

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

In the Matter of the Accusation
Against:

David Leonard Belk, M.D.

Physician's and Surgeon's
Certificate No. A 66844

Respondent.

Case No. 800-2018-043450

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 September 30, 2021.

IT IS SO ORDERED July 29, 2021.

MEDICAL BOARD OF CALIFORNIA



William Prasifka
Executive Director

1 ROB BONTA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LYNNE K. DOMBROWSKI
Deputy Attorney General
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7 *Attorneys for Complainant*

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

13 In the Matter of the Accusation Against:

Case No. 800-2018-043450

14 **DAVID LEONARD BELK, M.D.**
2070 Clinton Avenue, 5th Floor
Alameda, CA 94501

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

15 **Physician's and Surgeon's Certificate No.**
16 **A 66844**

17 Respondent.

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

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

26 2. DAVID LEONARD BELK, M.D. (Respondent) is represented in this proceeding by
27 attorney Shannon V. Baker, whose address is: Rothschild Wishek + Sands LLP, 765 University
28 Ave., Sacramento, CA 95825, E-mail: sbaker@rwslaw.com.

1 9. For the purpose of resolving the Accusation without the expense and uncertainty of
2 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
3 basis for the charges in the Accusation and that those charges constitute cause for discipline.
4 Respondent believes that he could present evidence disputing the factual basis for some of the
5 charges in the Accusation. Respondent hereby gives up his right to contest that cause for
6 discipline exists based on those charges because he is in the process of closing his private practice
7 and retiring from the practice of medicine.

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

11 11. The parties agree that the effective date for the Decision and for Respondent's
12 surrender of license shall be no earlier than September 30, 2021.

13 **CONTINGENCY**

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

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

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

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ORDER

1
2 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 66844, issued
3 to Respondent DAVID LEONARD BELK, M.D., is surrendered and accepted by the Board.

4 1. Respondent shall lose all rights and privileges as a physician and surgeon in
5 California as of the effective date of the Board's Decision and Order, which shall be September
6 30, 2021.

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

9 3. If Respondent ever files an application for licensure or a petition for reinstatement in
10 the State of California, the Board shall treat it as a petition for reinstatement. Respondent may
11 file a petition for reinstatement after a period of at least two years has elapsed from the effective
12 date of the Decision. Respondent must comply with all the laws, regulations and procedures for
13 reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all
14 of the charges and allegations contained in Accusation No. 800-2018-043450 shall be deemed to
15 be true, correct and admitted by Respondent when the Board determines whether to grant or deny
16 the petition.

17 4. If Respondent should ever apply or reapply for a new license or certification, or
18 petition for reinstatement of a license, by any other health care licensing agency in the State of
19 California, all of the charges and allegations contained in Accusation, No. 800-2018-043450 shall
20 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
21 Issues or any other proceeding seeking to deny or restrict licensure.

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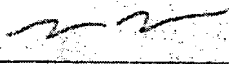
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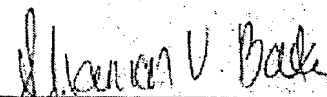
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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Shannon V. Baker. 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 Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7/21/21 
DAVID LEONARD BELK, M.D.
Respondent

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

DATED: 7/22/2021 
SHANNON V. BAKER
Rothschild Wishek + Sands LLP
Attorney for Respondent

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ENDORSEMENT

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

DATED: 07/23/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

Lynne K. Dombrowski
LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

SF2020401708

Exhibit A

Accusation No. 800-2018-043450

1 MATTHEW RODRIQUEZ
Acting Attorney General of California
2 JANE ZACK SIMON
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3 LYNNE K. DOMBROWSKI
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7 *Attorneys for Complainant*

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11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

Case No. 800-2018-043450

14 **David Leonard Belk, M.D.**
15 **2070 Clinton Avenue, 5th Floor**
16 **Alameda, CA 94501**

ACCUSATION

17 **Physician's and Surgeon's Certificate**
18 **No. A 66844,**

Respondent.

19
20 **PARTIES**

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

24 2. On or about October 30, 1998, the Medical Board issued Physician's and Surgeon's
25 Certificate Number A 66844 to David Leonard Belk, M.D. (Respondent). The Physician's and
26 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
27 herein and will expire on March 31, 2022, unless renewed.

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1 3. At all times herein alleged, Respondent was board-certified in Internal Medicine.
2 Since July 2003, Respondent has maintained a solo private practice specializing in general
3 internal medicine for adults.

4 JURISDICTION

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

8 5. Section 2227 of the Code states:

9 (a) A licensee whose matter has been heard by an administrative law judge of
10 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
11 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:

12 (1) Have his or her license revoked upon order of the board.

13 (2) Have his or her right to practice suspended for a period not to exceed one
14 year upon order of the board.

15 (3) Be placed on probation and be required to pay the costs of probation
monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may include a
17 requirement that the licensee complete relevant educational courses approved by the
board.

18 (5) Have any other action taken in relation to discipline as part of an order of
19 probation, as the board or an administrative law judge may deem proper.

20 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
21 medical review or advisory conferences, professional competency examinations,
22 continuing education activities, and cost reimbursement associated therewith that are
agreed to with the board and successfully completed by the licensee, or other matters
made confidential or privileged by existing law, is deemed public, and shall be made
available to the public by the board pursuant to Section 803.1.

23 6. Section 2234 of the Code, states:

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

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

28 (b) Gross negligence.

1 (c) Repeated negligent acts. To be repeated, there must be two or more
2 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.

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

5 (2) When the standard of care requires a change in the diagnosis, act, or
6 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
7 licensee's conduct departs from the applicable standard of care, each departure
constitutes a separate and distinct breach of the standard of care.

8 (d) Incompetence.

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

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

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

14 7. Section 2242 of the Code states, in pertinent part:

15 (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
16 4022 without an appropriate prior examination and a medical indication, constitutes
unprofessional conduct. An appropriate prior examination does not require a
17 synchronous interaction between the patient and the licensee and can be achieved
through the use of telehealth, including, but not limited to, a self-screening tool or a
18 questionnaire, provided that the licensee complies with the appropriate standard of
care. . . ."

19 8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
20 adequate and accurate records relating to the provision of services to their patients constitutes
21 unprofessional conduct.

22 **CALIFORNIA HEALTH AND SAFETY CODE**

23 9. Section 11165.4 of the California Health and Safety Code, effective January 1, 2017,
24 operative as of October 2, 2018, requires a health care practitioner to consult the CURES database
25 to review a patient's controlled substance history before prescribing controlled substances
26 (Schedule II – IV) to the patient for the first time, and at least once every four months thereafter,
27 if the prescribing continues as treatment.

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1 10. Section 11190 of the California Health and Safety Code sets forth the required
2 contents of a prescriber's record when issuing prescriptions for controlled substances, in pertinent
3 part, as follows:

4 (a) Every practitioner, other than a pharmacist, who prescribes or administers a
5 controlled substance classified in Schedule II shall make a record that, as to the transaction,
6 shows all of the following:

7 (1) The name and address of the patient.

8 (2) The date.

9 (3) The character, including the name and strength, and quantity of controlled
10 substances involved.

11 (b) The prescriber's record shall show the pathology and purpose for which the
12 controlled substance was administered or prescribed.

13 **PERTINENT DRUGS/CONTROLLED SUBSTANCES**

14 11. Carisoprodol, known by the trade name Soma, is a muscle-relaxant and sedative. It is
15 a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of
16 the Health and Safety Code, and a Schedule III controlled substance as defined by section
17 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in
18 Business and Professions Code section 4022. Since the effects of carisoprodol and alcohol or
19 carisoprodol and other central nervous system depressants or psychotropic drugs may be
20 addictive, appropriate caution should be exercised with patients who take more than one of these
21 agents simultaneously.

22 12. Diazepam, known by the trade name Valium, is a psychotropic drug used for the
23 management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a
24 Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and
25 section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as
26 defined in Business and Professions Code section 4022. Diazepam can produce psychological
27 and physical dependence and it should be prescribed with caution particularly to addiction-prone
28 individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to
habituation and dependence.

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

4 14. Hydrocodone bitartrate with acetaminophen, known by the trade names of Vicodin
5 and Norco, combines hydrocodone bitartrate, a semisynthetic narcotic analgesic, with
6 acetaminophen (Tylenol) which is a non-opiate, non-salicylate analgesic and antipyretic. It
7 belongs to the class of medications called analgesics, opioid combos. It is used to treat symptoms
8 of moderate to severe pain. It is a Schedule II controlled substance as defined by section 11055,
9 subdivision (e) of the Health and Safety Code and is a dangerous drug as defined in Business and
10 Professions Code section 4022.¹

11 15. Hydromorphone hydrochloride, known by the trade name Dilaudid, is a hydrogenated
12 ketone of morphine and is a narcotic analgesic used for relief of moderate to severe pain. It is a
13 Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and
14 Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (d) of Title 21
15 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions
16 Code section 4022. Patients receiving other narcotic analgesics, anesthetics, phenothiazines,
17 tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system
18 depressants, including alcohol, may exhibit an additive central nervous system depression. When
19 such combined therapy is contemplated, the use of one or both agents should be reduced.

20 16. Methadone hydrochloride is a synthetic opioid analgesic with multiple actions
21 quantitatively similar to those of morphine. Methadone may be administered as an injectable
22 liquid or in the form of a tablet, disc, or oral solution. It is a Schedule II controlled substance as
23 defined by section 11055, subdivision (c) of the Health and Safety Code, and by Section 1308.12
24 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business
25 and Professions Code section 4022. Methadone can produce drug dependence of the morphine
26

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

1 type and, therefore, has the potential for being abused. Methadone should be used with caution
2 and in reduced dosage in patients who are concurrently receiving other opioid analgesics.

3 17. Morphine sulfate, known by the trade name MSContin, is an opioid pain medication
4 indicated for the management of pain severe enough to require daily, around-the-clock, long-term
5 opioid treatment and for which alternative treatment options are inadequate. Morphine is a
6 Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and
7 Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.
8 Morphine is a highly addictive drug which may rapidly cause physical and psychological
9 dependence and, as a result, creates the potential for being abused, misused, and diverted.

10 18. Oxycodone hydrochloride, known by the trade name OxyContin for its extended-
11 release version, is a pure opioid agonist whose principal therapeutic action is analgesia. Other
12 therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation.
13 Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055,
14 subdivision (b)(1) of the Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the
15 Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions
16 Code section 4022. Respiratory depression is the chief hazard from all opioid agonist
17 preparations. OxyContin should be used with caution and started in a reduced dosage (1/3 to 1/2
18 of the usual dosage) in patients who are concurrently receiving other central nervous system
19 depressants, including sedatives or hypnotics, general anesthetics, phenothiazines, other
20 tranquilizers, and alcohol.

21 19. Percocet 10/325 is a trade name for a combination of 10 mg. of acetaminophen
22 (APAP or Tylenol) and 325 mg. of oxycodone hydrochloride. Percocet is a semisynthetic opioid
23 analgesic combination drug with multiple actions qualitatively similar to those of morphine. It is
24 a Schedule II controlled substance as defined by section 11055, subdivision (b)(1)(N), of the
25 Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal
26 Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.
27 Acetaminophen is a non-opiate, non-salicylate analgesic and antipyretic that has been associated
28 with cases of hepatotoxicity.

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct re Patient A²: Gross Negligence, Repeated Negligent Acts,**
3 **Prescribing without Appropriate Examination and Medical Indication)**

4 20. Respondent David Leonard Belk, M.D. is subject to disciplinary action for
5 unprofessional conduct under Business and Professions Code sections 2234, subdivision (b)
6 and/or subdivision (c), and/ or section 2242 in that Respondent's overall conduct, acts and/or
7 omissions, with regard to Patient A constitutes gross negligence and/or repeated negligent acts
8 and/or prescribing without an appropriate prior examination and medical indication, as more fully
9 described herein below.

10 21. Patient A, a female who was born in 1959, has been Respondent's patient since at
11 least December 2003.

12 22. On or about March 31, 2014, Respondent saw Patient A who reported seeing two pain
13 specialists in the past month and that neither physician would take over her care for chronic pain
14 management. Respondent noted the patient's vital signs were within normal limits. It was also
15 documented that there was limited range of motion of most joints due to pain but no signs of
16 acute inflammation. Respondent's diagnosis was chronic severe pain due to multiple etiologies
17 with an unclear psychological component. Respondent noted encouraging the patient to follow-
18 up with other pain specialists. Respondent also wrote in the progress note: "In spite of her severe
19 chronic pain it's unlikely she's really benefited (sic) from her extreme narcotic regemine (sic)."
20 It is noted that he was decreasing the Dilaudid prescribed from four times a day to three times a
21 day, as recommended by one of the pain specialist physicians in a consultation report dated
22 March 20, 2014.

23 23. Respondent's note of the March 31, 2014 visit does not contain any details of the
24 patient's current medications or of the medications being prescribed/refilled by Respondent.
25 According to his progress note from the prior month's visit on February 3, 2014, Respondent was
26

27
28 ² To protect the patients' privacy rights, they will be identified by letters in this pleading.
Respondent will be provided the patients' names through the discovery process.

1 prescribing monthly the following controlled substances to Patient A: #120 OxyContin 80 mg.;
2 #240 oxycodone 30 mg.; #120 Dilaudid 8 mg.; and #360 methadone 10 mg.

3 24. In 2014, Patient A continued to see Respondent on a monthly basis with no change in
4 her pain complaints and no significant change in her physical condition. Respondent continued to
5 prescribe large quantities of controlled substances to Patient A.

6 25. On or about January 12, 2015, Respondent saw Patient A and noted a diagnosis of
7 "DJD," degenerative joint disease. There were no changes in the patient's physical condition.
8 The patient's vitals were within normal limits. Other than the vitals, no physical examination was
9 documented, the progress note states "No changes in PE." Respondent's plan was to "Refill pain
10 medications" without any specifics documented as to what was being prescribed.

11 26. In June, July, and August of 2015, Respondent noted a total of seven visits by Patient
12 A for pain medication refills. During those visits, the patient's reported pain level varied between
13 4 – 6 out of 10. Respondent's assessment on June 4, 2015 was that the patient had "Chronic
14 diffuse pain. Depression. Extreme dependence on narcotics."

15 27. For the July 2, 2015 visit, Respondent noted that he informed Patient A that the
16 oxycodone and Norco would be tapered over several months to zero and that he would continue
17 to prescribe OxyContin, Dilaudid, and methadone. Yet, at the patient's next visit on July 17,
18 2015, Respondent refilled the prescription for #150 Norco 10/325. He also refilled prescriptions
19 at the visit on July 30, 2015. At the August 20, 2015 visit, Respondent noted issuing a
20 prescription for #120 Norco 10/325, which was a reduction of one pill a day.

21 28. On August 26, 2015, Respondent saw Patient A and noted that she was unhappy with
22 the tapering of medications and believed that he was "lying" to her. Respondent noted that he
23 informed the patient of the "dangers of being on so many controlled substances." The progress
24 note indicates vitals, including the patient's temperature of 100.2 and reported pain level of 5 out
25 of 10. Respondent's assessment was "DJD and severe dependence on controlled substances."
26 His subjective narrative stated that the patient was currently taking "large daily doses of five
27 separate narcotics as well as valium and soma." His plan was to refill the prescriptions of
28

1 controlled substances while continuing to taper the oxycodone, with no details about the specific
2 drugs and quantities that he prescribed.

3 29. According to the CURES database, in June through August 2015, Respondent
4 prescribed the following controlled substances to Patient A: #420 Norco 325/10 mg.; #630
5 oxycodone 30 mg.; #360 OxyContin 80 mg.; #1,080 methadone 10 mg.; #270 Dilaudid 8 mg.;
6 #450 Soma 350 mg.; and #120 Valium 10 mg.

7 30. From September through December 2015, Respondent saw Patient A on seven
8 occasions with no change to her condition or pain complaints. Respondent's assessment was
9 listed as "diffuse pain DJD" or "chronic pain," sometimes with a mention that the pain was due to
10 lupus, without any detailed findings documented.

11 31. According to the CURES database, in September through December 2015,
12 Respondent prescribed the following controlled substances to Patient A: #300 Norco 325/10 mg.;
13 #420 oxycodone 30 mg.; #480 OxyContin 80 mg.; #1,440 methadone 10 mg.; #360 Dilaudid 8
14 mg.; #750 Soma 350 mg.; and #120 Valium 10 mg.

15 32. On or about January 15, 2016, Respondent saw Patient A who is noted to have a
16 complaint of pain "everywhere," with her subjective pain level at 6 out of 10. Vitals were taken
17 but there was no physical examination documented, simply a note that there was "no change in
18 her condition." Respondent documented that he issued a refill prescription for #30 Norco for the
19 last time. No other medications were mentioned in the note.

20 33. On or about January 21, 2016, Respondent saw Patient A who was there for her pain
21 medication refills. Respondent noted that he was issuing the last refill for oxycodone, but he did
22 not document any specific details as to what refills he prescribed. According to the CURES
23 database, Respondent issued to Patient A and she filled the following prescriptions for controlled
24 substances on January 21, 2016: #30 oxycodone 30 mg.; #120 OxyContin 80 mg.; #360
25 methadone 10 mg.; and #90 Dilaudid 8 mg.

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1 34. Throughout 2016, Respondent saw Patient A on monthly basis and refilled her pain
2 medications. His diagnosis remained as chronic diffuse pain with DJD. There were no
3 significant changes in the patient's condition.

4 35. According to the CURES database, from January through December 2016,
5 Respondent prescribed and Patient A filled his prescriptions for the following controlled
6 substances: #30 Norco 352/20 mg.; #30 oxycodone 30 mg.; #600 oxycodone 80 mg.; #960
7 OxyContin 80 mg.; #4,680 methadone 10 mg.; #1,170 Dilaudid 8 mg.; #2,100 Soma 350 mg.; and
8 #480 Valium 10 mg.

9 36. On or about January 17, 2017, Respondent wrote a handwritten referral for Patient A
10 to see a pain specialist due to severe chronic pain secondary to DJD.

11 37. On January 31, 2017, Respondent saw Patient A who complained about the cost of
12 the OxyContin and asked to be switched to oxycodone. Respondent noted that the OxyContin
13 would be discontinued and that, at the next "refill" he would issue a prescription for #270
14 oxycodone 30 mg. The progress note does not specify what current medications the patient was
15 taking and what prescriptions were issued at that visit.

16 38. There is an inconsistency about the actual date of the patient's visit at the end of
17 January 2017 because, according to the CURES database, Patient A filled the following
18 controlled substances prescriptions from Respondent on January 30, 2017: #120 oxycodone 80
19 mg.; #360 methadone 10 mg.; and #90 Dilaudid 8 mg. The CURES report also shows that Patient
20 A filled a prescription from Respondent for #150 Soma 350 mg. on January 16, 2017, which is
21 not mentioned in Respondent's records for Patient A.

22 39. In Patient A's chart, Respondent has a report from a gastroenterologist that Patient A
23 was seen by a gastroenterologist for rectal bleeding and constipation on or about February 27,
24 2017. It was noted in the report that the patient's constipation was a result of her narcotic use.

25 40. On or about March 1, 2017, Respondent saw Patient A who presented with one week
26 of intermittent left-sided lower abdominal pain with rectal bleeding. Respondent documented that
27 there was left lower quadrant tenderness without rebound. The plan was for the patient to
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1 undergo a colonoscopy. Respondent did not document issuing any prescriptions at this visit and
2 did not list the current medications that the patient was taking.

3 41. On March 1, 2017, according to the CURES database, Patient A filled the following
4 prescriptions from Respondent: #270 oxycodone 30 mg.; #360 methadone 10 mg.; and #90
5 Dilaudid 8 mg.

6 42. Respondent's records for Patient A appear to contain two inaccurate progress notes in
7 2017. There are visit notes for both January 30, 2017 and March 31, 2017 in which Respondent
8 noted that Patient A was there for a pain medication refill and that: "He [sic] continues to have
9 severe shoulder pain unrelieved by OTC meds. Refilled Norco 10/325 mg #90." These two notes
10 appear to pertain to a different patient because Patient A is a female and there is no record in the
11 CURES database that Respondent prescribed Norco 10/325 to Patient A after January 15, 2016.

12 43. From April 2017 through at least July 2018, Respondent saw Patient A on a monthly
13 basis and entered the same general note that the patient had "severe pain in multiple joints."
14 Respondent did not document any physical examination or the patient's vitals. Respondent
15 documented in each progress note that he prescribed the following controlled substances: #270
16 oxycodone 30 mg., #360 methadone 10 mg., #90 Dilaudid 8 mg.

17 44. There is no documentation in Respondent's medical records for Patient A that he
18 issued regular monthly prescriptions for Soma and for Valium from June 2015 through at least
19 July 2019.

20 45. In 2017, according to the CURES database, Patient A filled prescriptions from
21 Respondent for a total of #1950 Soma 350 mg. and #240 Valium 10 mg. In 2017, Respondent
22 also prescribed to Patient A: #120 oxycodone 80 mg.; #2970 oxycodone 30 mg.; #4320
23 methadone 10 mg.; and #1080 Dilaudid 8 mg.

24 46. In 2018, Respondent continued to see Patient A on approximately a monthly basis
25 and refilled her pain medications. There were no significant changes in the patient's condition.
26 His progress notes continued to provide scant information.

27 47. On or about August 17, 2018, Respondent saw Patient A, who continued to have
28 "severe pain in multiple joints." Respondent noted that he reviewed the CURES database and

1 that he would start tapering the monthly oxycodone prescription by ten less tablets each month.
2 He noted that he issued prescriptions for #260 oxycodone 30 mg., #360 methadone 10 mg., and
3 #90 Dilaudid 8 mg.

4 48. From September through December 2018, Respondent continued to see Patient A
5 monthly and continued to prescribe #360 methadone 10 mg. and #90 hydromorphone 8 mg.
6 Respondent continued to reduce the quantity prescribed of oxycodone so that by the December 7,
7 2018 visit, he prescribed #200 tablets of oxycodone 30 mg. to Patient A. Respondent also
8 documented reviewing the CURES database at each monthly visit, except for the November 9,
9 2018 visit.

10 49. In 2018, according to the CURES database, Patient A filled prescriptions from
11 Respondent for a total of: #3320 oxycodone 30 mg.; #4680 methadone 10 mg.; #1170 Dilaudid 8
12 mg.; #2220 Soma 350 mg.; and #300 Valium 10 mg.

13 50. In 2019, Respondent continued to see Patient A whose condition did not change,
14 described as "severe pain in multiple joints. Respondent documented that he reviewed the
15 CURES database at each visit. Respondent prescribed to Patient A on a monthly basis the
16 following controlled substances: #180 oxycodone 30 mg. and #90 hydromorphone 8 mg.
17 Respondent reduced the monthly prescription for methadone 10 mg. by 30 tablets each month, so
18 that he prescribed #360 methadone 10 mg. in January 2019 and got to #60 methadone 10 mg. by
19 October 2019, which quantity he continued to prescribe to Patient A in November 2019 but did
20 not refill after that visit.

21 51. On or about January 3, 2020, Respondent saw Patient A and noted that he prescribed
22 #120 morphine ER 60 mg. and #60 Dilaudid 8 mg. There is no physical exam or vitals listed,
23 except for the patient's subjective pain level of 9 out of 10.

24 52. On or about January 31, 2020, Respondent saw Patient A. His progress note states:
25 "Patient continues to suffer from severe pain in multiple joints. Continue to taper. Checked
26 CURES. Filled Morphine ER 100 mg. #60." There is no physical exam or vitals listed, except for
27 the patient's subjective pain level of 9 out of 10. This is the last progress note for Patient A that
28 Respondent produced to the Board during its investigation.

1 53. In January 2020, according to the CURES database, Patient A filled a prescription
2 from Respondent for #150 Soma 350 mg. that is not documented in Respondent's medical records
3 for Patient A.

4 54. During the course of his treatment of Patient A with controlled substances for chronic
5 pain, Respondent never entered into an agreement with the patient about the prescribing, and
6 never documented advising the patient of the risks of chronic prescribing of opioids in
7 combination and of alternatives to the treatment, i.e. informed consent.

8 55. In summary, Respondent's overall conduct, through his acts and omissions, regarding
9 Patient A, as set forth in paragraphs 20 through 54 herein, constitutes unprofessional conduct
10 under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent
11 acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and
12 medical indication] and is therefore subject to disciplinary action. More specifically, Respondent
13 is guilty of unprofessional conduct with regard to Patient A as follows:

14 a. Respondent failed to adequately assess Patient A's risk of drug addiction and
15 aberrancy before or during his treatment using long-term prescribing of opioids.

16 b. Respondent never discussed and never entered into a pain management agreement
17 with the patient to establish the expectations and responsibilities of both Respondent and the
18 patient regarding long-term therapy using controlled substances (opioids).

19 c. Respondent failed to adequately document a treatment plan and failed to conduct
20 proper periodic review to assess the effectiveness of the treatment. Functional goals and adverse
21 events were not clearly delineated. Prior to 2018, Respondent failed to provide appropriate
22 continuation, titration and monitoring of his chronic opiate pain management.

23 d. Respondent failed to adequately monitor the patient's compliance with the prescribed
24 treatment and never conducted random urine drug screens or other similar monitoring.

25 e. Respondent failed to obtain informed consent by informing the patient of the benefits,
26 risks, and alternatives to the long-term opiate therapy and the chronic treatment using
27 combinations of controlled substances. Respondent failed to inform the patient that her treatment
28

1 regimen, of extremely high levels of morphine equivalent doses, put her in an extremely high risk
2 group for adverse events such as overdose.

3 f. Respondent concurrently prescribed opioids and benzodiazepines to Patient A
4 without documenting a medical indication for the prescribing and without advising the patient of
5 the risks of accidental drug overdose and of alternatives to the treatment.

6 g. Respondent failed to maintain adequate and accurate medical records for his
7 treatment of Patient A. There were abnormal findings that were not consistently addressed and
8 diagnoses that were not consistently charted. Appropriate physical examinations and findings
9 were not documented. Most progress notes lacked details about relevant care, did not have
10 reconciled medications listed, and failed to document all prescriptions that were issued.

11 **SECOND CAUSE FOR DISCIPLINE**

12 **(Unprofessional Conduct re Patient B: Gross Negligence, Repeated Negligent Acts, 13 Prescribing without Appropriate Examination and Medical Indication)**

14 56. Respondent David Leonard Belk, M.D. is subject to disciplinary action for
15 unprofessional conduct under Business and Professions Code sections 2234, subdivision (b)
16 and/or subdivision (c), and/or section 2242 in that Respondent's overall conduct, acts and/or
17 omissions, with regard to Patient B constitutes gross negligence and/or repeated negligent acts
18 and/or prescribing without an appropriate prior examination and medical indication, as more fully
19 described herein below.

20 57. On or about May 18, 2012, Respondent first saw Patient B, a male who was born in
21 1952. Respondent's handwritten note of the initial visit is not completely legible. It does not
22 appear that a full history and physical examination was performed and documented. It is unclear
23 what treatment was provided by Respondent.

24 58. Respondent saw the patient occasionally between May 18, 2012 and April 2019. His
25 progress notes are scant, mostly handwritten and illegible.

26 59. On or about April 29, 2016, Respondent saw Patient B for pain medication "refills"
27 for chronic severe back pain. It was noted that Patient B was a full-time caregiver for his father-
28 in-law. Respondent prescribed #180 Percocet 10/325 mg. Other than a note that the patient's

1 subjective pain level was 5 out of 10, there were no subjective or objective findings and no
2 physical examination was documented. There is an inconsistency in the progress note because
3 Respondent electronically signed it on April 28, 2016 yet the note for the visit is dated April 29,
4 2016. So, it is unclear if Respondent actually saw the patient before prescribing a refill
5 prescription for Percocet.

6 60. Between April 29, 2016 and December 9, 2016, Respondent saw Patient B on a
7 monthly basis to refill the prescription for #180 Percocet 10/325 mg. The patient's subjective
8 pain level remained unchanged at 4 out of 10. There were no subjective or objective findings and
9 no physical examination was documented by Respondent in the progress notes.

10 61. On or about September 1, 2016, Respondent saw Patient B for a visit that was not for
11 a pain medication refill but was for a follow-up regarding "diabetes, hyperlipidemia and
12 hypertension." A physical examination is documented with no mention of the patient's back pain.
13 The patient's subjective pain level is noted to be 3 out of 10. Respondent noted that the patient's
14 conditions were controlled with medications and that the current medications would be continued,
15 without specifically documenting the medications that were prescribed to the patient.

16 62. In 2017, Respondent continued to see Patient B on a monthly basis for medication
17 refills. Respondent's progress notes all state: "Here for chronic back pain medication refill.
18 Refilled Percocet 10/325 mg. #180." The only other note is the subjective pain level, which
19 varied between 4 and 6 out of 10. There was no documentation of vitals, a physical examination,
20 or other objective or subjective findings about the patient's condition, function, or other pain
21 assessment.

22 63. On or about March 14, 2017, Respondent saw Patient B for a non-medication refill
23 visit. It was a follow-up visit for conditions of diabetes, hyperlipidemia and hypertension.
24 Respondent documented a physical exam and noted that the patient had been hospitalized for
25 acute kidney injury from obstruction but was doing well. There was no mention of the patient's
26 chronic back pain. No specific medications were listed. Respondent only noted that the same
27 medication regimen was to be continued.

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1 64. From January 2018 through July 20, 2018, Respondent saw Patient B on a monthly
2 basis with the same note that the visit was for "chronic back pain medication refill." There was
3 no documentation of an examination or findings, except for a subjective pain level that varied
4 between 6 and 7 out of 10. Respondent prescribed #180 Percocet 10/325 at each visit.

5 65. At the February, March, and April 2018 visits, Respondent noted that the
6 prescriptions were to be dated for the following day, without documenting a reason for the post-
7 dating.

8 66. On or about August 17, 2018, Respondent saw Patient B for a monthly visit for
9 "chronic back pain medication refill" and noted that he had "checked CURES." Respondent
10 noted that the plan was to begin tapering the Percocet by ten pills a month. Respondent issued a
11 prescription for #170 Percocet 10/325 mg.

12 67. From September 2018 through December 2018, Respondent continued to see Patient
13 B on a monthly basis and noted in each progress note that he checked the CURES database. No
14 physical examination or findings were documented. Respondent continued to reduce the quantity
15 of Percocet prescribed by ten tablets each month, except for the visits in November and
16 December 2018 when Respondent prescribed the same quantity of #130 Percocet 10/325 mg.

17 68. From January 4, 2019 through November 5, 2019, Respondent continued to see
18 Patient B on a monthly basis, except there is no progress note for a visit in September.
19 Respondent's progress notes all state the same thing: "Patient continues to have chronic back.
20 (sic) Checked CURES." Respondent continued to reduce the quantity of Percocet prescribed by
21 ten tablets each month, so that the prescription issued at the November 5, 2019 visit was for #10
22 Percocet 10/325 mg.

23 69. The November 5, 2019 progress note is the most recent medical record for Patient B
24 that Respondent produced to the Medical Board during its investigation.

25 70. According to the CURES database, Patient B has not received a controlled substance
26 prescription from Respondent after November 2019.

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1 71. In summary, Respondent's overall conduct, through his acts and omissions, regarding
2 Patient B, as set forth in paragraphs 56 through 70 herein, constitutes unprofessional conduct
3 under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent
4 acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and
5 medical indication] and is therefore subject to disciplinary action. More specifically, Respondent
6 is guilty of unprofessional conduct with regard to Patient B as follows:

7 a. Respondent failed to adequately assess Patient B's risk of drug addiction and
8 aberrancy before or during his treatment using long-term prescribing of opioids.

9 b. Respondent never discussed and never entered into a pain management agreement
10 with the patient to establish the expectations and responsibilities of both Respondent and the
11 patient regarding long-term therapy using controlled substances (opioids).

12 c. Respondent failed to adequately document a treatment plan and failed to conduct
13 proper periodic review to assess the effectiveness of the treatment. Functional goals and adverse
14 events were not clearly delineated. During his treatment of Patient B, at least prior to August
15 2018, Respondent failed to provide appropriate continuation, titration and monitoring of his
16 chronic opiate pain management.

17 d. Respondent failed to adequately monitor the patient's compliance with the prescribed
18 treatment and never conducted random urine drug screens or other similar monitoring.

19 e. Respondent failed to obtain informed consent by informing the patient of the benefits,
20 risks, and alternatives to the long-term opiate therapy. Respondent failed to inform the patient
21 that his treatment regimen, of high levels of morphine equivalent doses, put him in an extremely
22 high risk group for adverse events such as overdose.

23 f. Respondent failed to maintain adequate and accurate medical records for his
24 treatment of Patient B. There were diagnoses that were not consistently addressed. Most
25 progress notes lacked details about relevant care and did not document appropriate physical
26 examinations and findings to support a medical indication for the treatment. Many progress notes
27 appeared to have been copied and pasted, without any additional current information.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct re Patient C: Gross Negligence, Repeated Negligent Acts,**
3 **Prescribing without Appropriate Examination and Medical Indication)**

4 72. Respondent David Leonard Belk, M.D. is subject to disciplinary action for
5 unprofessional conduct under Business and Professions Code sections 2234, subdivision (b)
6 and/or subdivision (c), and/ or section 2242 in that Respondent's overall conduct, acts and/or
7 omissions, with regard to Patient C constitutes gross negligence and/or repeated negligent acts
8 and/or prescribing without an appropriate prior examination and medical indication, as more fully
9 described herein below.

10 73. On or about March 12, 2015, Respondent saw Patient C, a male who was born in
11 1950, for a "refill" of his pain medications. It appears that it had been about two years since
12 Respondent had seen the patient. It was noted that the patient "continues to have ankle and knee
13 pain status post fall." No vitals, physical examination, or findings were documented. Respondent
14 issued a prescription for #240 oxycodone 30 mg.

15 74. From that March 2015 visit through December 18, 2015, Respondent continued to see
16 Patient C on approximately a monthly basis and prescribed #240 oxycodone 30 mg. at each visit.
17 Respondent's progress notes for those nine visits contain the same general progress note without
18 details as the March 12, 2015 progress note.

19 75. From January to December 22, 2016, Respondent continued to see Patient C on
20 approximately a monthly basis and prescribed each month #240 oxycodone 30 mg. Respondent's
21 progress notes for these "medication refill" visits contain the same general description that the
22 patient continued to have "ankle and knee pain" without any documented examination or detailed
23 findings.

24 76. On or about February 8, 2016, Patient C saw Respondent with a complaint of severe
25 leg cramps at night. Respondent noted in the progress note that the patient said that the
26 gabapentin helps but that he needed an increased dose. Respondent's plan was to increase
27 gabapentin "to maximum of 600 mg. TID PRN." Prior to this progress note and after this date,
28

1 Respondent did not document in his monthly progress notes that Patient C was being prescribed
2 gabapentin in addition to the oxycodone.

3 77. Between May 10, 2016 and October 27, 2016, Respondent also noted that the patient
4 was having "hernia pain," but did not document any additional details or findings.

5 78. On or about December 22, 2016, Respondent saw Patient C and wrote the same
6 general progress note that the patient had "chronic ankle and knee pain" without documenting an
7 examination or other findings, except for noting a subjective pain level of 4 out of 10. However,
8 Respondent prescribed #200 oxycodone 30 mg, which was a reduction from the prior #240 tablets
9 monthly, without any documentation of his rationale or plan.

10 79. On or about January 12, 2017, Respondent saw Patient C for a "medication refill"
11 visit and his progress note repeats the same general statement that the patient "continues to have
12 chronic ankle and knee pain." Respondent noted that the patient lost his prescription coverage
13 and so would be paying cash. Respondent issued a prescription for #160 oxycodone 30 mg.
14 There is no other documentation of Respondent's treatment plan.

15 80. At the monthly visit on or about February 1, 2017, Respondent saw Patient C and his
16 progress note is the same general statement as in prior months, that the patient continued to have
17 chronic ankle and knee pain. There is no documentation of vitals, physical examination or other
18 findings or assessments, particularly regarding the patient's condition as a result of the prior
19 month's decreased dosage of oxycodone. Respondent increased the dosage prescribed to #240
20 oxycodone 30 mg.

21 81. On or about March 2, 2017, Respondent saw Patient C for a medication refill and
22 made the same general note that the patient continued to have chronic ankle and knee pain.
23 Another prescription for #240 oxycodone 30 mg. was issued by Respondent.

24 82. On or about March 27, 2017, Respondent saw Patient C for a follow-up visit
25 regarding his hypertension. Respondent documented that the patient said that "he accidentally
26 lost several of his oxycodone pills" and that he "[u]nderstands that he has a problem with drug.
27 Starting to consider treatment program." Respondent's assessment was hypertension and
28

1 narcotics addiction. Respondent's documented plan was: "Recommend treatment. Need to check
2 labs. Won't refill oxycodone until at least Friday."

3 83. From April through December 2017, Respondent continued to see Patient C on a
4 monthly basis and continued to prescribe #240 oxycodone 30 mg. monthly. There is no mention
5 in Respondent's progress notes regarding the status and treatment of Patient C's narcotics
6 addiction or of any random lab testing for drug screening. Most of Respondent's progress notes
7 merely stated that the patient continued "to have chronic pain in several areas" and included a
8 subjective pain level of 4 or 5 out of 10, without any further details.

9 84. In July 2017, Respondent noted that Patient C had a 3 cm mass removed from his
10 bladder. There are no further details documented.

11 85. From January through June 22, 2018, Respondent saw Patient C on about a monthly
12 basis and issued prescriptions for #240 oxycodone 30 mg. Respondent's progress note for each
13 of the visits is that the patient continued to have "chronic pain in several areas" with a subjective
14 pain level of 5 out of 10, without any further details.

15 86. On or about June 28, 2018, Respondent saw Patient C for a follow-up visit after the
16 patient had visited the ER after one week of nausea. The assessment was gastroenteritis and the
17 plan was to take Reglan, as needed.

18 87. At the next monthly medication refill with Patient C on or about July 20, 2018,
19 Respondent noted that the patient continued to have "chronic pain in several areas" with a
20 subjective pain level of 4 out of 10. It was also noted that oxycodone was being tapered by ten
21 pills a month, without any additional details or findings. Respondent issued a prescription for
22 #230 oxycodone 30 mg.

23 88. Respondent has no progress note for a monthly visit with Patient C in August 2018.
24 However, according to the CURES database, on August 17, 2018, Patient C filled Respondent's
25 prescription for #220 oxycodone 30 mg.

26 89. Starting on or about October 12, 2018 through December 2018, Respondent's
27 monthly progress notes for Patient C described his diagnosis as "chronic pain DJD" and included
28 a note that CURES was checked.

1 90. From August to November 9, 2018, Respondent continued to reduce the monthly
2 oxycodone prescription to Patient C by ten pills a month. However, Respondent issued
3 prescriptions to Patient C for the same quantity, #190 oxycodone 30 mg., on both November 9,
4 2018 and December 5, 2018. Respondent's progress notes did not document any detailed
5 findings or assessments about the patient's condition.

6 91. On or about January 2, 2019 and January 31, 2019, Respondent saw Patient C and
7 issued refill prescriptions for #180 oxycodone 30 mg. Both of Respondent's progress notes state:
8 "Patient continues to have chronic pain DJD, Checked CURES." Except for a subjective pain
9 level of 3 out of 10, there is no documentation of findings or a physical examination or any
10 assessment of a treatment plan.

11 92. In his progress notes of the monthly visits with Patient C on March 29, 2019 and on
12 April 26, 2019, Respondent merely noted that the patient continued to have "chronic pain DJD,"
13 reported a pain level of 3 out of 10, and that he checked CURES. He issued monthly
14 prescriptions for #160 oxycodone 30 mg.

15 93. On or about May 15, 2019, Respondent saw Patient C and documented a physical
16 examination. He noted that the plan was to switch from oxycodone to morphine ER with low
17 dose oxycodone "on the next refill" without any details about the planned dosages, or the
18 patient's current medications.

19 94. On or about May 17, 2019, Respondent saw Patient C and changed the prescription
20 regimen to: #90 oxycodone 10 mg. plus #90 morphine ER 60 mg. The progress note merely
21 states the patient continued to have "chronic pain DJD," reported a subjective pain level of 3 out
22 of 10, and noted that CURES was checked.

23 95. During monthly visits between June 14, 2019 through November 1, 2019, Respondent
24 saw Patient C and continued to note that the patient "suffers from chronic pain DJD," with a
25 reported pain level of 3 out of 10, and that CURES was checked, without any additional
26 information. While consistently prescribing to Patient C the same monthly quantity of #90
27 morphine ER 60 mg., Respondent continued to reduce by ten tablets each month the quantity of
28

1 oxycodone 10 mg. prescribed, except for both October and November 2019 when he prescribed
2 the same amount of #40 oxycodone 10 mg.

3 96. On or about November 1, 2019, Respondent saw Patient C and noted that the patient
4 requested that the oxycodone refill issued that day be the last prescription for oxycodone.
5 Respondent prescribed #30 oxycodone 10 mg. and #90 morphine ER 60 mg.

6 97. On or about December 13, 2019, Respondent saw Patient C and noted the purpose of
7 the visit was to follow-up on the patient's hypertension and "chronic pain from multiple injuries."
8 Respondent documented that the patient was fully aware that he had become addicted to opioids
9 and that he was willing to get off them completely. Respondent's assessment was controlled
10 hypertension and opioid dependence. Respondent noted that the patient's opioid use had
11 decreased in the past 18 months from a morphine equivalent dose (MED) of 360 mg. daily to 195
12 mg. daily but that tapering was difficult because of persistent pain issues. Respondent noted that
13 the patient did not want more opiate prescriptions and was concerned about being investigated by
14 the California Department of Consumer Affairs. This is the most recent progress note for Patient
15 C that Respondent produced to the Board during its investigation.

16 98. In summary, Respondent's overall conduct, through his acts and omissions, regarding
17 Patient C, as set forth in paragraphs 72 through 97 herein, constitutes unprofessional conduct
18 under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent
19 acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and
20 medical indication] and is therefore subject to disciplinary action. More specifically, Respondent
21 is guilty of unprofessional conduct with regard to Patient C as follows:

22 a. Respondent failed to adequately assess Patient C's risk of drug addiction and
23 aberrancy before or during his treatment using long-term prescribing of opioids. Respondent did
24 not seek to obtain records of the patient's previous treatment modalities prior to assuming the
25 prescribing of opioids to Patient C.

26 b. Respondent never discussed and never entered into a pain management agreement
27 with the patient to establish the expectations and responsibilities of both Respondent and the
28 patient regarding long-term therapy using controlled substances (opioids).

1 c. Respondent failed to adequately document a treatment plan and failed to conduct
2 proper periodic review to assess the effectiveness of the treatment. Functional goals and adverse
3 events were not clearly delineated. During his treatment of Patient C, at least prior to July 2018,
4 Respondent failed to provide appropriate continuation, titration and monitoring of his chronic
5 opiate pain management.

6 d. Respondent failed to adequately monitor the patient's compliance with the prescribed
7 treatment and never conducted random urine drug screens or other similar monitoring.

8 e. Respondent failed to obtain informed consent by informing the patient of the benefits,
9 risks, and alternatives to the long-term opiate therapy. Respondent failed to inform the patient
10 that his treatment regimen, of high levels of morphine equivalent doses, put him in an extremely
11 high risk group for adverse events such as overdose.

12 f. Once he documented that Patient C was addicted to opiates, Respondent failed to
13 consult with and/or refer the patient to a specialist in either addiction medicine or pain
14 management.

15 g. Respondent failed to maintain adequate and accurate medical records for his
16 treatment of Patient C. There were diagnoses that were not consistently addressed. Most
17 progress notes lacked details about relevant care and did not document appropriate physical
18 examinations and findings to support a medical indication for the treatment. Many progress notes
19 appeared to have been copied and pasted, without any additional current information. Some
20 progress notes did not list the medications prescribed.

21 **FOURTH CAUSE FOR DISCIPLINE**

22 **(Unprofessional Conduct: Patients A, B, C: Failure to Maintain Adequate and Accurate** 23 **Medical Records)**

24 99. Respondent David Leonard Belk, M.D. is subject to disciplinary action, jointly and
25 severally, for unprofessional conduct under Business and Professions Code section 2266 for his
26 failure to maintain adequate and accurate medical records regarding his treatment of Patient A
27 and/or Patient B and/or Patient C.

28 100. Paragraphs 20 through 98 are incorporated herein by reference, as if fully set forth.

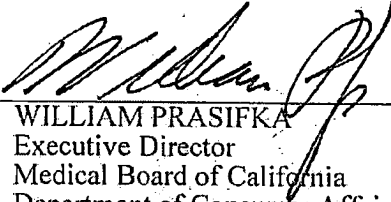
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PRAYER

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 66844, issued to David Leonard Belk, M.D.;
2. Revoking, suspending or denying approval of David Leonard Belk, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering David Leonard Belk, 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: MAR 24 2021



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

SF2020401708