequent basis; and

e. Respondent prescribed Patient C controlled substance medications in excessive amounts and combinations.

Patient D

106. In an interview with Board investigators, Respondent said that he treated Patient D, a man born in 1982, starting in 2014. According to Respondent's medication logs, Respondent started prescribing alprazolam to Patient D in or around April 2013. Through the rest of 2013 and 2014, Respondent continued to prescribe alprazolam, Vicodin, and Norco. Per the medication logs in Respondent's records, Patient D was prescribed alprazolam to treat stress. In 2016, Respondent gave Patient D prescriptions for alprazolam, Norco, zolpidem, and Lunesta.[23]

107. Respondent's records include an MRI was taken of Patient D's left knee on or about October 10, 2016, which indicated bursitis.

108. On or about February 1, 2017, Patient D came to the office and saw Respondent. According to Respondent's medication logs, Respondent was prescribing 50 tablets of 325-5 mg Norco, 90 tablets of 2 mg alprazolam, and 30 tablets of 10 mg zolpidem per month. Respondent's records for this visit lack any assessment or plan.

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[23] Lunesta, brand name for eszopiclone, is a sedative used to treat insomnia.

109. On or about March 3, 2017 and April 2, 2017, Patient D filled prescriptions written by Respondent, each for 50 tablets of Norco. According to CURES, the prescription filled on or about April 2, 2017 increased the Norco dose from 325-5 mg to 325-10 mg. Respondent failed to document this changed dose or the rationale for the change in his progress notes.

110. On or about April 28, 2017, Patient D returned to the office for a medication management visit. The documentation appears to show that Patient D received a trigger point injection in his left knee. No objective findings other than vital signs were documented. No assessment or plan was documented.

111. On or about June 30, 2017, Patient D returned to the office for a medication management visit. Respondent documented pain and osteoarthritis in the left knee.

112. On or about August 29, 2017, Patient D returned to the office for a medication management visit.. The documentation appears to show that Patient D received a trigger point injection in his left knee. No assessment or plan was documented.

113. On or about October 30, 2017, Patient D returned to the office. Respondent's notes are mostly illegible, although "left knee pain" and "bursitis" can be seen.

114. On or about November 22, 2017, Patient D returned to the office and saw N.S., a nurse practitioner. N.S. documented the visit via electronic medical record software. N.S. documented that Patient D had left knee pain, anxiety disorder, myalgia, and insomnia. N.S. also documented that Patient D was a welder and that he worked on his feet all day, and that his left knee pain was worse at night. She also documented that an MRI of Patient D's left knee taken six months prior was normal.

115. On or about February 28, 2018, Patient D returned to the office and reported that he had fainted on February 27 from a panic attack. Respondent wrote "syncopal episode" and ordered labs to rule out a cardiac event.

116. On or about March 28, 2018, Patient D returned to the office for a medication management visit. Respondent documented left and right knee pain.

117. On or about April 26, 2018, Patient D returned to the office for a medication management visit. Respondent wrote "check right knee" but there is no assessment or plan.

118. On or about June 27, 2018, Patient D returned to the office for a comprehensive physical exam. Respondent failed to document a physical exam or assessment, including an assessment of the continued prescribing of opiates and benzodiazepines.

119. On or about August 28, 2018, Patient D submitted to a urine drug screen which was positive for opiates and benzodiazepines. The sample, however, was negative for muscle relaxants, zolpidem, and/or their metabolites, which was inconsistent with the medications prescribed. Respondent failed to document any follow up with Patient D about the inconsistent results. Respondent appears to have discontinued Patient D's zolpidem prescription, although he does not document this in the records.

120. On or about November 27, 2018, Patient D submitted to a urine drug screen which was positive for opiates and benzodiazepines.

121. On or about December 12, 2018, Patient D returned to the office for an allergy injection. Toradol[24] and Norflex[25] are documented in the handwritten note, although it is not clear whether Patient D was given the medications. According to the corresponding electronic medical record drafted by N.S., Patient D complained of exacerbated pain in his left knee and was doing physical therapy. N.S. ordered an x-ray of Patient D's left knee.

122. On or about December 26, 2018, Patient D returned to the office and saw N.S. In addition to left knee pain, N.S. documented that Patient D had low back pain due to strenuous work requirements. N.S. also noted that Patient D had tried ibuprofen and Tylenol, and that massage helped. The nurse practitioner documented a physical exam and noted tenderness to palpitation in the paravertebral muscles. Her plan was for Patient D to continue physical therapy and submit to a urine drug screen. She told Patient D that Respondent's office would no longer be concurrently prescribing opioids with benzodiazepines and that his alprazolam use would be weaned down.

123. On or about January 25, 2019, Patient D returned to the office and saw N.S. She noted that Patient D was to start weaning down his alprazolam dose and to submit to a urine drug

[24] Toradol, brand name for ketorolac, is a nonsteroidal anti-inflammatory drug (NSAID).
[25] Norflex, brand name for orphenadrine, is a muscle relaxant.

screen. She also told Patient D to complete the left knee x-ray. On or about the same day, Patient D submitted to a urine drug screen which was positive for opiates and benzodiazepines.

124. On or about April 1, 2019, an x-ray ordered by N.S., N.P., of Patient D's lumbosacral spine showed mild levoscoliosis with multilevel spondylosis.

125. On or about April 26, 2019, Patient D saw Respondent for a comprehensive medical exam. No physical exam was documented, nor is there any evaluation of Patient D's continued treatment with Norco and alprazolam. On or about the same day, Patient D submitted to a urine drug screen which was positive for opiates and benzodiazepines.

126. On or about May 28, 2019, Patient D returned to the office to see Respondent for medication refills. His subjective complaints include low back pain (intensity 7 out of 10) and left knee pain. Physical therapy is noted regarding the left knee. No physical exam was documented, nor are there any assessments or plans. On or about the same day, Patient D submitted to a urine drug screen which was positive for opiates and benzodiazepines.

127. On or about June 28, 2019, Patient D returned to the office to see Respondent for a comprehensive physical exam. Chest pain, GAD (generalized anxiety disorder), and IBS (irritable bowel syndrome) are listed under the diagnoses.

128. On or about July 27, 2019, Patient D returned to Respondent's office and reported that he had two anxiety attacks. No physical exam or assessment were documented, and the plan is illegible. On or about the same day, Patient D submitted to a drug screen which was positive for opiates and benzodiazepines.

129. On or about August 28, 2019, Patient D submitted to a drug screen which was positive for opiates and benzodiazepines.

130. On or about September 27, 2019, Patient D returned to the office for medication refills. It appears that Respondent wrote "LS [lumbosacral] pains." Patient D submitted to a urine drug screen which was positive for opiates and benzodiazepines.

131. On or about January 28, 2020, Patient D returned to the office for a medication management visit. Respondent wrote left knee pain, but failed to document any assessment or

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plan. On or about the same day, Patient D submitted to a drug screen which was positive for opiates and benzodiazepines.

132. On or about February 25, 2020, Patient D returned to the office for medication refills. Patient D reported his left knee pain level was 4 out of 10. Respondent noted "LS [lumbosacral] pain" and his plan was to add Naprosyn[26] and reduce Norco.

133. Respondent committed gross negligence in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent failed to conduct an appropriate examination before prescribing controlled substance medications;

b. Respondent failed to document a justifiable treatment plan, discussion of treatment goals, and regular pain and functional assessments;

c. Respondent failed to document an appropriate history and physical exam prior to prescribing or refilling controlled substance medications, legible and/or adequate progress notes, or a discussion of the major potential risks of the controlled substances; and

d. Respondent prescribed Patient D controlled substance medications in excessive amounts and combinations.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

134. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 8441 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereafter:

Patient A

135. Paragraphs 9 through 58, above, are hereby reincorporated by reference and re-alleged as if fully set forth herein.

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[26] Naprosyn, brand name for naproxen, is a NSAID.

136. Respondent committed negligence by failing to conduct and/or document a discussion with Patient A about the major potential risks of taking controlled substances, including potentially dangerous combinations.

Patient B

137. Paragraphs 59 through 84, above, are hereby reincorporated by reference and re-alleged as if fully set forth herein.

138. Respondent committed negligence by failing to conduct and/or document a discussion with Patient B about the major potential risks of taking controlled substances, including potentially dangerous combinations.

Patient C

139. Paragraphs 85 through 105, above, are hereby reincorporated by reference and re-alleged as if fully set forth herein.

140. Respondent committed negligence by failing to conduct and/or document a discussion with Patient C about the major potential risks of taking controlled substances, including potentially dangerous combinations.

Patient D

141. Paragraphs 106 through 133, above, are hereby reincorporated by reference and re-alleged as if fully set forth herein.

142. Respondent committed negligence that includes, but is not limited to the following: (1) failing to conduct and/or document a discussion with the patient about the major potential risks of taking controlled substances, including potentially dangerous combinations; and (2) failing to perform and document the appropriate necessary monitoring when prescribing controlled substance medications on a frequent basis.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

143. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 8441 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records of his care and treatment of

Patients, A, B, C, and D, as more particularly alleged in paragraphs 9 through 142, above, which are hereby re-alleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 8441, issued to Respondent Richard J. Winkle, M.D.;

2. Revoking, suspending or denying approval of Respondent Richard J. Winkle, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Richard J. Winkle, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Richard J. Winkle, 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: MAR 0 2 2021

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

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