

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

In the Matter of the Accusation
Against:

John Robert Logan, M.D.

Physician's and Surgeon's
Certificate No. G 49918

Respondent.

Case No. 800-2017-037573


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 October 31, 2021.

IT IS SO ORDERED September 14, 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 LAWRENCE MERCER
Deputy Attorney General
4 State Bar No. 111898
455 Golden Gate Avenue, Suite 11000
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Attorneys for Complainant
7

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

12 In the Matter of the Accusation Against:

Case No. 800-2017-037573

13 **JOHN ROBERT LOGAN, M.D.**
14 **3417 Forbes Avenue**
15 **Santa Clara, CA 95051**

OAH No. 2021060152

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

16 **Physician's and Surgeon's Certificate No. G
49918**

Respondent.

17
18 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
19 entitled proceedings that the following matters are true:

20 **PARTIES**

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

25 2. JOHN ROBERT LOGAN, M.D. (Respondent) is represented in this proceeding by
26 attorneys, Dennis R. Thelen and Amanda M. Lucas, whose address is: 5001 E. Commerce Center
27 Dr., Ste. 300, Bakersfield, CA 93309-1687.
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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: 9/3/2021

Respectfully submitted,
ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General



LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-037573

1 XAVIER BECERRA
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8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2017-037573

13 **John Robert Logan, M.D.**
14 **3417 Forbes Avenue**
Santa Clara, CA 95051

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **No. G 49918,**

Respondent.

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19
20 **PARTIES**

21 1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity
22 as the Interim Executive Director of the Medical Board of California, Department of Consumer
23 Affairs (Board).

24 2. On May 16, 1983, the Medical Board issued Physician's and Surgeon's Certificate
25 Number G 49918 to John Robert Logan, M.D. (Respondent). The Physician's and Surgeon's
26 Certificate was in full force and effect at all times relevant to the charges brought herein and will
27 expire on March 31, 2021, unless renewed.

JURISDICTION

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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 unless otherwise indicated.

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

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

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

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

“(b) Gross negligence.

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

“”

6. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.”

1 FACTS

2 7. At all times relevant to this matter, Respondent was licensed and practicing medicine
3 in California.

4 PATIENT P-1¹

5 8. Respondent treated Patient P-1 from as early as May 2011 and has chart notes for her
6 from September 16, 2011 through November 3, 2015. He saw her approximately monthly over
7 that time. He treated her for, among other conditions, abdominal pain of no known etiology,
8 cirrhosis of the liver, anxiety, depression, bipolar disorder, post-traumatic stress disorder, knee
9 pain, and insomnia.

10 9. Respondent initially prescribed oxycodone with acetaminophen 5/325² for P-1 for
11 pain, and then switched to morphine sulfate³ and, by 2012, to hydromorphone⁴ which he
12 continued prescribing, occasionally with various other opioid medications, through November 11,
13 2015. P-1's average morphine milligram equivalency (MME)⁵ for the entire period she was
14 under Respondent's care was approximately 148 MME per day. By the final eleven and a half
15 months that he treated her, her dose had increased to approximately 167 MME daily. Opioid
16 dosages over 50 MME should be carefully used and dosages exceeding 90 MME should be very
17 limited and clearly justified. Respondent prescribed the opioid medications for abdominal pain of
18

19 _____
20 ¹ The patients are designated in this document as Patients P-1 through P-4 to protect their
21 privacy. Respondent knows the names of the patients and can confirm their identities through
22 discovery.

23 ² Oxycodone with acetaminophen (trade name Percocet) is indicated for moderate to
24 moderately severe pain. The 5/325 reflects that each pill contains 5 mg of oxycodone HCl and
25 325 mg of acetaminophen. Oxycodone HCl is semisynthetic narcotic analgesic and a dangerous
26 drug as defined in section 4022 and a Schedule II controlled substance.

27 ³ Morphine sulfate is an opioid medication indicated for moderate to severe pain. It is a
28 dangerous drug as defined in section 4022 and a Schedule II controlled substance.

⁴ Hydromorphone, also known by the trade name Demerol, is an opioid analgesic. It is a
dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as
defined in section 11055 of the Health and Safety Code. Hydromorphone is four times as potent
as morphine and can produce drug dependence. It has a central nervous system depressant effect.

⁵ MME stands for morphine milligram equivalency. This is used to convert the many
different opioids into one standard value based on morphine and its potency. Oxycodone, for
example, is 1.5 times as potent as morphine so 100 mg of oxycodone is equivalent to 150 MME.
The concept is alternatively referred to as morphine equivalent dose (MED).

1 unknown etiology without documenting a thorough investigation or medical necessity for the
2 medications.

3 10. At the same time Respondent was prescribing these high levels of opioid medications
4 for P-1, he was simultaneously prescribing various benzodiazepines including temazepam,⁶
5 clonazepam,⁷ diazepam,⁸ and flurazepam⁹ for her for anxiety and insomnia and, from June 4,
6 2015, carisoprodol¹⁰ as well. Respondent did not document a clinical indication for long-term,
7 i.e. over four years, benzodiazepine therapy.

8 11. Over this period, Respondent did not document a comprehensive treatment plan or
9 specify measurable goals and objectives to evaluate progress toward treatment goals except to
10 note that opioid medications permitted her to perform activities of daily living (ADLs) more
11 easily. He did not document evaluating P-1's progress toward treatment objectives, discussion of
12 improvement in level of function, discussion of medication abuse or diversion He did not
13 document an exit strategy for discontinuing controlled substances therapy in the event it became
14 medically necessary to taper or discontinue the therapy.

15 12. Respondent continued prescribing a combination of opioids and benzodiazepines for
16 Patient P-1 despite evidence of numerous risk factors including diagnoses of anxiety, depression,
17 bipolar disorder, and post-traumatic stress disorder and a past history of alcohol and drug abuse.
18 P-1 had multiple emergency room visits for apparent opioid overdoses, pain and withdrawal

19 ⁶ Temazepam (trade name Restoril) is a benzodiazepine. It is a sedative used to treat
20 anxiety and insomnia. It is a dangerous drug as defined in section 4022 and a Schedule IV
21 controlled substance. Since temazepam has a central nervous system (CNS) depressant effect,
22 special care should be taken when prescribing temazepam with other CNS depressant drugs.

23 ⁷ Clonazepam (trade name Klonopin) is an anticonvulsant of the benzodiazepine class of
24 drugs. It is a long-acting benzodiazepine. It is a dangerous drug as defined in section 4022 and a
25 Schedule IV controlled substance. It produces central nervous system depression and should be
26 used with caution with other central nervous system depressant drugs.

27 ⁸ Diazepam (trade name Valium) is a benzodiazepine. It is a psychotropic drug used for
28 the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is
a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

⁹ Flurazepam (trade name Dalmane) is a benzodiazepine. It is a psychotropic drug used to
treat insomnia. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled
substance

¹⁰ Carisoprodol (trade name Soma) is a muscle relaxant and sedative. Carisoprodol is a
Schedule II controlled substance and a dangerous drug as defined by Business and Professions
Code section 4022. Using carisoprodol together with an opioid may increase side effects such as
dizziness, drowsiness, confusion, and difficulty concentrating.

1 symptoms having run out of pain medication early, and altered mental status. On November 8,
2 2012, she was administered and responded to Narcan¹¹ and the ER physician recommended
3 tapering hydromorphone and gave diagnoses of altered mental status and overdose of drugs. In
4 addition, she reported several falls, often exhibited confusion, presented with slurred speech, and
5 ran out of pain medications early on a number of occasions.

6 13. Respondent failed to document having considered P-1's symptoms, diagnosis,
7 alternatives to treatment, and goals of treatment as well as her substance abuse history and other
8 risk factors when prescribing and increasing dosages of opioid medications. He did not document
9 using tools to assess risk of medication abuse such as the SOAP-R, Opioid Risk Tool, or GAD-7
10 and did not document classifying P-1's risk of addiction.

11 **FIRST CAUSE FOR DISCIPLINE**

12 **(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate**
13 **Records)**

14 14. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and
15 subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266
16 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts
17 and/or failed to maintain adequate medical records, including but not limited to the following:

18 A. Respondent failed to address or respond to numerous red flags for abuse or
19 diversion of controlled substances by Patient P-1 and to classify and/or to document having
20 classified Patient P-1's risk of abuse or diversion prior to initiating or continuing long-term use of
21 high dosage controlled substances.

22 B. Respondent prescribed high doses of opioid medications for Patient P-1—an
23 average of 167 MME over the final 11 months he treated her—over an extended period without
24 documenting a clinical indication or medical necessity for the medications.

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27 ¹¹ Narcan, a trade name for naloxone, is an opioid antagonist and is indicated for the
28 complete or partial reversal of opioid depression, including respiratory depression, induced by
natural and synthetic opioids. Narcan is also indicated for diagnosis of suspected or known acute
opioid overdose.

1 C. Respondent failed to specify measurable goals and objectives to evaluate
2 Patient P-1's treatment progress, to document evidence of Patient P-1's progress toward treatment
3 objectives, and to document an exit strategy for discontinuing drug therapy if medically
4 necessary.

5 D. At the same time Respondent was prescribing high doses of opioid medications
6 for Patient P-1, he was also prescribing various benzodiazepines without documenting a clinical
7 indication for the potentially dangerous combination of opioids and benzodiazepines or for long-
8 term benzodiazepine therapy.

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10 **PATIENT P-2**

11 15. Respondent has chart notes for Patient P-2 for at least the period from March 9, 2012
12 through October 14, 2015. He saw her approximately monthly over that time. He treated her for,
13 among other conditions, chronic pain associated with rheumatoid arthritis.

14 16. On March 9, 2012, P-2's initial visit, Respondent diagnosed her with advanced
15 rheumatoid arthritis and noted that she was no longer able to get out of bed. She was transported
16 to her visits with Respondent by gurney. On her first visit, Respondent prescribed MS Contin¹²
17 15 mg twice a day and naprosyn 500, a non-steroidal anti-inflammatory. Two months later, P-2
18 reported to another health care provider in Respondent's practice that she had been taking the 15
19 mg tablets of MS Contin three to four times a day instead of two times daily as it was prescribed.
20 Respondent did not document discussing this overuse with P-2. A few months after that, on
21 August 17, 2012, Respondent increased P-2's dose of MS Contin to 30 mg two times a day
22 without explanation, then to 30 mg three times a day, and on February 5, 2013, to 100 mg three
23 times a day. He did not document a risk/benefit analysis and rationale for these increases. On
24 October 12, 2013, P-2 reported to Respondent that she had run out of morphine and gotten

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26 ¹² MS Contin, a trade name for morphine sulfate extended-release tablets, is a strong
27 opioid pain medicine that is used to manage pain severe enough to require daily around-the-clock,
28 long-term treatment with an opioid. It is a dangerous drug as defined in section 4022 and a
Schedule II controlled substance and narcotic as defined in section 11055 of the Health and
Safety Code.

1 hydrocodone/acetaminophen from the ER to tide her over to her appointment with him. He did
2 not document discussing with P-2 her using more medication than prescribed and, without
3 documenting a risk/benefit analysis or rationale, added hydrocodone/acetaminophen 10/325¹³
4 four times a day to the MS Contin. On April 15, 2015, P-2 reported that she had run out of pain
5 medication four to five days earlier and had had nausea and been vomiting for two days. Again,
6 Respondent failed to document a discussion of the medication overuse and refilled P-2's
7 prescriptions. A month after that, without explanation, Respondent increased the potency of P-
8 2's break-through pain medication by twelve and a half percent by replacing
9 hydrocodone/acetaminophen 10/325 four times a day with the stronger opioid medication
10 oxycodone/acetaminophen 10/325 three times a day.

11 17. P-2's average morphine milligram equivalency when she started seeing Respondent
12 was 30 MME a day. Her average MME during the time Respondent was prescribing for her was
13 around 180 MME daily. By the final five months, her dose had increased to an average of
14 approximately 317 MME daily. Opioid dosages over 50 MME should be carefully used and
15 dosages exceeding 90 MME should be very limited and clearly justified. Respondent prescribed
16 high-dose long-term opioid therapy for P-2's rheumatoid arthritis without documenting a medical
17 necessity for the medications despite there being no scientific evidence to support either high-
18 dose or long-term use of opioid medications.

19 18. At the same time Respondent was prescribing these high levels of opioid medications
20 for P-2, he was simultaneously prescribing the benzodiazepines temazepam and clonazepam for
21 her to treat insomnia and anxiety, respectively.

22 19. Respondent did not document using tools to assess risk of medication abuse such as
23 the SOAP-R, Opioid Risk Tool, or GAD-7 and did not document classifying P-2's risk of
24 addiction.

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26 ¹³ Hydrocodone bitartrate with acetaminophen (trade name Norco) is an analgesic used to
27 treat moderate to severe pain. The 10/325 reflects that each pill contains 10 mg of hydrocodone
28 bitartrate and 325 mg of acetaminophen. Hydrocodone bitartrate is a dangerous drug as defined
in section 4022 and, since October 6, 2014, a Schedule II controlled substance. Before that date,
it was categorized as a Schedule III controlled substance.

1 C. Respondent failed to specify measurable goals and objectives to evaluate
2 Patient P-2's treatment progress, to document evidence of Patient P-2's progress toward treatment
3 objectives, and to document an exit strategy for discontinuing drug therapy if medically
4 necessary.

5 **PATIENT P-3**

6 22. Respondent has chart notes for Patient P-3 from at least June 2012 through November
7 2015 and saw her approximately monthly over that time. She had abdominal pain, back pain,
8 rectal and uterine prolapse, hypertension, and anxiety, among other conditions.

9 23. Respondent began prescribing hydrocodone with acetaminophen 10/325 for P-3 in
10 February 2012 and continued prescribing opioid medications for her along with the
11 benzodiazepine temazepam through November 14, 2015. While the medical records are not
12 always clear, it appears that he was prescribing the opioid medications for abdominal and back
13 pain. Over this period, Respondent did not document a physical examination of P-3's back
14 except, occasionally, to note that she had mid and lower back tightness and tenderness. Nor did
15 he document a treatment plan or specify measurable goals and objectives to evaluate progress
16 toward treatment goals except to note that opioid medications permitted her to perform activities
17 of daily living (ADLs) with less discomfort. He did not document an exit strategy for
18 implementation in the event it became medically necessary to discontinue her controlled
19 substances.

20 24. Over the period he was treating P-3, Respondent prescribed the opioids hydrocodone
21 and oxycodone for her. P-3's average morphine milligram equivalent (MME) for the entire
22 period she was under Respondent's care was approximately 176 MME per day. By the final
23 eleven and a half months he treated her, her dose had increased to approximately 230 MME daily.

24 25. Respondent continued prescribing a combination of controlled substances for P-3
25 despite evidence of numerous risk factors including a diagnosis of and treatment for anxiety,
26 several falls and feelings of light-headedness, and running out of pain medications early on a
27 number of occasions. She also had multiple emergency room visits for complaints such as pain
28 with the hope of getting pain medication, light-headedness, and altered mental status. On one

1 occasion—October 16, 2014—she was administered and responded to Narcan and the ER
2 physician recommended stopping oxycodone and temazepam and gave a differential diagnosis of
3 narcotic abuse. Also, although a urine toxicology screen done in the ER on June 5, 2014 was
4 positive for barbiturates and Respondent was not prescribing barbiturates for P-3, there is no
5 documentation of his having discussed this with her. Respondent did not document using such
6 tools to assess risk of medication abuse as the SOAP-R, Opioid Risk Tool, PHQ-2 or otherwise
7 document undertaking an assessment of risk.

8 26. Respondent did not document having discussed with P-3 the potential risks of
9 combining opioid medications with benzodiazepines and did not document having placed P-3 on
10 a controlled substances contract until May 6, 2015, several years after he began prescribing
11 controlled substances for her.

12 **THIRD CAUSE FOR DISCIPLINE**

13 **(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate** 14 **Records)**

15 27. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and
16 subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266
17 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts
18 and/or failed to maintain adequate medical records, including but not limited to the following:

19 A. Respondent failed to address or respond to numerous red flags for abuse or
20 diversion of controlled substances by Patient P-3 and to classify and/or to document having
21 classified Patient P-3's risk of abuse or diversion prior to initiating or continuing long-term use of
22 high dosage controlled substances.

23 B. Respondent failed to have a comprehensive treatment plan specifying
24 measurable goals and objectives to evaluate Patient P-3's treatment progress, to document
25 evidence of Patient P-3's progress toward treatment objectives, and to document an exit strategy
26 for discontinuing drug therapy if medically necessary.
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1 C. Respondent failed to document that he discussed the potential risks of long-
2 term use of controlled substances with Patient P-3 or that he discussed the risks specific to
3 combining opioid medications with benzodiazepines with her.

4 D. Respondent failed to place, or to document having placed, Patient P-3 on a
5 controlled substances contract until over three years into her treatment.

6 **PATIENT P-4**

7 28. Respondent first saw Patient P-4 on April 2, 2012. He had a history of cerebral palsy,
8 COPD/asthma, and hypertension among other conditions. P-4's insurer no longer covered his
9 pain management physician and Respondent agreed to refill his pain medication prescriptions
10 until he found a new pain management specialist. Initially, Respondent prescribed for P-4, as the
11 pain management physician had, one 60 mg tablet of OxyContin twice a day and three 30 mg
12 tablets of oxycodone four times a day for a daily total of 720 MME. Respondent's chart notes do
13 not include a muscle-skeletal examination or neurological examination and do not indicate what
14 exactly the pain medication was intended to treat.

15 29. Respondent continued treating P-4 for what was eventually identified as chronic back
16 pain secondary to cerebral palsy until October 2015 when he referred him to pain management for
17 ongoing care and treatment. After about a year and a half of treating P-4, Respondent reduced his
18 oxycodone to two 30 mg tablets four times a day where it remained until he referred him to pain
19 management. From August 2013 through October 2015, Respondent's prescriptions for P-4 for
20 OxyContin and oxycodone totaled approximately 540 MME a day.

21 30. Despite prescribing high doses of opioid medications for P-4 for an extended period
22 of time, Respondent did not document using such tools as the SOAP-R, Opioid Risk Tool, PHQ-
23 2, PHQ-9 to assess P-4's risk of medication abuse or otherwise document undertaking an
24 assessment of risk. Nor did he document a treatment plan or specify measurable goals and
25 objectives to evaluate progress toward treatment goals except to note that opioid medications
26 permitted P-4 to perform activities of daily living with less discomfort. He did not document an
27 exit strategy for implementation in the event it became medically necessary to discontinue his
28 controlled substances.

1 FOURTH CAUSE FOR DISCIPLINE

2 **(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate**
3 **Records)**

4 31. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and
5 subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266
6 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts
7 and/or failed to maintain adequate medical records, including but not limited to the following: :

8 A. Respondent failed to classify and/or to document having classified Patient P-4's
9 risk of abuse or diversion prior to initiating or continuing long-term use of high dosage opioid
10 medications.

11 B. Respondent failed to have a comprehensive treatment plan specifying
12 measurable goals and objectives to evaluate Patient P-4's treatment progress, to document
13 evidence of Patient P-4's progress toward treatment objectives, and to document an exit strategy
14 for discontinuing drug therapy if medically necessary.

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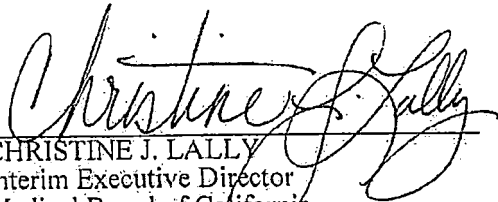
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 49918, issued to John Robert Logan, M.D.;
2. Revoking, suspending or denying approval of John Robert Logan, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering John Robert Logan, 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: MAY 26 2020


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

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