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

In the Matter of the Accusation Against: Benjamin Shwachman, M.D. Physician's & Surgeon's Certificate No. G 11026 Respondent.	Case No. 800-2018-043920

DECISION and ORDER

The attached Stipulated Settlement and Disciplinary 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. January 7, 2022.

IT IS SO ORDERED December 9, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
EDWARD KIM
Deputy Attorney General
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California Department of Justice
300 So. 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 Accusation Against: **BENJAMIN SHWACHMAN, M.D.** **P.O. Box 4157** **Covina, CA 91723** **Physician's and Surgeon's Certificate No. G 11026,** Respondent.	Case No. 800-2018-043920 OAH No. 2021080467 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Benjamin Shwachman, M.D. (Respondent) is represented in this proceeding by attorney Joel Bruce Douglas, Esq., whose address is: 355 South Grand Ave., Ste. 1750, Los Angeles, CA 90071-1562.

3. On or about August 9, 1965, the Board issued Physician's and Surgeon's Certificate No. G 11026 to Benjamin Shwachman, M.D. (Respondent). The Physician's and Surgeon's

Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-043920, and will expire on July 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-043920 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 29, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-043920 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-043920. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-043920, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent does not contest that at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation 800-2018-043920, and that he has thereby subjected his license to disciplinary action.

9. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the imposition of discipline by the Board as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, 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 Settlement 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.

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

12. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above entitled matter.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 11026 issued to Respondent Benjamin Shwachman, M.D. (Respondent) is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4), with the following attendant terms and conditions:

1. PUBLIC REPRIMAND.

The Public Reprimand issued in connection with Accusation No. 800-2018-043920, against Respondent is as follows:

As alleged in Accusation No. 800-2018-043920, you failed to maintain adequate and adequate records as required by section 2266 of the Business and Professions Code on four occasions between November 2015 and April 2018 in connection with your care of Patient 1, on three occasions between March and November 2016 in connection with your care of Patient 2, and on five occasions between April 2016 and December 2017 in connection with your care of Patient 3.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the prescribing practices course within the designated time period, Respondent shall receive a notification from

the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the prescribing practices course has been completed. Failure to successfully complete the prescribing practices course outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the medical record keeping course within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the medical record keeping course has been completed. Failure to successfully complete the medical record keeping course outlined above shall constitute unprofessional

conduct and is grounds for further disciplinary action.

ACCEPTANCE

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

DATED: 09/02/21

BENJAMIN SHWACHMAN, M.D.
Respondent

I have read and fully discussed with Respondent Benjamin Shwachman, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/8/21

JOEL BRUCE DOUGLAS, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 9-9-21

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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64499255

Exhibit A

Accusation No. 800-2018-043920

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

In the Matter of the Accusation Against: **BENJAMIN SHWACHMAN, M.D.** **Post Office Box 4157** **Covina, California 91723** **Physician's and Surgeon's Certificate** **G No. 11026,** Respondent.	Case No. 800-2018-043920 **A C C U S A T I O N**

PARTIES

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

2. On August 9, 1965, the Board issued Physician's and Surgeon's Certificate Number G 11026 to Benjamin Shwachman, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code, states:

> 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.

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

FACTUAL ALLEGATIONS

7. From at least 2012 to the present, Respondent practiced medicine in private practice as a board-certified anesthesiologist and pain management specialist. Respondent's patients generally had chronic, severe pain arising from traumatic injuries. In connection with this practice, he committed violations of the Medical Practice Act, as follows:

Patient 1[1]

8. Respondent first saw Patient 1 on September 14, 2015. At the time, Patient 1 was a 49-year-old male with severe pain from earlier trauma and was receiving numerous medications from various sources. Respondent concluded that Patient 1 was abusing his medication and further prescriptions should be stopped. The patient had a long history of alcoholism and polysubstance abuse and was engaged in the illegal procurement of opioid medications from Mexico.

9. In regards to this treatment, Respondent failed to document informed consent regarding the potential risks of using opioids to treat chronic pain. The standard of care requires a prudent physician to provide basic information to patients receiving opioids for chronic pain, such as alternatives of treatment, the potential benefits of opioid therapy, the potential risks of opioid therapy, and precautions while taking opioid therapy.

10. On December 5, 2017, Patient 1 had a follow-up visit with Respondent. The medical record does not show that Respondent discussed with Patient 1 the known risks and realistic benefits of opioid therapy. The same was true on April 16, 2018, and on February 13, 2019, when Respondent again saw Patient 1; there is no documentation in the record discussing precautions while taking opioid therapy, such as keeping these medications out of reach of children and

[1] In the interest of privacy, the patients' names are rendered in this document by numbers.

avoiding driving or other high-risk activities if sedated while taking these medications. There is no documentation of the dangers of mixing opioids with benzodiazepines.

11. Respondent failed to document his patient monitoring adequately. Despite the notation in the medical record that the patient would require closer monitoring, no additional monitoring was initiated. A prudent physician would have significantly increased monitoring once it was determined that the patient had lost control of the use of the medication and had developed an opioid use disorder. In his subject interview, Respondent admitted that the prescriptions were often given without a face-to-face meeting with his patients.

12. On September 7, 2017, Respondent again saw Patient 1, who was complaining of low back pain. The medical record showed that Patient 1 was taking "10 hydrocodone per day in last two weeks and last time he was here in December." This note was made after an interval of nine months. The standard of care requires that the patient should be seen on a regular basis. If the patient on chronic opioid therapy should demonstrate an increased risk while taking this therapy, a reasonably prudent physician should change the monitoring interval to at least 30 days.

13. The documentation of physical examinations performed by Respondent is cut-and-pasted in most follow-up reports. The physical examination was limited to vital signs. There is no documentation that the CURES[2] report was ever evaluated. These omissions were in the medical records dated November 30, 2015; December 5, 2016; September 7, 2017; and April 16, 2018, when Patient 1 was seen by Respondent. For example, the medical records on those dates have the same notes:

"Had C Spine ESI by me about 8 years ago and did well Was Getting random blind injections by VA and quit and came here."

in which the typographical errors are the same and the same "8 years ago" interval is repeated.

15. Respondent failed to refer the patient to drug rehabilitation services. Given the high dose of medication that Patient 1 was using, Respondent was obligated to refer him to a drug

[2] CURES stands for Controlled Substance Utilization Review and Evaluation System (CURES). It is a record from the pharmacy containing controlled substances prescribed to a patient. Physicians are mandated to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II-IV controlled substance.in order to determine whether the patient is receiving substance dosages or dangerous combinations that put patient at high risk for overdose.

treatment center. The medical records, including those dated November 30, 2015; December 5, 2016; September 7, 2017; and April 16, 2018, do not show that the patient was referred for rehabilitation services.

16. Respondent's medical records, including those dated November 30, 2015; December 5, 2016; September 7, 2017; and April 16, 2018, failed to provide documentation of an adequate interim history, an appropriate physical examination, his treatment plan, adequate records of Schedule II and III prescriptions, and informed consent.

Patient 2

17. Respondent first saw Patient 2 on September 27, 2011. At that time, she was 61 years old. Patient 2 was seen by Respondent in three-month intervals between September 27, 2011, and January 2017 and was prescribed opioid analgesics for chronic pain. On February 10, 2017, Patient 2 died as a result of acetaminophen toxicity. Her death was not related to the deficiencies in Respondent's treatment, prescribing, or documentation.

18. Respondent failed to monitor Patient 2 adequately. Patient 2's follow-up history was cut and pasted into subsequent reports, and physical exams were limited to vital signs. In addition, the medical records, including those for patient visits on March 17, 2016; July 19, 2016; and November 17, 2016, contain no documentation that a CURES report was ordered or evaluated, and the analgesic effect of the medications already prescribed to the patient was not documented.

19. Patient 2 received 150 tablets of Norco on October 10, 2016; November 8, 2016; December 7, 2016; and January 11, 2017. However, the medical records show that Respondent did not see the patient on or just before those dates. Therefore, these medications were prescribed without face-to-face evaluation of the patient. CURES reports showed that Respondent prescribed controlled substances to Patent 2 on multiple occasions, including February 27, 2016; October 10, 2016; November 8, 2016; December 7, 2016; and January 11, 2017. There were no medical records for Patient 2 during this period.

20. Respondent's documentation of physical examinations was inadequate. The medical records, including those dated March 17, 2016; July 19, 2016; and November 17, 2016, have

inadequate documentation of regular face-to-face physical examinations, and exam details in follow-up reports again were cut-and-pasted.

21. As with Patient 1, the medical records for Patient 2 had repeated copied and pasted entries, including those dated March 17, 2016; July 19, 2016; and November 17, 2016. For example, each had the same entry repeated: *"Pain flared in low back for about 2 months and then subsided considerably."* The entry on each record contained the same typographical error: "cnsiderably."

22. Medical records showed that Respondent failed to adequately document patient encounters, including for records dated March 17, 2016; July 19, 2016; and November 17, 2016. Respondent failed to provide documentation of an adequate interim history, an appropriate physical examination, his treatment plan, adequate records of Schedule II and III prescriptions and informed consent.

23. In addition, Respondent was required to maintain an analgesic agreement with Patient 2, for her opioid therapy for chronic pain, but Respondent failed to document an analgesic agreement with Patient 2 in the medical records, including records dated March 17, 2016; July 19, 2016; and November 17, 2016.

Patient 3

24. When Respondent first saw Patient 3 on March 15, 2012, she was a 65-year-old female suffering from chronic pain from cervical and lumbar spine areas, apparently due to an automobile accident in 2009 that resulted in cord compression.

25. The medical records for Patient 3 are missing required documentation. This includes the records dated December 19, 2017; June 20, 2017; March 21, 2017; August 2, 2016; and April 28, 2016. The patient's medical records required additional information because there were controlled substances prescribed to Patent 3 as follows: Patient 3 received 90 tablets of acetaminophen-codeine on January 19, 2017; December 4, 2017; June 13, 2017; March 17, 2017; and September 20, 2016. The medical records for the visits, including those listed above were inadequate as follows:

A. There was no documentation in the medical record of any informed consent regarding the potential risks of using opioids for the treatment of chronic pain being given to the patient. There was no documentation in the record of discussing precautions while taking opioid therapy, such as keeping these medications out of reach of children and avoiding driving or other high-risk activities if sedated by these medications.

B. Respondent failed to document an analgesic agreement with this patient, which would include provisions that would reduce the risk of patients receiving medications from other prescribers or using the prescribed medications in an unsanctioned or inappropriate manner.

C. There is inadequate documentation regarding regular face-to-face physical examinations of Patient 3. Physical examination documentation was again cut-and-pasted in most of the follow-up reports. There was no documentation that CURES was evaluated. Patient 3 received controlled substances, including those listed above, but there were no medical records for these dates or immediately prior. An evaluation of the CURES report, which was not available in the medical records, reveals that the patient did, in fact, receive prescriptions on a regular basis from only one physician, Respondent. There was no clear documentation of the analgesic effect on the activities of daily living, or any adverse effects.

D. There was no clear documentation that Respondent performed sufficient monitoring of Patient 3. The follow-up history appears to have been cut-and-pasted. The physical examination was limited to vital signs.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

26. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts in his care of Patients 1, 2, and 3. The circumstances and allegations set forth in Paragraphs 7 through 25 above are incorporated by reference as if fully set forth herein. In addition, Respondent's management care and inadequate medical record-keeping for Patients 1, 2, and 3 constitutes negligence, and are as follows:

A. Patient 1:

1) Failure to document informed consent regarding the use of opioid treatment therapy for the treatment of chronic pain;

2) Failure to document adequate monitoring of a patient prescribed opioid medication for the treatment of chronic pain conditions;

3) Failure to document appropriate physical examinations prior to the prescription of opioid analgesics;

4) Failure to refer to drug rehabilitative services; and

5) Failure to maintain adequate and accurate medical records.

B. Patient 2:

1) Failure to document informed consent regarding the use of opioid treatment therapy for the treatment of chronic pain;

2) Failure to document adequate monitoring of a patient prescribed opioid medication for the treatment of chronic pain conditions;

3) Failure to document appropriate physical examinations before the prescription of opioid analgesics;

4) Failure to maintain adequate and accurate medical records.

5) Failure to maintain an analgesic agreement with a patient on opioid therapy for chronic pain.

C. Patient 3:

1) Failure to document informed consent regarding the use of opioid treatment therapy for the treatment of chronic pain;

2) Failure to maintain an analgesic agreement with a patient on opioid therapy for chronic pain.

3) Failure to maintain adequate and accurate medical records.

4) Failure to document appropriate physical examinations prior to the prescription of opioid analgesics;

5) Failure to document adequate monitoring of a patient prescribed opioid medication for the treatment of chronic pain conditions;

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records of Patient Care)

27. Respondent is subject to disciplinary action under Code section 2266 by failing to maintain adequate and accurate records of his care and treatment of Patients 1, 2, and 3. The circumstances and allegations set forth in Paragraph 7 through 26 above are incorporated by reference and re-alleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

28. Respondent is subject to disciplinary action under Code section 2234 for unprofessional conduct in his care and treatment of Patients 1, 2 and 3. The circumstances and allegations set forth in Paragraph 7 through 27 above are incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 11026, issued to Benjamin Shwachman, M.D.;

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

3. If placed on probation, ordering Benjamin Shwachman, M.D. to pay the Board the costs of probation monitoring; and

4. 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