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

In the Matter of the First Amended Accusation Against:	
Leon G. Robb, M.D.	**Case No. 800-2018-042718**
Physician's and Surgeon's Certificate No. A 28599	
Respondent.	

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 November 24, 2021.

IT IS SO ORDERED November 17, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
State Bar No. 155307
California Department of Justice
300 South Spring Street, Suite 1702
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **LEON G. ROBB, M.D.** **2270 Canyonback Rd.** **Los Angeles, CA 90049** **Physician's and Surgeon's Certificate No. A 28599,** Respondent.	Case No. 800-2018-042718 **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 Judith T. Alvarado, Supervising Deputy Attorney General.

2. Leon G. Robb, M.D. (Respondent) is represented in this proceeding by attorney Mark B. Guterman, Esq., whose address is: LaFollette Johnson, et al., 701 North Brand Boulevard, Suite 600, Glendale, CA 91203.

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3. On or about March 21, 1975, the Board issued Physician's and Surgeon's Certificate No. A 28599 to Leon G. Robb, M.D. (Respondent). The certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-042718 and will expire on February 28, 2022, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-042718 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 April 5, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2018-042718 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 First Amended Accusation No. 800-2018-042718. 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 First Amended 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 First Amended Accusation No. 800-2018-042718, 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 First Amended 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 First Amended 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 Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

MITIGATION

12. Respondent practiced pain management for forty-six years without prior incident. He is retiring from the practice of medicine.

CONTINGENCY

13. 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.

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14. 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.

15. 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. A 28599, issued to Respondent LEON G. ROBB, M.D., is surrendered and accepted by the Board.

1. 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.

2. 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.

3. 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 First Amended Accusation No. 800-2018-042718 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

4. 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 First Amended Accusation, No. 800-2018-042718 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 Mark B. Guterman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of

License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11-4-21

LEON G. ROBB, M.D.
Respondent

I have read and fully discussed with Respondent Leon G. Robb, 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: 11-15-21

MARK B. GUTERMAN, ESQ.
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: _____

Respectfully submitted,

ROB BONTA
Attorney General of California

Judith T. Alvarado
Digitally signed by Judith T. Alvarado
Date: 2021.11.16 10:57:41 -08'00'

JUDITH T. ALVARADO
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2018-042718

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **LEON G. ROBB, M.D.** **2270 Canyonback Rd.** **Los Angeles, CA 90049-1177** **Physician's and Surgeon's Certificate No. A 28599,** Respondent.	Case No. 800-2018-042718 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about March 21, 1975, the Medical Board issued Physician's and Surgeon's Certificate Number A 28599 to Leon G. Robb, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2022, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (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.

STATUTORY PROVISIONS

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 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.

8. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the

disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

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

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

(e) Section 2314 shall not apply to this section.

FACTUAL ALLEGATIONS

9. Respondent is an anesthesiologist. He is not board certified. He has been practicing pain management since 1975. He is currently part of a group practice in Reseda, California.

Patient 1[1]

10. Patient 1 was a 66-year-old male when he first present to Respondent's clinic on June 15, 2016. Between June 21, 2016 and April 3, 2018, Patient 1 was seen twenty-seven times by Respondent for a chief complaint of lower back pain that radiated to his right leg.

11. At his initial evaluation on June 21, 2016, Patient 1 stated that he underwent epidural shots by a prior physician, which did not help. He tried physical therapy, which "worsened pain." He was taking two Norco 5mg, three to four times a week at night and Advil. He reported

[1] The patients are identified in this First Amended Accusation by number to protect their identities.

drinking two glasses of wine two to three time a week. Patient 1 completed paperwork and an initial patient intake form, but he did not sign an opioid or pain contract. Respondent reports that all his patient sign a pain contract before they are prescribed controlled substances.[2]

In this first chart note, Respondent stated that radiologic studies were negative, except an MRI, which demonstrated some disc protrusion and foraminal narrowing, but his symptoms were inconsistent with discogenic radiculopathy. Respondent noted that Patient 1 had significant findings of lumbar degenerative facet disease. On physical exam, the patient complained of pain with deep palpation of the lower back. Respondent rendered a diagnosis of spondylosis of lumbosacral region without myelopathy or radiculopathy; disc degeneration-lumbosacral region; and chronic low back pain without sciatica. The plan was to have the patient return for diagnostic/therapeutic lumbar region intrafacet injections to diagnose significant facet disease. Respondent prescribed Percocet[3] 325/10 mg, #90 to Patient 1.

12. Patient 1 returned on June 28, 2016, for a right lumbar intrafacet injection at three levels: L3/L4, L4/L5, and L5/S1. The indication for the lumbar injections was persistent pain and that the MRI evidenced facet atrophy.

13. Patient 1 returned on July 12, 2016. He denied back pain and his visual analog scale (VAS) [pain scale] score was 6/10. Nevertheless, Respondent performed a second facet nerve block injection.

14. Patient 1 returned approximately two weeks later on July 26, 2016. His VAS was 5/10, but he complained that he was in continuous pain. Family and work demands increased his lumbar pain. No physical examination was noted. An assessment of spondylosis with back pain and disc [herniation] without radiculopathy was rendered. Respondent prescribed Percocet 325/10 mg, #90; Soma[4] #90; and ibuprofen #90 for Patient 1.

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[2] Respondent also acknowledged that his records for the patients discussed in this First Amended Accusation may be incomplete as he has converted from paper charts, to one form of electronic records (EMR), then a second form of EMR in 2018, and portions of charts are or may be missing. Not only are Respondent's medical records for the five patients in various formats, they are not kept in chronological order, are difficult to follow, and are somewhat illegible.

[3] Percocet is a combination of oxycodone, an opioid pain medication, and acetaminophen. It is a dangerous drug pursuant to section 4022 of the Code.

[4] Soma is a muscle relaxant and a dangerous drug, pursuant to section 4022 of the Code.

15. On August 24, 2016, Respondent performed a right lumbar facet radio-frequency denervation procedure on Patient 1. The patient's medications were refilled on August 23, 2016. He was given Percocet 325/10 mg, #90; Soma 350 mg, #90; and ibuprofen 600 mg, 1 tablet three times per day.

16. A left lumber facet procedure was to be performed on September 22, 2016, but was cancelled. Patient 1's medications of Percocet, Soma and ibuprofen were refilled in the same doses.

17. Patient 1 was seen on October 19, 2016. The plan was for a "left facet denervation procedure." His medications were refilled by Respondent.

18. The left lumbar facet radio-frequency denervation procedure was performed by Respondent on Patient 1 on October 27, 2016.

19. On November 17, 2016, a left transforaminal lumbar epidural was performed by Respondent on Patient 1. Patient 1's medications were refilled by Respondent on November 15, 2016.

20. The chart entry for December 13, 2016 has only vital signs noted and a list of medications. It appears that the medications were not refills, as it was too soon for refills.

21. Patient 1 was seen on January 1, 2017. He was noted to be stable. Patient 1 requested a back brace. His medications were refilled by Respondent.

22. On January 24, 2017, Respondent performed lumbar facet joint injections under fluoroscopic guidance at levels L3/L4, L4/L5, and L5/S1 on Patient 1. The indication for the procedure was that the patient complained of severe low back pain. He stated he had relief from the denervation procedures. Patient 1 was traveling for work and had increased pain. Patient 1 also complained of insomnia. Respondent prescribed Ambien[5] 10 mg, #30, 1 tablet at bedtime.[6]

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[5] Ambien is a sedative-hypnotic. It is used to treat insomnia. It is a dangerous drug pursuant to section 4022 of the Code.

[6] According to CURES, Patient 1 had been receiving Ambien from another provider. The Controlled Substance Utilization Review and Evaluation System or CURES is a database maintained by the Department of Justice, which tracks all Schedule II, III, and IV controlled substances dispensed in California.

23. Patient 1 returned on February 22, 2017, reporting that air travel increased nocturnal pain. Patient 1 was noted to be stable. The risk of medications was discussed. Physiotherapy was to be considered. Patient 1's prescriptions for Percocet, Soma, and Ambien were refilled.

24. Patient 1 had an appointment for March 22, 2017. He presented for his appointment, but stated he had a family emergency and had to leave. His medications were nevertheless, refilled.

25. Patient 1 returned on April 18, 2017. He stated he was leaving for New Orleans. He complained of back pain. No physical examination was performed and no assessment was rendered. Patient 1's medications were refilled by Respondent as follows: Oxycodone 30 mg, #90, 1 tablet every 8 hours; Soma 350 mg, #90, 1 tablet three times per day; Ambien 10 mg, #30, 1 tablet at bedtime; and ibuprofen 600 mg #90, 1 tablet three times per day.

26. Patient 1 returned on May 17, 2017. He wanted to "go over procedures." No physical examination was performed, no assessment was rendered, however, Patient 1's medications were refilled. Patient 1 was a "no show" for his appointment on May 20, 2017.

27. Patient 1 returned on June 15, 2017, for bilateral facet injections. In addition to the facet injections, his medications were refilled.

28. Patient 1 returned on July 25, 2017, with complaints of back pain due to stress. The patient was noted to have lumbar instability with increased back pain and elbow strain. An assessment of epicondylitis, back pain, and spondylitis was rendered. Respondent refilled Patient 1's medications.

29. Patient 1 returned on August 22, 2017, for refills of his medications. His back was noted to be unstable. His medications were refilled.

30. Respondent performed facet injections on Patient 1 on September 15, 2017. Patient 1 returned on September 19, 2017, stating he got relief from the injections. His medications were refilled.

31. Patient 1 returned on November 15, 2017. He reported lower back pain and bilateral elbow pain. An impression of spondylysis with facet atrophy and medial epicondylitis, bilateral, was rendered. Respondent refilled Patient 1's medications. Patient 1 returned the next day,

November 16, 2017, complaining of lower back weakness and left leg pain. X-rays showed foraminal stenosis on the left at L4-L5.

32. On December 14, 2017, Respondent performed bilateral facet injections on Patient 1 for spondylosis with facet atrophy and severe back strain.

33. On January 7, 2018, Patient 1 returned for a follow-up. He had complaints of tenderness and instability. The plan was to refill the patient's medications of Percocet, Soma, ibuprofen and Ambien. He was to have bilateral radio-frequency facet injections.

34. Patient 1 returned on January 11, 2018, reporting that he got relief from the injections for three weeks. He complained of low back pain, bilateral leg pain and that the medications helped with the pain. His medications were refilled.

35. Patient 1 returned to Respondent on April 3, 2018, with complaints of "back pain with facet." The patient had instability. The plan was for radio-frequency denervation of the lumbar region.

36. A note dated April 9, 2018 states that C.W., the patient's wife, called. She reported that Patient 1 was an addict and had been hospitalized. He was in court now on a DUI. She also stated Patient 1 takes multiple opiates. She reported that she does not see him in pain. A second note of the same date regarding a second telephone call with Patient 1's wife states that "Wife says he is a drug addict, has been in rehab in the past. Got drugs from different sources. Has been in court for DUI."

37. Patient 1 did not return to Respondent's office.

Patient 2

38. Patient 2, was a 31-year-old female at the time of her first visit with Respondent on March 15, 2017. Between March 15, 2017 and February 3, 2021, Patient 2 saw Respondent twenty-nine times for a chief complaint of back pain that radiated down to her right leg.

39. At her initial visit with Respondent, Patient 2 reported pain in her right leg, which was severe and idiopathic at onset. She had difficulty with standing. A diagnosis after a CT scan from a prior provider was sciatica. She had limited pre-op therapy and no epidural treatment. Patient 2 underwent lumbar disc surgery, which provided relief for about 1 year with recurrence.

Patient 2 had a second surgery by the same surgeon, followed by physiotherapy, ibuprofen, and hydrocodone. Her pain persisted and recently became severe, followed by an emergency room visit where Patient 2 was given the pain medication Norco, which did not provide sufficient relief. She was referred to Respondent for evaluation and treatment. Patient 2 stated that a friend gave her oxycodone 30 mg, which ameliorated her pain.

Patient 2 described her pain as horrible to excruciating which increased with activity, including walking, sitting, and standing. Dampness and cold weather created more pain as did sexual activity. Pain in her low back was burning, with tingling and aching down the right leg to the foot. A physical examination demonstrated weakness to the right lower extremity. Deep tendon reflexes were hypoactive. The right anterior thigh and calf demonstrated decreased sensation to pin scratch and vibration. There was lumbar tenderness from L3 to sacrum. Sciatic notch tenderness was noted on the right. An impression of post laminectomy syndrome, right lumbar radiculopathy was rendered. The plan was for a caudal epidural with epidurogram under fluoroscopy. The risks and benefits were explained.

40. The epidurogram was scheduled for April 6, 2017, but the patient did not show. She presented on May 3, 2017, and underwent a caudal epidural, which was noted as uncomplicated. Respondent prescribed oxycodone 10 mg, #90, take 1-3 tablets per day PRN (as needed) for pain and Neurontin[7] 300 mg, #90, 1 tablet, three times per day (tid). The medications were listed as a "refill," however, this was the first time Respondent prescribed medications for Patient 2.

41. Between May 4, 2017 and May 16, 2017, Patient 2's husband called advising that Patient 2 was in a lot of pain, suffering from a headache. He repeatedly requested a prescription for Xanax. Patient 2 presented on May 17, 2017. She was requesting an increase in her dose of oxycodone. Patient 2 stated the injection only worked for 2 days and after that the pain returned. Prozac[8] 20 mg, #30, was added to her medications. Patient 2 did not show for her next

[7] Neurontin is a anti-epileptic medication used to treat seizures and nerve pain. It is a dangerous drug pursuant to section 4022 of the Code.

[8] Prozac is a Selective Serotonin Reuptake Inhibitor (SSRI). It is used to treat depression. It is a dangerous drug pursuant to section 4022 of the Code.

appointment of May 30, 2017. She was seen on June 8, 2017, and received a refill of her medications. No physical examination was performed and no assessment was rendered.

42. A caudal epidural was performed on Patient 2 on June 20, 2017. She returned on July 12, 2017, for an episodic check. She reported lower back pain of 9/10. No physical examination was performed and no assessment was rendered. Respondent refilled her prescriptions.

43. Patient 2 did not show for her August 2, 2017 appointment. A note dated August 16, 2017, states that Patient 2 attempted to fill a lost prescription from June 8, 2017, which had been called in. Patient 2 then did not show up for or cancelled her next two scheduled appointments. Respondent did not recognize Patient 2's behavior as a red flag for drug seeking or diversion.

44. Patient 2 underwent another caudal epidural on September 13, 2017. Her medications were also refilled and Xanax[9] was added to her regimen: Neurontin 300 mg #90, tid; oxycodone 10 mg, #90, 1-3 tablets a day PRN; Prozac 20 mg, #30; and Xanax 2 mg. On September 18, 2017, the patient's husband called and stated the patient was in pain and that the procedure did not work. Patient 2 cancelled her October 4, 2017 appointment. Respondent noted that the patient's husband may be stealing her medications.

45. At her November 29, 2017 visit, Patient 2 reported that she had lower back pain and bilateral lower extremity pain. A limited examination was performed and an assessment of failed back surgery times two was rendered. Respondent increased Patient 2's medication to Neurontin 300 mg, #90, tid; oxycodone 10 mg, #120, increased to every 6 hours prn pain; Prozac 20 mg #30; and Xanax 2 mg, #60, 1 tablet twice a day (bid).

46. The note for January 3, 2018 shows "N/S" or no show. However, a "SOAP"[10] note is prepared, appearing as if Patient 2 presented for the visit. Her medications were increased as

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[9] Xanax is a benzodiazepine anxiolytic. It is a dangerous drug pursuant to section 4022 of the Code. On August 31, 2016, the Federal Drug Administration issued a Black Box Warning regarding the combined prescribing of opioids and benzodiazepines that depress the central nervous system and has resulted in serious side effects, including slowed or difficult breathing and death.

[10] The SOAP Note is an acronym for Subjective, Objective, Assessment and Plan. It is a method of organized documentation for healthcare providers.

follows: Oxycontin[11] 20 mg, #60, 1 tablet every 12 hours; Xanax 2 mg, #60, bid; Prozac 20 mg, #30; oxycodone 10 mg, #90; and Neurontin 300 mg tid #90.

47. The patient signed a pain contract on January 10, 2018.

48. On February 8, 2018, Patient 2 reported that her insurance did not pay for oxycontin. She requested a change in medications for control of back pain and otherwise poor health. A limited physical exam was performed showing numbness of the lower back and weakness in her legs. An assessment of status-post two spine surgeries was rendered. Her medication was changed to: Xanax 2 mg, #60, bid; Prozac 20 mg, #30; oxycodone 10 mg, #90, and Neurontin 300 mg #90.

49. At her next appointment of March 8, 2018, Patient 2 complained of pain at level of 10/10. She wanted to review her medications. Respondent increased her oxycodone 10 mg to 1 tablet every 6 hours, #120. Five days later, on March 13, 2018, the patient called stating she wanted to go on Percocet. She reported her pain as a 10/10. Respondent did not appreciate this call as a red flag for drug seeking behavior or diversion.

50. At Patient 2's next visit on April 5, 2018, Respondent again increased her pain medication to: oxycodone 20 mg, #90, 1 tablet every 8 hours or ½ tablet every 4 hours. A limited physical examination was positive for radiculopathy, straight leg raise testing was positive, a tender back, a scar, and numbness were noted. No assessment was rendered. An epidural was planned.

51. From October 18, 2018 to January 17, 2020, Patient 2 was seen by different providers. Patient 2's opioid dosing was being tapered. She demanded her care be returned to Respondent.

52. Patient 2 returned to Respondent's care on February 20, 2020. He placed her back on Xanax 0.5 mg, tid, although a prior note by Patient 2's prior provider dated January 17, 2020 stated that she had not had Xanax since October 15, 2019. Respondent refilled her Percocet and muscle relaxant, tizanidine.

[11] Oxycontin is an extended release from of the medication, oxycodone. It is a dangerous drug pursuant to section 4022 of the Code.

53. Beginning on March 18, 2020, Respondent provided care to Patient 2 via telemedicine due to the COVID-19 pandemic. On this visit, he started her on indomethacin[12] 50 mg, tid (no amount listed). Telemedicine visits were held on June 2, 2020 and July 3, 2020. At the July 3, 2020 visit, Respondent placed Patient 2 back on oxycodone 20 mg, every 8 hours.

54. Respondent restarted Percocet 10-325 mg, #120, every 6 hours, along with oxycodone 20 mg, #90, every 8 hours, prn as needed for pain, on October 21, 2020.

55. Respondent's last encounter noted in the chart is dated February 3, 2021. At that visit, a right transforaminal epidural was performed at L4/L5 and L5/S1. Patient 2 was continued on Xanax 2 mg, #60, bid; indomethacin 50 mg, #90; oxycodone 20 mg, #90 1 tablet every 8 hours prn pain; Percocet 10-325 mg, #120, 1 tablet every 6 hours prn pain; tizanidine 4 mg, #30; and Neurontin 300 mg, #90, tid.

Patient 3

56. Patient 3 was a 33-year-old male at the time of his first visit with Respondent on March 19, 2020. He is noted to be the husband of Patient 2. Respondent has only one chart entry for Patient 3, a note dated March 19, 2020.

57. According to CURES, Respondent prescribed Percocet, Norco and Xanax for Patient 3 from March 18, 2017 through January 18, 2018. There are no chart notes to correspond to this prescribing.

58. Patient 3's chart indicates that he was seen by different providers on November 12, 2019 and December 9, 2019. When he was seen by Respondent on March 19, 2020, he complained of neck and back pain. Patient 3 stated that he had not seen Respondent for almost 2 years. Patient 3 stated while he had been in prison, he had chronic pain that caused sleeplessness, difficulty walking, and lower extremity pain. He also had an excision of cyst of the pituitary gland and was taking steroids. Patient 3 desired to get back on a regimen to control his back pain. Respondent rendered an assessment of backache, cervicalgia, pituitary cyst, pituitary disorder, insulin-dependent diabetic with neurological complications-long term, lumber disc disorder,

[12] Indomethacin is a nonsteroidal anti-inflammatory medication used to relieve pain, swelling and joint stiffness.

adjustment reaction with anxiety and depression. He prescribed Percocet 325/10 mg, #60, 1 tablet, bid; and Xanax 0.5 mg, #90, tid, for Patient 3. Respondent did not see Patient 3 again, according to the chart notes.

59. Patient 3 was discharged from the group's practice on August 20, 2020, by another provider for disruptive behavior after he was denied Percocet.

Patient 4

60. Patient 4 was a 28-year-old female when she first treated with Respondent on August 11, 2015. She has had forty-seven visits with Respondent from August 11, 2015 through January 13, 2021, and remains his patient.

61. Patient 4 was referred to Respondent by another physician for pain management. She was taking oxycodone 30 mg, #90, as needed for pain, and reported that sometimes she took 4 pills a day. Her onset of pain was idiopathic in 2012, but she had a motor vehicle accident in 2013. Patient 4 stated she was in constant excruciating low back pain, spreading to the posterior lateral aspect of the leg down to the foot. Her back pain was sharp and throbbing. Her anterior thigh tingled, ached and throbbed. Her left knee pain was sharp. There was also an indication of left arm tingling, throbbing and aching. Notes from a chiropractor indicate lumbar spine facet syndrome, spine strain/sprain and sacroiliac joint sprain/strain. Patient 4 denied the use of alcohol or illicit drugs.

A physical exam showed mild antalgic gait, favoring the left leg. Weakness was demonstrated on repeated toe-raise testing on the left. A positive bowstring sign on the left was noted. Extension in the prone position produced left anterior thigh pain. Decreased sensation to scratch and tuning fork over thigh, knee, and lateral leg to the ankle was noted. The medial aspect of the left foot had decreased sensation. There was no atrophy or wasting. The lungs were clear, the heart had a regular sinus rhythm with no murmurs. Imaging studies and an MRI from August 16, 2013 were reviewed and noted as negative.

An impression of persistent lumbar symptomatology with lower extremity radiculopathy was rendered. Respondent noted, "Negative MRI, but may benefit from epidural therapy. Refer for orthopedic consult. Alternative is further physical therapy." Respondent prescribed

Oxycontin 30 mg; tid. He noted that Patient 4 was reluctant to try Neurontin. Her medication was changed to oxycodone on August 15, 2015.

62. Patient 4 continued to treat with Respondent about once a month. Her medication remained unchanged. She was started on Neurontin 300 mg, # 90, tid, on May 18, 2016. She received her first steroid injection on October 4, 2016.

63. On February 23, 2017, Patient 4 began to complain of knee swelling and arm pain. On June 16, 2017, she underwent an epidural block with epidurography. Patient 4 continued to treat with Respondent approximately every month and remained on the same medications. Respondent noted that Patient 4 could not undergo epidurals under local anesthesia, they must be performed in the hospital.

64. On March 12, 2018, Patient 4 stated her ex-boyfriend hit her and now she was having a hard time hearing out of her right ear. Respondent refilled her prescriptions for oxycodone 30 mg, #90, tid; Neurontin 300 mg, #90, tid; and started Soma 350 mg, #90, tid.

65. On May 10, 2018, Patient 4 underwent an epidural block and epidurography. She continued to treat with Respondent monthly, receiving the same medications. On November 8, 2018, she reported opioid induced constipation. She remained on the same medications with Movantik[13] 25 mg, #25, added to address the constipation issue.

66. On December 10, 2018, Patient 4 complained of left leg pain and back pain. She reported that she had struck her left knee and had swelling and pain. Her weight bearing was affected due to the knee issue. On examination, her knee had tenderness with no swelling and it was difficult to bend. An assessment of left knee injury, left knee pain, left knee sprain, lumbar disc disease with radiculopathy, lumbago due to displacement of intervertebral disc, constipation due to pain medication-drug induced constipation, was rendered. She was continued on the same medications.

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[13] Movantik is a prescription medication used to treat opioid induced constipation in adults with chronic, non-cancer pain.

67. On January 19, 2019, Patient 4 continued to complain of the left knee issues and her back pain and tenderness persisted. Her medications were continued and Xanax 0.5 mg, #90, 1-2 tablets, bid, was added to her regimen.

68. Patient 4 continued to see Respondent monthly. Her medications continued. On July 24, 2019, Patient 4 reported "recent ER visits" for severe extremity pain and spasms. She stated she received intramuscular steroids and an opioid injection. Her symptoms resolved in several days. Respondent refilled her medications and added a Medrol Dosepak[14] to her medication regimen.

69. Patient 4 continued to see Respondent monthly and received the same medications, including the Medrol Dosepak, up to September 18, 2019. On November 6, 2019, she underwent a lumbar epidural with epidurogram under conscious sedation. On February 19, 2020 Patient 4 underwent a genicular nerve block of left knee. She was to return for "possible radiofrequency/denervation funicular nerves".

70. From March 19, 2020 through October 28, 2020 Respondent held telephone or telehealth visits with Patient 4 either monthly or every other month. Patient 4 would describe her symptoms and Respondent would refill her medications.

71. On November 18, 2020, Patient 4 presented for an in-person visit with Respondent. Her lumbar pain persisted with left radiculopathy. On examination she had lumbar tenderness, restricted motion with flexion, extension, rotation and side bending. An assessment of left knee pain, knee ankylosis, degenerative arthritis of left knee, lumbar disc disease with radiculopathy-intervertebral disc disorders with radiculopathy, lumbar region, was rendered. Respondent noted that Patient 4 was dependent on pain medication and had drug induced constipation. Respondent changed Patient 4's medications to Xanax to 2 mg, #90, 1 tablet tid; Soma 350 mg, #90, 1 tablet tid; Neurontin 300 mg, #120, 1 capsule every 6 hours; Movantik 25 mg, #30, 1 tablet every morning; oxycodone 30 mg, #120, 1 tablet every 6 hours.

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[14] A Medrol Dosepak is a tapering dose of methylprednisolone, used to treat inflammatory conditions. It is a dangerous drug pursuant to section 4022 of the Code.

72. Respondent resumed telehealth visits with Patient 4 on December 22, 2020 and January 13, 2021. She was continued on the same medications.

Patient 5

73. Patient 5 was 28-years-old when she first presented to Respondent's office on July 27, 2016. Between July 28, 2016 and January 10, 2019, Patient 5 had twenty-seven visits with Respondent. Between July 27, 2016 and May 8, 2017, Patient 5 received twenty-nine prescriptions for tramadol, 50 mg. Patient 5's tramadol 50 mg dose started at #60 tablets. It was increased to #90 tablets on March 24, 2017, then lowered to #60 tablets on April 10, 2017 (but, this was an early refill). Her dose was then increased to #90 tablets on July 25, 2017, where it remained until December 13, 2017. On December 13, 2017 the dose was increased to #240 tablets. The last refill reflected on CURES was on May 8, 2018, for #240 tablets.

74. When Patient 5 began treating with Respondent she was in training to become a registered nurse. She reported that she hurt her back moving a patient in 2015. However, she had a seven-year history of episodic pain secondary to very active dancing. Her pain was constant and variable from uncomfortable to horrible. It was relieved with an application of topical cream, lying, or sitting. Her pain was worse with pulling, lifting, bending, turning, or twisting. She also complained of dysmenorrhea. Patient 5 stated that she took naproxen and ibuprofen and was prescribed tramadol and Flexeril.[15]

On examination, she was in no distress, was oriented, had no indication of somatization in the Wahler Physical System Inventory test. She had no indication of depression. Repeated toe raises did not induce fatigue. Supine straight leg raising caused low back pain. Prone extension was positive. Tenderness to deep palpation of the lumbar paraspinals was present. Deep tendon reflexes were satisfactory. Reactions to vibration and pin scratch were decreased on the right calf. Straight-leg raising did not evoke positive sciatic stretch signs. No atrophy or wasting of lower extremities was noted. Palpation of the abdomen was negative for rebound or tenderness. The heart had a regular sinus rhythm with no murmur. The lungs were clear. An assessment of

[15] Flexeril or cyclobenzaprine is a skeletal muscle relaxant. It is used to treat muscle spasms. It is a dangerous drug pursuant to section 4022 of the Code.

spondylosis with radiculopathy, back pain, and dysmenorrhea was rendered. Respondent prescribed Motrin 600 mg, #120, 1 tablet four times per day; tramadol 50 mg, #60, 2 tablets twice a day (bid); and Flexeril 5 mg, #60, bid.

75. On December 14, 2016, Respondent noted that Patient 5 completed her nursing program. Her diagnosis was spondylosis with radiculopathy. She remained on tramadol and Flexeril. On March 22, 2017, Respondent increased the dose of tramadol to #90 tablets and Flexeril to #90. Motrin was discontinued as it upset the patient's stomach.

76. Patient 5 continued to see Respondent monthly for pain medication refills. On February 8, 2018, the patient requested to add Motrin back to her medication regimen. Her tramadol was increased to #240 tablets as well. She continued on this dose for the next six months. On August 23, 2018, cyclobenzaprine 10 mg, #90, three times a day, was added to Patient 5's medication regimen.

77. On September 26, 2018, Respondent noted "no finding" on physical the examination. Nevertheless, he prescribed tramadol 50 mg, #90 for Patient 5. She is continued on Flexeril and tramadol #90 tablets through October 31, 2018. On November 21, 2018, Patient 5 complained of back and leg pain. On examination, she had mild antalgic gait, lower extremity pain, radiculopathy, and neurological findings were positive with back tenderness. An assessment of spondylosis of the lumbosacral region without myelopathy or radiculopathy, lumbago with sciatica right side, and dysmenorrhea was rendered. Respondent increased Patient 5's dose of tramadol 50 mg to #240 pills again.

78. Patient 5's last visit with Respondent was on January 10, 2019. He noted that Patient 5 was deteriorating. He recommended a lumbar steroid injection. Respondent refilled the tramadol 50 mg, #240, and restarted Flexeril 10 mg, #30, 1 tablet at bedtime.

Standard of Care

79. The standard of care for radio-frequency ablation for the medial branches of the posterior primary ramus require a thorough physical examination pointing to the diagnosis of facet syndrome. Imaging should correlate appropriately. A diagnostic block, including a pain diary, showing more than 80% relief on repeated blocks is also standard of care. If the diagnostic

block and objective physical examination findings support the assessment, then destructive lesioning of the medial branch can be offered to the patient.

80. The standard of care for epidural injections includes a verifiable nerve root lesion on imaging and/or nerve conduction studies. No more than four injections a year are indicated. Appropriate patient response includes relief lasting at least three weeks between injections. Monitoring and recording of potential side effects from repeated exposures to off-label steroids should be indicated in the record.

81. A history and physical, including a complete intake must be performed at the outset when prescribing controlled substances. Informed consent for treatment with controlled substances must be obtained from the patient. This may include a "pain agreement." Risks and benefits of treatment with controlled substances must be explained. Prior to prescribing opioids, there must be an identifiable, documented diagnosis causing chronic pain in the patient. Opioid prescriptions must not be considered an ongoing ever-escalating therapeutic plan. Rather, it should be a part of a comprehensive treatment plan that includes referrals to subspecialists, including fellowship trained pain management specialists, addiction specialists, psychiatrists, physical therapists, and surgeons, when appropriate.

82. Treatment objectives, including specifically identifiable pain management goals must be clearly identified in the rendering of the provider's plan. Periodic review by the provider of the patient's response to treatment should be documented in the treatment plan and adjusted accordingly. A clear plan of action by the physician must be legible and logical. Treatment objectives should be clearly delineated and substantiated in the plan section. Response to therapy must be clearly indicated in the treatment plan. If there is a failure to respond adequately to the stated goals of treatment, then it is incumbent on the prescriber to taper and stop the opioid prescriptions.

83. In addition to regular assessment of efficacy of treatment, assessment of possible diversion is incumbent on the prescriber. Regular drug screens (urine or other), CURES review, or other objective means of review must be conducted. If a urine drug screen identifies illicit substances or if diversion is suspected, a frank discussion must be had and appear in the patient's

record. If analysis indicates diversion, prescriptions for scheduled medications must be stopped. Suspicion for use of illicit substances or misuse of controlled substances requires referral to an addiction specialist for patient management. It is problematic to prescribe to a known addict without the involvement of a sub-specialist. Continued unexplained increases in dose requirements without concurrent improvement in quality-of-life and participation in valued activities should spur a referral to a pain management specialist for an opinion to help guide treatment.

84. There is unequivocal peer-reviewed literature that demonstrates that the chronic use of opioid medications are associate with increased depression, opioid tolerance, addiction potential, dependence, decreased immune function, risk to the fetus in a pregnant patient, significantly abnormal endocrine function, including osteoporosis and fractures, and opioid induced hyperalgesia. These negative effects should be discussed with the patient and noted in an informed consent document. In addition, there is relative contraindication to co-prescribe benzodiazepine medications and opioids concurrently given the risk of respiratory depression and death.

85. A good faith examination consists of vital signs. Also, a visual analog scale for pain assessment is advocated in the absence of any objectifiable scan to indicate the patient's pain; it should also be documented. A focused system evaluation is indicated. Copying and pasting from one visit to another may indicate that an examination may not have been performed.

86. The failure to intervene when life is at stake represents the most important standard of care followed by all physicians. When evidence of self-harm or addiction is witnessed, there is a duty to intervene. The physician should stop the prescribing, taper the prescriptions, provide appropriate psychiatric referral and involve family members to the extent permitted by the patient.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

87. Respondent Leon G. Robb, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that his care and treatment of three patients was grossly negligent. The circumstances are as follows:

Patient 1

88. The facts and allegations set forth in paragraphs 10 through 37 and 79 through 86, are incorporated herein, as if fully set forth.

89. Respondent was grossly negligent in his care and treatment of Patient 1 in that:

A. Many of his handwritten notes do not include an analysis of the patient's response to opioid therapy, including addressing quality of life, goals or compliance to therapy.

B. Physical examinations do not include vital signs or a visual analog pain scale score.

C. There was no attempt to check for diversion, there was no urine drug screening, CURES was not checked, and a pill count was never conducted.

D. His continued prescribing of opioid therapy was not justified.

Patient 2

90. The facts and allegations set forth in paragraphs 38 through 55 and 79 through 86, are incorporated herein, as if fully set forth.

91. Respondent was grossly negligent in his care and treatment of Patient 2 in that:

A. There was no opioid contract until January 1, 2018, a year after Respondent started prescribing opioids for Patient 2.

B. There was no urine drug screening conducted, CURES was not checked, and there were no pill counts to ensure there was no diversion of medication.

C. There was no associated physical examination or intermittent plan in response to therapy or an assessment of effectiveness of therapy.

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D. There were multiple red flag findings, including the illegal use of medication by the patient at her first visit and the patient's husband repeatedly calling and requesting controlled substances.

E. The continued prescription of opioid therapy was an extreme departure from the standard of care.

Patient 4

92. The facts and allegations set forth in paragraphs 60 through 72 and 79 through 86, are incorporated herein, as if fully set forth.

93. Respondent was grossly negligent in his care and treatment of Patient 4 in that:

A. There were no urine drug screen results in the patient's chart, CURES was not checked, and there were no pill counts to check for medication diversion.

B. There were no associated physical examinations, no intermittent plans in response to therapy, and no assessment of the effectiveness of therapy.

C. Morphine Milligram Equivalent (MME)[16] dosing exceeded 90 mg when Patient 4 was given up to 120 mg of MME per day, without additional documentation regarding medication effectiveness and ultimate therapy goals.

D. The continued prescription of opioid therapy was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

94. Respondent Leon G. Robb, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that his care and treatment of four patients was negligent. The circumstances are as follows:

Patient 1

95. The facts and allegations set forth in paragraphs 10 through 37 and 79 through 86, are incorporated herein, as if fully set forth.

[16] MME is a numerical standard against which most opioids can be compared. It is used to determine how different opioids relate to each other, using morphine as the standard.

96. Respondent was negligent in his care and treatment of Patient 1 in that:

A. Many of his handwritten notes do not include an analysis of the patient's response to opioid therapy, including addressing quality of life, goals or compliance to therapy.

B. Physical examinations do not include vital signs or a visual analog pain scale score.

C. There was no attempt to check for diversion, there was no urine drug screening, CURES was not checked, and a pill count was never conducted.

D. His continued prescribing of opioid therapy was not justified.

E. He failed to conduct a physical examination to support a diagnosis of lumbar facet syndrome. An MRI showed normal facets at L3, L4, and L5, which were the targets of repeated destructive procedures.

F. There does not appear to be diagnostic blocks recorded or a response to the procedures recorded, prior to a decision to move ahead to nerve destruction.

G. There was no record of informed consent from the patient.

Patient 2

97. The facts and allegations set forth in paragraphs 38 through 55 and 79 through 86, are incorporated herein, as if fully set forth.

98. Respondent was negligent in his care and treatment of Patient 2 in that:

A. There was no opioid contract until January 1, 2018, a year after Respondent started prescribing opioids for Patient 2.

B. There was no urine drug screening conducted, CURES was not checked, and there were no pill counts to ensure there was no diversion of medication.

C. There was no associated physical examination or intermittent plan in response to therapy or an assessment of effectiveness of therapy.

D. There were multiple red flag findings, including the illegal use of medication by the patient at her first visit and the patient's husband repeatedly calling and requesting controlled substances.

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E. The continued prescription of opioid therapy was a departure from the standard of care.

F. There does not appear to be a physical examination which supports a diagnosis of lumbar radiculopathy.

G. MRI imaging fails to show any nerve root impingement.

H. Indications for repeated caudal epidural injections is "laminectomy." This is not an accepted diagnosis which warrants an epidural injection.

Patient 4

99. The facts and allegations set forth in paragraphs 60 through 72 and 79 through 86, are incorporated herein, as if fully set forth.

100. Respondent was negligent in his care and treatment of Patient 4 in that:

A. There were no urine drug screen results in the patient's chart, CURES was not checked, and there were no pill counts to check for medication diversion.

B. There were no associated physical examinations, no intermittent plans in response to therapy, and no assessment of the effectiveness of therapy.

C. Morphine Milligram Equivalent (MME) dosing exceeded 90 mg when Patient 4 was given up to 120 mg of MME per day, without additional documentation regarding medication effectiveness and ultimate therapy goals.

D. The continued prescription of opioid therapy was a departure from the standard of care.

E. There does not appear to be a physical examination supporting a diagnosis of lumbar radiculopathy or facet disease. MRI imaging is relatively normal in reference to the age of the patient. Two independent consultants, an orthopedist and a chiropractor, indicated that there were no significant spinal lesions requiring treatment other than rehabilitation.

F. Repeated epidural and facet injections were not indicated.

Patient 5

101. The facts and allegations set forth in paragraphs 73 through 86, are incorporated herein, as if fully set forth.

102. Respondent was negligent in his care and treatment of Patient 5 in that:

A. He failed to conduct a good faith physical examination at subsequent visits and there was no appropriate response to therapy.

B. He failed to evaluate the potential for abuse of tramadol by the patient. The continued use of Flexeril in excess of ten days was questionable, as it is recommended for short-term use.

C. The continued prescribing of controlled substance medications is negligence.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Medical Examination)

103. Respondent Leon G. Robb, M.D. is subject to disciplinary action under section 2242 of the Code, in that he prescribed dangerous drugs to five patients without proper medical examinations and without medical indication. The circumstances are as follows:

104. The facts and allegations set forth in paragraphs 10 through 86, are incorporated herein, as if fully set forth.

105. Respondent prescribed dangerous drugs to Patients 1 through 5, including opioid medications, without conducting complete examinations and without medical indication, in violation of section 2242 of the Code.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

106. Respondent Leon G. Robb, M.D. is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records for Patients 1 through 5. The circumstances are as follows:

107. The facts and allegations set forth in paragraphs 10 through 86, are incorporated herein, 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 28599, issued to Leon G. Robb, M.D.;

2. Revoking, suspending or denying approval of Leon G. Robb, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Leon G. Robb, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. If disciplined, ordering Leon G. Robb, M.D. to disclose his discipline to patients as required by section 2228.1 of the Code; and

5. Taking such other and further action as deemed necessary and proper.

DATED: APR 29 2021

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

LA2021601178