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

In the Matter of the Accusation Against: **Edmund Peter Kemprud, M.D.** **Physician's and Surgeon's Certificate No. G 28372** **Respondent.**	**Case No. 800-2017-038680**

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 25, 2021.

IT IS SO ORDERED October 18, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
ALICE W. WONG
Deputy Attorney General
State Bar No. 160141
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3873
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against: **EDMUND PETER KEMPRUD, M.D.** **7667 Amador Valley Blvd.** **Dublin, CA 94568** **Physician's and Surgeon's Certificate No. G28372** Respondent.	Case No. 800-2017-038680 OAH No. 2021050772 **STIPULATED SURRENDER OF LICENSE AND 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 Rob Bonta, Attorney General of the State of California, by Alice W. Wong, Deputy Attorney General.

2. Edmund Peter Kemprud, M.D. (Respondent) is represented in this proceeding by attorney John Fleer, whose address is: 273 Orchard Road, Orinda, CA 94563.

3. On or about October 28, 1974, the Board issued Physician's and Surgeon's Certificate No. G28372 to Edmund Peter Kemprud, M.D. (Respondent). The Physician's and Surgeon's Certificate will expire on July 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-038680 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 November 9, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-038680 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. 800-2017-038680. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and 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. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-038680, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

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.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

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

14. 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:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G28372, issued to Respondent Edmund Peter Kemprud, 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.

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. 800-2017-038680 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. 800-2017-038680 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 Order and have fully discussed it with my attorney John Fleer. 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: 10-7-21

EDMUND PETER KEMPRUD, M.D.
Respondent

I have read and fully discussed with Respondent Edmund Peter Kemprud, 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: 10-11-21

JOHN FLEER
Attorney for Respondent

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: October 12, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

Alice W. Wong

ALICE W. WONG
Deputy Attorney General
Attorneys for Complainant

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Stipulated Surrender.docx

EXHIBIT A

Accusation No. 800-2017-038680

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
ALICE W. WONG
Deputy Attorney General
State Bar No. 160141
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3873
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Edmund Peter Kemprud, M.D.** **7667 Amador Valley Blvd.** **Dublin, CA 94568** **Physician's and Surgeon's Certificate No. G28372,** Respondent.	Case No. 800-2017-038680 **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 October 28, 1974, the Medical Board issued Physician's and Surgeon's Certificate Number G28372 to Edmund Peter Kemprud, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

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.

STATUTORY PROVISIONS

4. Section 2227 of the Code states:

(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:

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

(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.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, 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.

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

(g) The failure by a certificate holder, in the absence of good cause, to attend 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.

6. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a 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 questionnaire, provided that the licensee complies with the appropriate standard of care.

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

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

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

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

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

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

in strength or amount or for more than one refill.

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

7. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

8. Section 2052 of the Code states:

(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

(c) The remedy provided in this section shall not preclude any other remedy provided by law.

9. 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.

FACTUAL ALLEGATIONS

PATIENT P-1[1]

10. Patient P-1, a female born in 1988, first saw Respondent on September 22, 2014. The chart notes of this visit are largely illegible, although there is a medication section with Vicodin[2]

[1]The patients are designated in this document as Patients P-1 through P-2 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Vicodin® is a trade name for hydrocodone bitartrate – acetaminophen, an opioid pain medication used for relief from moderate to moderately severe pain and has a high potential for

circled and a Controlled Substances Utilization and Review System (CURES[3]) report for this day show Respondent prescribed to P-1 a 7-day supply of hydrocodone[4], 5 mg. Respondent did not document an appropriate history and physical examination for P-1.

11. Respondent treated P-1 for leg pain on November 15, 2014 and prescribed a 30-day supply of oxycodone[5], 10 mg. Respondent did not perform and document any physical examination and information about the patient's condition and complaints. The chart notes are largely illegible.

12. On December 19, 2014, Respondent prescribed a 30-day supply of oxycodone, 10 mg. Respondent did not perform or document any physical examination. The chart notes are largely illegible.

13. On January 3, 2015, P-1 was treated for pain in her leg and sore throat. Respondent did not perform or document any physical examination. The chart notes are largely illegible.

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abuse. Vicodin is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

[4] Hydrocodone Bitartrate – Acetaminophen is also known under the brand names of Lorcet®, Lortab®, Norco® and Vicodin®. Hydrocodone Bitartrate – Acetaminophen is an opioid pain medication used for relief from moderate to moderately severe pain and has a high potential for abuse. Vicodin is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Oxycodone (with trade names Oxaydo®, OxyCONTIN®, Oxyfast®, Roxicodon®, Xtampza ER®) is a white odorless crystalline power derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of Oxycodone include anxiolysis, euphoria and feelings of relaxation. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to ½ of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers and alcohol.

14. On January 5, 2015, Respondent prescribed a 22-day supply of oxycodone, 10 mg. There is no medical indication for the early refill of 14 days. The chart notes are largely illegible.

15. On January 23, 2015, P-1 reported she is unable to "shut brain off." Respondent diagnosed P-1 with Attention Deficit Disorder (ADD) and possibly General Anxiety Disorder (GAD[6]) and prescribed a 30-day supply of alprazolam[7], 1 mg, and a 30-day supply of Adderall[8], 10 mg, for treatment. The chart notes are largely illegible.

16. On February 4, 2015, P-1 requested another pain medication. Respondent had already filled a 22-day supply of oxycodone, 10 mg on January 25, 2015. Respondent diagnosed P-1 with chronic leg pain. Respondent did not perform or document any physical examination. There was no medical indication why Respondent added a 20-day supply of hydrocodone, 7.5 mg to his treatment of P-1. The chart notes are largely illegible.

17. On March 2, 2015 the CURES report noted P-1 was provided a 30 day supply of oxycodone, 10 mg. On March 13, 2015, Respondent again provided a 30-day supply of oxycodone, 10 mg. There is no chart note evidence or medical indication why the additional prescription was provided 19 days early. On April 8, 2015, another 23-day supply of oxycodone, 10 mg was provided without any medical indication why the prescription was written 5 days early. The chart notes are largely illegible.

18. On May 8, 2015, P-1 reported knee pain and Respondent added a 30-day supply of Soma®)[9], 350 mg, to the 30-day supply of oxycodone prescribed for pain. Respondent did not

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[6] Due to the illegibility of the chart notes, it appeared "GAD" was written, which denote General Anxiety Disorder as a diagnosis.

[7] Alprazolam, also known by the trade name Xanax, is a benzodiazepine. It is a psychotropic drug used to treat anxiety and panic disorders. Alprazolam is contra-indicated in patients with narrow-angle glaucoma or who are taking certain medications. It is a dangerous drug as defined in section 4022, and a Schedule IV controlled substance.

[8] Adderall is a trade name for a combination of amphetamine and dextroamphetamine, central nervous system stimulants that is used to treat narcolepsy and attention deficit hyperactivity disorder. Adderall is a dangerous drug as defined in section 4022, and a Schedule II controlled substance.

[9] Carisoprodol (with trade name Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed as indicated, it is used

perform or document any physical examination and there was no medical indication why Soma® was added to P-1's treatment. The chart notes are largely illegible.

19. Respondent continued to prescribe hydrocodone, oxycodone, alprazolam and Adderall to P-1 for pain management and ADD on a monthly basis until September 2018. P-1 saw Respondent for the last time on September 21, 2018. The chart notes are largely illegible.

20. According to the CURES Report, between May 2014 and May 31, 2019, P-1 received approximately the following: 780 tablets of hydrocodone bitartrate acetaminophen 325/10 mg; 1,505 tablets of oxycodone (10 mg); 2,130 tablets of alprazolam (1 mg); and 1,890 tablets of Adderall (10 mg).

21. During this time period between May 2014 and May 31, 2019, Respondent did not perform or document any risk assessment of P-1 prior to initiating long-term use of narcotics and combinations of controlled substances. Respondent did not have a comprehensive treatment plan that specified measurable goals and objectives used to evaluate treatment progress for P-1. Respondent did not undertake or document any compliance monitoring such as drug testing, review of CURES reports, pill counts or utilize a pain management agreement[10] with P-1 to ensure appropriate medications used by P-1. Respondent did not evaluate P-1's progress toward established treatment objectives or evaluate other treatment goals such as patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and/or concerns such as reports of lost prescriptions or early refill

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for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

[10] Also known as a pain contract or controlled substance agreement. A pain management agreement is recommended for patients on short-acting opioids at the time of the third visit; on long acting opioids; or, expected to require more than three months of opioids. A pain management agreement outlines the responsibilities of the physician and patient during the time that controlled substances are prescribed. See Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain, November 2014.

requests), patient's affect (changes to mood, depression or anxiety), and accurate medical records reflecting the evaluation of treatment goals, including changes to management plan.

22. Respondent did not obtain, or document obtaining informed consent from P-1 regarding potential risks of long-term opioid use and combined use of opioid and other controlled substances.

PATIENT P-2

23. Patient P-2, a female born in 1967, saw Respondent between December 2015[11] and April 2019 for back pain. Respondent's chart notes for P-2 are largely illegible. The prescribing information are obtained from the CURES Report for P-2, between May 31, 2014 and May 31, 2019.

24. Between December 2015 and September 2016, Respondent prescribed hydrocodone, 10 mg and diazepam[12], 10 mg on a monthly basis to P-2. The chart notes are largely illegible. Respondent did not document an adequate patient history relating to the presenting complaint to support the prescribed medication.

25. On October 17, 2016, Respondent added Soma®, 350 mg, to the monthly prescriptions of hydrocodone and diazepam. The chart notes are largely illegible and do not document medical indication why the additional monthly prescription of Soma® was added.

26. On February 6, 2017, P-2 reported her pain level was at 6-7 on a scale of 10, but on medication, the pain level was at 2-4 on a scale of 10, which would be considered well controlled with the use of the prescribed medication. However, Respondent added methadone[13], 10 mg to

[11] The first available chart notes for P-2 was on December 18, 2015. The CURES Report show Respondent began prescribing narcotics to P-2 on November 28, 2014.

[12] Diazepam, also known by its trade name as Valium, is a benzodiazepine, used to treat anxiety, alcohol withdrawal, and seizures. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. It is a dangerous drug as defined in section 4022, and a Schedule IV controlled substance.

[13] Methadone is an opioid medication that has a high potential for abuse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs. It may cause a prolonged QT interval (a rare heart problem that may cause irregular heartbeat, fainting, or sudden death).

the monthly prescriptions of hydrocodone, diazepam, and Soma®. There is no documentation or medical indication why methadone was needed or added to P-2's treatment plan. The addition of methadone, 10 mg, increased the morphine milligram equivalent (MME[14]) from 60 to 240 MME per day.[15] It also appeared Norco was crossed off the prescribed medication. P-2 was continued on diazepam and Soma®.

27. P-2 was continued on monthly prescriptions of diazepam, Soma and methadone until September 6, 2017.

28. On September 6, 2017, the chart note appeared to state P-2 was in a motor vehicle accident three weeks ago. Respondent added Norco, 10 mg. to P-2's medication. Additionally, Respondent increased P-2's methadone from 3 to 4 times per day at 10 mg, which increased the MME of P-2 from 240 MME to 350 MME. There was no discussion, medical indication, or rationale for the addition of Norco or increase in methadone.

29. On October 2, 2017, Respondent increased P-2's prescription of methadone from 120 tablets to 135 tablets, which increased P-2's MME from 350 MME to 360 MME. There was no discussion, medical indication, or rationale for the increase in methadone.

30. On October 24, 2017, P-2 reported her back pain was worse with pain level of 9-10 on a scale of 10. There were no changes to P-2's medication.

31. On October 30, 2017, P-2 filled her prescription for methadone and hydrocodone four days early, without any medical indication why the prescription was written 4 days early.

32. P-2 was continued on monthly prescriptions of diazepam, Soma and methadone until July 2018.

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[14] 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 320 mg of oxycodone is equivalent to 480 MME. The CDC recommends avoiding or carefully justifying any dosage greater than 90 MME/day.

[15] Calculating Total Daily Dose of Opioids for Safer Dosage. CDC. www.cdc.gov/drugoverdose/prescribing/guideline.html.

33. On July 18, 2018, P-2 reported her back pain was at a 9-10 on a scale of 10. The chart notes appeared to state the prescription for Soma, 350 mg was reduced by one-half; however, the CURES Report reflected no change to the monthly prescription of Soma.

34. On October 5, 2018, P-2 reported being tired. Respondent decreased the hydrocodone prescription from 90 pills to 75 pills each month.

35. The last entry for chart notes for P-2 was completed by Respondent on October 31, 2018. It was largely illegible. On this day, P-2's CURES report showed a refill of one month supply of methadone. While P-2's last visit with Respondent appeared to be October 31, 2018 based on P-2's medical records, Respondent continued to write prescriptions for P-2 until May 2, 2019 according to P-2's CURES report.

36. According to P-2's CURES report, on January 9, 2019, Respondent decreased P-2's hydrocodone prescription from 75 pills to 60 pills. There are no chart notes, medical records, medical indication, or rationale related to this decrease in hydrocodone.

37. According to P-2's CURES report, on March 6, 2019, Respondent increased P-2's hydrocodone prescription from 60 pills to 240 pills, four times the amount of prescribed hydrocodone since P-2's last visit on October 31, 2018. There are no chart notes, medical records, medical indication, or rationale related to this substantial increase in hydrocodone.

38. According to P-2's CURES report, on April 3, 2019 and May 2, 2019, Respondent again renewed P-2's hydrocodone prescription at 240 pills, four times the amount of prescribed hydrocodone since P-2's last visit on October 31, 2018. There are no chart notes, medical records, medical indications, or rationale related to this substantial increase in hydrocodone prescribed for P-2.

39. According to P-2's CURES report, between May 2014 and May 31, 2019, P-2 received approximately the following: 6,930 tablets of hydrocodone bitartrate acetaminophen 325/10 mg; 2,706 tablets of methadone (10 mg); 1,395 tablets of Soma (350 mg); 90 tablets of lorazepam (.5 mg); 40 tablets of alprazolam (.5 mg) and 2,055 tablets of diazepam (10 mg).

40. During this time period between May 2014 and May 31, 2019, Respondent did not perform or document any risk assessment of P-2 prior to initiating long-term use of narcotics and

combinations of controlled substances. Respondent did not have a comprehensive treatment plan that specified measurable goals and objectives used to evaluate treatment progress for P-2. Respondent did not undertake or document any compliance monitoring such as drug testing, review of CURES reports, pill counts or utilize a pain management agreement with P-2 to ensure appropriate medications used by P-2. Respondent did not evaluate P-2's progress toward established treatment objectives or evaluate other treatment goals such as patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and/or concerns such as reports of lost prescriptions or early refill requests), patient's affect (changes to mood, depression or anxiety), and accurate medical records reflecting the evaluation of treatment goals, including changes to management plan.

41. Respondent did not obtain, or document obtaining, informed consent from P-2 regarding potential risks of long-term opioid use and combined use of opioid and other controlled substances.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

42. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (b) of the Code, in that he committed gross negligence in his care and treatment of Patients P-1 and P-2, in that Respondent engaged in the conduct described above including, but not limited to, the following:

A. Respondent failed to establish a diagnosis of medical necessity for treating P-1's report of muscle skeletal pain, notably knee pain, with long-term use of opioids for chronic non-cancer pain.

B. Respondent failed to establish a diagnosis of medical necessity for treating P-2's report of muscle skeletal pain, notably back pain, with long-term use of opioids for chronic non-cancer pain.

C. Respondent did not document an adequate patient history relating to the presenting complaint at each visit for P-1 and P-2.

D. Respondent did not document an adequate physical examination to support the treatment plan for P-1 and P-2 or the prescribed medications.

E. Respondent failed to undertake any risk assessment of P-1 and P-2 prior to initiating long-term use of narcotics and combinations of controlled substances.

F. Respondent failed to have a comprehensive treatment plan that specified measurable goals and objectives used to evaluate treatment progress for both P-1 and P-2.

G. Respondent failed to obtain, or document obtaining, informed consent from P-1 and P-2, regarding potential risks of long-term opioid use and combined use of opioid and other controlled substances.

H. Respondent failed to undertake any compliance monitoring such as drug testing, review of CURES reports, or conduct pill counts with P-1 and P-2 to ensure appropriate medication use by P-1 and P-2.

I. Respondent failed to evaluate P-1 and P-2's progress toward established treatment objectives and failed to consistently evaluate other treatment goals such as patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and/or concerns such as reports of lost prescriptions or early refill requests), patient's affect (changes to mood, depression or anxiety), and accurate medical records reflecting the evaluation of treatment goals, including changes to management plan.

J. Respondent failed to place P-1 and P-2, both patients on long-term use of controlled substances (greater than 90 days) on a controlled substance contract.

K. Respondent did not maintain an accurate and current medication list for P-1 and P-2 in the patients' medical files.

L. Respondent failed to maintain adequate and accurate medical records in connection with the care and treatment of P-1 and P-2.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts)

43. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients P-1 and P-2, as more particularly alleged in paragraphs 10 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Records)

44. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2227 and 2234, as defined by 2266, of the Code, in that he failed to keep adequate and accurate medical records in his care and treatment of Patients P-1 and P-2, as more particularly alleged in paragraphs 10 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Aiding Unlawful Practice of Medicine)

45. Respondent Edmund Peter Kemprud, M.D. is subject to disciplinary action under sections 2052 and 2264 of the Code (aiding in the unlawful practice of medicine) in that Respondent engaged in the conduct described below including, but not limited to, the following:

46. On or about 2017 to 2018, Respondent worked for Relief Medical Group, Inc.[16] During his employment at Relief Medical Group, Inc., Respondent performed annual physical examinations and made prescription recommendations for patients. Respondent admitted he worked for Edward Cremata, who paid Respondent per physical examination performed.

[16] Relief Medical Group, Inc.'s Statement of Information filed on April 4, 2016 listed Edward E. Cremata as the Chief Executive Officer and Chief Financial Officer. Respondent is listed as the Secretary.

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 G28372, issued to Edmund Peter Kemprud, M.D.;

2. Revoking, suspending or denying approval of Edmund Peter Kemprud, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Edmund Peter Kemprud, 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: NOV 0 9 2020

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