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

In the Matter of the First Amended Accusation Against: Bhupinder Nath Bhandari, M.D. Physician's and Surgeon's Certificate No. A 50058 Respondent.	Case No.: 800-2017-039428

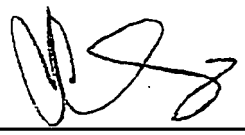
DECISION

The attached Proposed Decision 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 January 14, 2022.

IT IS SO ORDERED: December 16, 2021.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against:

BHUPINDER NATH BHANDARI, M.D.,

Physician's and Surgeon's Certificate No. A 50058

Respondent.

Agency Case No. 800-2017-039428

OAH No. 2021060829

PROPOSED DECISION

Administrative Law Judge Regina Brown, Office of Administrative Hearings, State of California, heard this matter via videoconference on August 30-31, and September 1-2 and 8, 2021.

David M. Carr, Deputy Attorney General, represented complainant William Prasifka, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Marvin Firestone, M.D., Attorney at Law, represented respondent Bhupinder Nath Bhandari, M.D.

The matter was submitted for decision on September 8, 2021.

FACTUAL FINDINGS

Jurisdictional Matters

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

2. On October 22, 1991, the Board issued Physician's and Surgeon's Certificate (Certificate) No. A 50058 to respondent Bhupinder Nath Bhandari, M.D. Respondent's Certificate was in full force and effect at the time of the acts set forth below and will expire on December 31, 2022, unless renewed. Respondent has no prior disciplinary action.

Summary of Case

3. This case came to the Board's attention after a consumer complaint was filed regarding respondent's prescribing practices. A Controlled Substance Review and Evaluation System (CURES) report was pulled of respondent's prescriber history which identified patients, herein referred to as Patient 1 and Patient 2.[1]

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[1] The patients are referred to by numbers to protect their privacy. The medical records admitted into evidence as Exhibits 2 through 8 and respondent's expert reports that identify Patient 1 and 2 have been sealed under a Protective Order Sealing

In February 2020, the case was assigned to a Board investigator who obtained the medical records of both patients, primarily covering the period of 2017-2020, and interviewed respondent on November 3, 2020. The Board's expert witness, after reviewing the medical records and other materials, issued a report concluding that respondent departed from the standard of care in his treatment and recordkeeping for the two patients.

On November 30, 2020, complainant filed an Accusation alleging that between 2017 and 2020, respondent committed unprofessional conduct (repeated acts of negligence, gross negligence, incompetence) and failed to maintain adequate and accurate medical records in his treatment of Patient 1, and committed unprofessional conduct (repeated negligent acts) and failed to maintain adequate and accurate medical records in his treatment of Patient 2.

4. Specifically, complainant alleges that respondent: prescribed dangerous combinations of drugs over a lengthy period of time to Patient 1 despite the patient's refusal to undergo laboratory testing and consultations; failed to document the patient's alcohol use history and document warning of the risks of alcohol consumption with the prescribed medications; failed to consider the effect of prescribing high-dose ibuprofen in conjunction with her other medical conditions; failed to consider medication-related liver toxicity; prescribed medications without documenting discussions of the associated risks; and prescribed a medication without an awareness of the efficacy of the treatment or potential for worsening her condition.

Confidential Records, dated August 12, 2021. The evidence did not establish that either patient was the author of the complaint.

Complainant alleges that respondent failed to document and provide a rationale for his treatment or non-treatment of Patient 2's hypertension and failed to follow through on his recommendation for Patient 2 to perform home blood pressure monitoring. Complainant also alleges that respondent failed to maintain adequate and accurate medical records for both patients.

5. On July 6, 2021, complainant filed a First Amended Accusation adding an allegation that respondent failed to report to the Board that a felony indictment had been filed against him.

6. Respondent filed a notice of defense and this hearing followed.

7. Respondent disputes the allegations in the First Amended Accusation and contends that no discipline is warranted.

Respondent's Education, Training and Medical Practice

8. Respondent earned his medical degree from All India Institute of Medical Sciences, New Delhi, India in 1984, and graduated at the top of his class. He received his membership in the Royal College of Physicians, London, United Kingdom (UK) in 1986. From 1985 to 1987, respondent completed residency training in emergency medicine in the UK. From 1987 to 1990, he completed a residency at the State University of New York at Stony Brook and served a year as chief medical resident. He completed a fellowship in gastroenterology/hepatology and was staff physician at the University of California, San Francisco (UCSF) from 1991 to 1995. He went to India for one year and returned to practice in Alameda County. He is board-certified in internal medicine and gastroenterology and a member of the American College of Gastroenterology.

9. Since 1993, respondent has held over 12 medical staff appointments at various hospitals in the Bay Area. Currently, he has medical staff appointments at Saint Rose Hospital in Hayward, Alameda Hospital, and Washington Hospital in Fremont. He has never had his privileges restricted. He has had no malpractice actions filed against him.

10. Respondent has had a private practice as a gastroenterologist in Fremont since 1995. His practice is diverse ethnically and economically, with fifty percent of his patients on Medi-Cal.

EXPERT WITNESSES' BACKGROUND AND EXPERIENCE

11. The experts who testified at hearing were familiar with the standard of care applicable to physicians such as respondent. Each expert reviewed the available medical records and documents, including the transcript and audio recording from the Board's interview with respondent on November 20, 2020.

Robert M. Franklin, M.D.

12. Board expert Robert M. Franklin, M.D., is board-certified in family medicine. He received his medical degree from George Washington University School of Medicine in 1990, and completed his residency in family practice at UCSF in 1993. Since 1995, Dr. Franklin has worked as a family physician at Southeast Health Center in San Francisco. Dr. Franklin worked as an emergency department physician at Kaiser Permanente in South San Francisco from 1997 to 2020, and St. Luke's Hospital from 1991 to 1999. He has trained physicians and nurse practitioners to use the Epic electronic medical recordkeeping system.

Dr. Franklin has held several academic positions at UCSF since 1995, including: Clinical Instructor (1995), Assistant Clinical Professor (2000), and Associate Clinical Professor (2007). In 2015, he was promoted to the position of Clinical Professor of Family and Community Medicine. He is a member of the American Academy of Family Physicians.

Dr. Franklin has provided expert testimony in civil court proceedings. Dr. Franklin began performing expert reviews for the Board in 2003, and has reviewed approximately 200 cases. He has testified in approximately 18 administrative hearings on behalf of the Board.

Dr. Franklin prepared a written report on the applicable standards of practice and his findings regarding respondent's treatment and care of Patient 1 and Patient 2, and respondent's medical documentation.

William G. Brose, M.D.

13. Respondent's expert, William G. Brose, M.D., is licensed to practice medicine in California, and is board-certified in anesthesiology. He graduated from the University of Kansas School of Medicine in 1984. He completed an internship in anesthesiology at Santa Clara Valley Medical Center in 1985, and a residency in anesthesiology at Stanford University School of Medicine (Stanford) in 1986. Dr. Brose completed a one-year fellowship in obstetric anesthesia in 1987, and the following year was a chief resident in anesthesia at Stanford. From 1988 to 1989, he served as a Physician Specialist at Stanford, and also completed a clinical research fellowship in anesthesia in South Australia.

Dr. Brose has held a number of academic positions at Stanford since 1989 including: Director of Pain Management Service (1989-1996); Associate Professor of Anesthesia (1995-1997); Adjunct Associate Professor of Anesthesia (1997-2011); and Adjunct Clinical Professor of Anesthesia (2011-present). He has also held numerous clinical positions over the years: President of Alpha Omega Pain Medicine Associates, Inc. (1998-2018); Chief Executive Officer (CEO) of HELP Holdings, Inc. and HELP Pain Medical Network (2010-2018); and CEO of American Health Medical Group (2014-2018). He has trained over 100 fellowship-trained pain management physicians. Dr. Brose has been awarded research grants, has published over 25 articles in peer-reviewed journals, and has written seven book chapters on pain management. He has given numerous presentations to physicians on chronic pain and opioid treatment. He is a qualified medical examiner in the workers' compensation system.

Dr. Brose has provided expert testimony in civil court proceedings and approximately five administrative hearings before the Board. He is enrolled as an expert reviewer for the Board, but has not yet evaluated a case or testified on behalf of the Board.

Dr. Brose prepared a written report regarding the applicable standards of care and his findings regarding respondent's treatment and care of Patient 1 and Patient 2, and respondent's medical documentation.

Frank J. Farrell, M.D., M.P.H., A.G.A.F.

14. Respondent's expert, Frank J. Farrell, M.D., M.P.H., A.G.A.F., is licensed to practice medicine in California and Guam, and is board-certified in gastroenterology and internal medicine. In 1988, he obtained a medical degree from UCSF, with a master's degree in public health from the University of California, Berkeley. He

completed an internship in internal medicine at Mount Zion Hospital and Medical Center in 1991, and was chief resident until 1992. He completed a two-year fellowship in gastroenterology in 1994.

Dr. Farrell has been in private practice as a gastroenterologist in San Francisco since 1994, and Guam since 2018. He is also an attending physician in the gastroenterology fellowship program at California Pacific Medical Center since 1994; medical director at the Golden Gate Endoscopy Center in San Francisco since 2014, and board member of inSite Digestive Health Care since 2015. Dr. Farrell has published articles in peer-reviewed journals on liver transplantation and related diabetes. He is a member of the American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, American College of Gastroenterology, and the California Medical Association.

Dr. Farrell has never provided expert testimony in civil court proceedings or administrative hearings before the Board.

Dr. Farrell prepared a written report, after interviewing respondent on April 24, 2021, regarding the applicable standards of care and his findings regarding respondent's treatment and care of Patient 1 and Patient 2, and his medical documentation.

Standards of Practice

15. The standard of practice refers to the level of skill, knowledge and care that would be exercised by a reasonably prudent and competent practitioner under similar circumstances. The standard of practice for the evaluation and management of medical conditions requires a practitioner to:

a. Carefully evaluate each presenting patient complaint, giving consideration to differential diagnosis and specific treatment.

b. Perform and document sufficient history, physical examination, and laboratory studies to confirm the diagnosis, exclude more serious pathology, and ensure that the treatment is safe and effective.

c. Document specific assessments for each medical problem identified with sufficient detail to provide a basis for rational, safe, effective, and evidence-based treatment plans.

d. Document the treatment plan for each problem in sufficient detail that an outside reviewer can determine exactly what is being done, why, and with what effect.

e. Identify and act upon serious or emergent medical conditions at any opportunity.

f. Be alert to serious pathology in their patients and to provide appropriate care or referral to appropriate care for those patients who present with evidence of serious conditions, be they medical or psychiatric.

g. Maintain a high index of suspicion for missed high-priority diagnoses at every visit.

h. Manage appropriately or refer the patient to another provider for appropriate management, and

i. Use the least number of the least toxic medications possible and to pay maximum attention to avoiding drug-to-drug interactions. For difficult cases, referral to a specialist is indicated.

16. The standard of practice regarding medical recordkeeping requires a practitioner to:

a. Document all significant findings, positive and negative, in the medical record.

b. Ensure that the medical record contains sufficient information to support every clinical decision that is made.

c. Document the rationale for intentional departures from general standards of practice in the medical record.

d. When prescribing controlled medication, it is the standard of practice to keep a detailed record of every prescription issued, including medication, dose, instructions, and quantity, and indicate the timing of the refills; and

e. Ensure that the medical record be able to quickly and efficiently give any physician with similar knowledge, experience, and training, to determine what conditions are under treatment, how those conditions were diagnosed, what are the specific patient-centered markers of those conditions, and what is being done to evaluate and manage those conditions.

Patient 1

17. In 2016, Patient 1 came under respondent's care for treatment of anxiety, hypertension, hyperlipidemia, migraine headache, insomnia, gastroesophageal reflux

disease (GERD) with a history of peptic ulcer disease (PUD), and hypothyroidism. Generally, respondent saw Patient 1 on a monthly basis. Her prior treating physician had Patient 1 on an unorthodox medication regimen, including benzodiazepines and a barbiturate, for approximately five years.

18. Respondent continued the medication regimen including: (a) Ativan[2] to treat Patient 1's anxiety at a dosage of approximately 8 mg per day, as-needed; (b) Ambien[3] to treat her insomnia at a dosage of 2 mg every six hours as-needed until July 2018, when he replaced it with Restoril[4] at an initial dosage of 30 mg per day, and fluctuated between 15 mg and 30 mg; (c) Fiorinal[5] every six hours to treat her migraine; (d) ibuprofen at the maximum dosage of 800 mg, three times a day, as-needed, to treat her migraine; (e) levothyroxine to treat her hypothyroidism; (f) metroprolol to treat her hypertension; (g) pantoprazole to treat her GERD; and (h) simvastatin at a dosage of 20 mg daily to treat her hyperlipidemia.

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[2] Ativan, a trade name for lorazepam, is a benzodiazepine and a controlled substance. It is a central nervous system depressant.

[3] Ambien, a trade name for zolpidem, is a benzodiazepine. It is a centrally acting sedative-hypnotic drug, a central nervous system depressant, and a controlled substance.

[4] Restoril, a trade name for temazepam, is another benzodiazepine hypnotic agent and a controlled substance.

[5] Fiorinal, a controlled substance, is a combination of 50 mg butalbital, a short-acting barbiturate, 325 mg of aspirin, and 40 mg of caffeine.

19. Benzodiazepines are sedative-hypnotic drugs that affect the central nervous system. Short-acting benzodiazepines like Ativan, Ambien, and Restoril are indicated for the treatment of anxiety and anxiety disorders. Benzodiazepines are highly habit-forming and common drugs of abuse.

20. Barbiturates, like Fiorinal, are sedative-hypnotic agents that have synergistic toxicity with other sedative agents, particularly benzodiazepines.

21. Patient 1 would report monthly that she was experiencing no side effects from the medications and that she was tolerating the medications well. Generally, respondent would refill all of her prescriptions at the same levels. This indicated to respondent that Patient 1 took the entire quantities of the medications each month, not on an as-needed basis as prescribed. Despite knowing this, respondent continued to write the monthly prescriptions for use on an as-needed basis. Respondent advised Patient 1 to avoid taking controlled substances when driving as it could impair her judgment.

22. Over the years, Patient 1 declined respondent's numerous recommended medication changes or dosage adjustments of the benzodiazepines. Patient 1 stated that her symptoms were controlled on her existing dosages. Respondent made no significant reduction in her benzodiazepine dosages from 2017 to July 2020, as confirmed by the CURES data.

23. Patient 1 had a fear of needle pricks. She declined to undergo laboratory testing as recommended by respondent on multiple occasions. Respondent periodically explained the need to test her thyroid levels, glucose, lipids, etc., but Patient 1 declined to be tested. She also declined other procedures, such as Pap smears, breast examinations and a colonoscopy.

24. On multiple occasions, respondent recommended consultations with a psychologist, psychiatrist or neurologist, which Patient 1 declined. She expressed having a fear of other providers. Respondent confirmed that he did not consult with a psychiatrist or psychologist regarding Patient 1's anxiety, when she refused his recommendation to consult with them herself.

25. Respondent continued to treat Patient 1 with a combination of benzodiazepines concomitantly with Fiorinal, a barbiturate. Respondent did not document in Patient 1's medical record any discussion of the rationale for prescribing Fiorinal, which is not indicated or approved for long-term treatment of migraines. During his interview on November 20, 2020, respondent indicated that he was unaware that Fiorinal can cause rebound headaches and is only indicated for short-term use, despite Patient 1's continued reports of having headaches.

26. Over the years, respondent also prescribed ibuprofen to Patient 1, in the maximum dosage of 800 mg on an as-needed basis. Respondent advised her to take the ibuprofen with meals. Patient 1 took the entire dosage every month, of which respondent was aware, but he continued to indicate on the prescription that it was prescribed an as-needed basis. Given that Patient 1 suffered from hypertension, monitoring her renal function was important while treating with ibuprofen. Patient 1 refused to undergo the laboratory testing necessary to assess her renal function.

27. Respondent regularly checked Patient 1's CURES report, as required by the Board to monitor prescriptions of controlled medications. Patient 1 signed a pain management agreement in February 2018, which included information regarding the risks and benefits of pain medication therapy. The agreement required the patient to agree: to follow the guidelines; that she understood the risk of psychological and/or physical dependence and addiction; that she would be amenable to seek psychiatric

treatment, psychotherapy, and/or psychological treatment if respondent deemed it necessary; that she would limit the use of alcohol to times when not driving or operating machinery; that she would not attempt to obtain controlled medications from another provider; and that she would submit to blood or urine tests if requested by respondent to determine her compliance with her program of pain control medications. She was informed that failure to adhere to the agreement could result in cessation of prescribing of pain control medicines.

28. Despite Patient 1's failure to adhere to the agreement to submit to laboratory testing or his other recommendations, respondent continued to prescribe the combination of controlled substances. Respondent reasoned that because Patient 1 was "reluctant to accept [his] recommendations and declined to accept therapy or treatment modalities other than those prescribed," he did not want to "make it worse."

29. In July 2018, Patient 1 told respondent that Ambien was not helping and requested a prescription for Restoril, which she had used in the past. Respondent prescribed Restoril at 15 mg every evening as-needed for insomnia.

30. According to the medical record, respondent prescribed lisinopril at a dose of 5 mg daily to treat Patient 1's hypertension on one occasion.[6] Lisinopril can potentially cause lethal hyperkalemia and renal dysfunction and its use without the ability to monitor renal function and electrolyte status can place a patient at high risk. The medical record did not mention lisinopril, did not document any discussion regarding the potential risks or explain why respondent started or stopped the treatment. During his interview in November 2020, when asked about monitoring

[6] The prescription was undated, but was likely in early 2019.

Patient 1's renal function, respondent did not demonstrate a working knowledge of the risk-to-benefit ratio of his prescribing the medication and monitoring the appropriate blood tests.

31. Respondent added an anti-hypertensive, amlodipine, to Patient 1's treatment regimen in February 2019. Respondent's existing regimen included simvastatin 20 mg daily presumably for Patient 1's hyperlipidemia. Amlodipine interacts with simvastatin and can elevate serum simvastatin levels. This combination should be avoided and if used, a treater must monitor creatinine kinase and liver function tests and warn the patient to report any symptoms of hepatitis. Respondent did not document in the medical record any discussion of the risks associated with prescribing amlodipine along with simvastatin, or the necessity of regular laboratory testing to monitor creatinine kinase and liver function. The medical record did not contain any other entries of the prescription for amlodipine.

32. Generally, respondent's handwritten medical records contained monthly progress notes with copies of the handwritten prescriptions attached. Some entries in the monthly progress notes were illegible and the record of prescriptions was difficult to follow. March 8, 2019, was the last handwritten entry for Patient 1's medical record. Laboratory work was ordered. The notes indicate that the prescriptions were refilled and the medications were reviewed and the side effects discussed with the patient.

In March 2019, respondent began to use Epic electronic software for his medical recordkeeping. The current outpatient medications section contained duplicate entries of respondent's prescriptions for Patient 1. For example, the entries for Restoril contained prescriptions for 15 mg and 30 mg, which made it difficult to determine the exact prescription. There were also eight duplicating prescription entries for Fiorinal, eight duplicating entries for Ativan, nine duplicating entries for Restoril, and two

duplicating entries for ibuprofen. The Epic records also indicated that Ativan, Fiorinal, and Restoril were discontinued, which was not accurate. These errors, and additional duplicates of other prescribed medications, continued in Patient 1's medical records through 2020. These duplicate entries made it impossible to determine which medications were prescribed at what dose and what frequency for which problem.

33. On April 13, 2019, Patient 1 underwent a laboratory blood test, which revealed mild anemia and mild elevation of liver enzymes, a common indicator of alcohol abuse. Co-administration of benzodiazepines and alcohol is contraindicated and the use of multiple different benzodiazepines increases the risk of toxicity, and the use of alcohol with a benzodiazepine increases the risk of toxicity. Respondent recommended further testing, which the patient declined.

34. Respondent's handwritten medical records did not include the prescription for simvastatin 20 mg daily.[7] In the Epic records on April 8, 2019, respondent noted the prescription for simvastatin 20 mg daily, and indicated "side effects of above medications discussed."

35. In May 2019, respondent discussed with Patient 1 the common causes of her liver function test abnormality as including fatty liver and viral hepatitis. However, respondent did not document in the Epic records whether he considered that the simvastatin might have caused simvastatin-related liver toxicity given her elevated liver function test. Respondent also did not note any discussion of the significant risk

[7] Respondent's typewritten chart notes that he prepared for his expert to review indicated that the prescription for simvastatin was in all of the handwritten medical records; however, these did not match.

alcohol use would pose given the combination of medications prescribed to the patient.

36. Patient 1 has a history of PUD and symptoms of GERD. Ibuprofen and aspirin can cause PUD. Fiorinal contains aspirin. The medical record did not indicate that respondent recommended an endoscopy when the patient was found to be anemic in April 2019. The medical record did not indicate that he considered discontinuing ibuprofen or Fiorinal when Patient 1 complained of GERD symptoms.

37. In June 2019, Patient 1 accepted respondent's recommendation to reduce the dosage of Restoril to 15 mg. In September 2019, respondent changed the Restoril prescription to 30 mg without providing an explanation in the medical record for the increase. In October 2019, respondent changed the prescription to 15 mg, again without providing an explanation for the decrease. In April 2020, Restoril was again increased to 30 mg without an explanation.

38. In January 2020, respondent again recommended laboratory testing because Patient 1's liver enzymes were elevated in the past and because she had been on ibuprofen which can diminish renal function. Patient 1 reiterated her fear of needles, declined any testing and stated that she accepted the risks.

39. In March 2020, respondent discussed with Patient 1 the risks of driving while under the influence of Ativan and its side effect of habituation. In June 2020, respondent discussed with the patient her chronic use of Ativan and Fiorinal and their potential side effects. In July 2020, respondent discussed safer migraine treatments; however, the patient declined, and she declined to undergo a neurology consultation.

40. Complainant alleged that there was no indication in the medical record that respondent documented Patient 1's alcohol use history or that alcohol use was

ever discussed with Patient 1. However, the medical records respondent provided at hearing established that Patient 1 told respondent, in July 2016 during her initial patient intake, that she never used alcohol.

Respondent's Testimony Regarding His Treatment of Patient 1

41. Respondent's testimony at hearing was candid and credible.

42. Respondent testified that he continued with the existing medication regimen because Patient 1 was benefitting and she was stable with no side effects. He reiterated that he often made efforts to modify the regimen, but she was extremely reluctant. Because he saw the patient on a monthly basis, this allowed him to monitor her and identify any adverse effects, and he concluded that the medication regimen was efficacious to serve the purpose. Respondent acknowledged that at the time of his interview, he was not aware that Fiorinal caused rebound headaches, but he did additional research about Fiorinal after the interview. He did not know if there was any clinical benefit to knowing Patient 1's Fiorinal levels because he did not know if that could be tested. Respondent had never prescribed Ambien or Ativan in his clinical practice.

43. Respondent described his recordkeeping method as compliant with the "SOAP" method of documenting the subjective, objective, assessment, and plan, as he was trained. When he wrote "no change" in the social or personal history sections of the record, this indicated that there was no change from the previous evaluation. Respondent explained that when he converted to Epic, the medications would automatically populate each month, as well as the previous diagnoses. Respondent confirmed that his expert requested that respondent transcribe his medical reviews for the expert to review.

44. Respondent believes that Patient 1 is habituated to benzodiazepines. Respondent stated that he did not attempt to assert his power to convince Patient 1 to comply with laboratory testing because that is "not his style," and he takes a "cafeteria" approach with "attempting many ways to handle many remedies for ailments, and the patient's experience determines the proper way to proceed."

45. Respondent has discharged patients before who are unwilling to cooperate with testing to diagnose an underlying condition. Respondent did not feel compelled to discharge Patient 1 because she had pre-determined diagnoses, she was a nice person, he believed her, she felt that she was well-controlled on the medication regimen, and she did not feel a need to change. Respondent believed that Patient 1 was more likely to be harmed if he discharged her. His primary concern was to check CURES monthly to ensure that she was not obtaining controlled substances medications from other providers. She was not and she never exceeded her prescriptions. Additionally, respondent considered the most important provision of the pain management agreement was her compliance with not accepting controlled substances from other provider and not the provision where she agreed to comply with laboratory testing. Respondent noted that Patient 1 did not have laboratory testing under her previous primary physician.

46. Respondent stated that he asked Patient 1 annually whether she used alcohol, and she said no. He clinically verified her response by determining that she did not have an odor of alcohol, she was always composed, she did not act erratically, and she had no indicators of self-neglect. He did not suspect that she used alcohol. He did not consider her elevated liver function test to be a marker for alcohol use.

47. As a liver specialist, respondent believes it is extremely unlikely that Patient 1 would have potential liver damage from his long-term prescribing of

benzodiazepines as he has never seen a rise in liver toxicity in other patients. He also believes that long-term use of Fiorinal with aspirin would be extremely unlikely to cause liver damage because he has never seen it in 30 years of practice.

48. Respondent believes that his treatment of Patient 1 met the standard of care in all respects. Patient 1 continues to be respondent's patient on the same medication regimen, except that he has reduced the Ativan prescription to 6 mg per day, and Fiorinal from 120 to 90 tabs per month to be taken on average three times per day. He states that the Board's request for his medical records in August 2020 did not precipitate the reductions in the medications. Patient 1 continues to take Restoril and periodically takes ibuprofen. Patient 1 is still reluctant to do laboratory testing, but respondent was able to convince her to test in September 2020.

49. Respondent provided additional medical records to his experts and at the hearing. These documents were not reviewed by the Board's expert prior to issuing his written report.

Experts' Opinions Regarding Care of Patient 1

50. Dr. Franklin based his opinions on his experience in family medicine; Epocrates.com, an online medical drug reference; and the Board's 2014 "Guidelines for Prescribing Controlled Substances for Pain," as referenced in his report. According to Dr. Franklin, the standard of practice regarding prescribing pain medications has not changed in many years and at the core remains unchanged from what was taught in residency programs decades ago. "Specifically, the guidelines indicate that medical history, physical examination, laboratory tests, informed consent, description of the treatment provided, instructions to the patient including specific discussions of risks and benefits of treatment, results of ongoing progress or lack of progress in pain

management and functional improvement, notes regarding specialty consultation, etc." are necessary. Dr. Franklin agreed that physicians must be allowed to use their clinical judgment without fear of being second-guessed by a reviewer who has the benefit of hindsight and who did not participate in the patient's care. Overall, Dr. Franklin believed that the care respondent rendered to Patient 1 was not supported by the medical record.

51. Dr. Brose, respondent's expert, described the federal and state guidelines which have developed on pain management practices over the years as "best practices," not a mandate and opined that they do not define the boundaries of the standard of practice, which is on a spectrum. Dr. Brose characterized Dr. Franklin's application of the standard of practice as a "restrictive and flawed set of boundaries." Dr. Brose also opined that the FDA package inserts, which Dr. Franklin referred to in his report, are only dosage recommendations and physicians can prescribe off label. Dr. Brose stated that a physician must communicate to a patient that he is prescribing outside of the recommended dosage and make the patient aware of the increased risk, while recognizing the benefit of the medication.

52. Dr. Farrell, respondent's expert, interviewed respondent before writing his report. Dr. Farrell considered Patient 1 to be a complex patient who had an unorthodox medication regimen initiated by her previous physician. Dr. Farrell described her as a challenging patient because of her reluctance to needle sticks and because of that, respondent was limited in what he could do to manage the patient. Dr. Farrell agreed that the standard of practice is the same for an internist and gastroenterologist in regard to the care of a patient and the associated medical recordkeeping.

DANGEROUS COMBINATION OF DRUGS

53. Dr. Franklin opined that it was an extreme departure from the standard of practice to prescribe 8 mg per day of Ativan to Patient 1 for more than four years, to add Restoril to her treatment regimen in July 2018, to prescribe daily Fiorinal when the patient was already taking a benzodiazepine, and to prescribe Ambien when the patient was already taking high-dose Ativan and regularly using Fiorinal. According to Dr. Franklin, when Patient 1 was taking all of her medications on a daily basis and continued to experience symptoms of her medical conditions, then she was not being treated in a safe modality. The combination of the sedatives Ativan and Restoril with the stimulant Fiorinal was sufficient to induce anxiety and significantly interfere with her sleep demonstrating that she was not being treated in a safe modality. This is especially true since Fiorinal, which contains barbiturate butalbital, has synergistic adverse effects with benzodiazepines. Furthermore, respondent admitted during his interview that he was unfamiliar with prescribing high-dosage Ativan and Fiorinal; therefore, respondent was practicing beyond his skill which is also a departure from the standard of practice. Dr. Franklin noted that although respondent stated during his interview that he diminished her overall benzodiazepine dosage, the CURES data did not support that representation and showed no significant reduction in her benzodiazepine dosage over the months of treatment he reviewed.

Dr. Franklin disagreed with respondent's characterization that Patient 1 was having no reported adverse effects and he did not want to "make it worse" by changing her medication regimen. Dr. Franklin noted that by prescribing multiple sedatives while prescribing a stimulant, respondent made it worse because she continued to have headaches, and suffered from insomnia and anxiety. He described the treatment plan as irrational, and opined that merely because the patient came to

respondent on an irrational treatment regimen did not reduce his responsibility in continuing to prescribe that regimen. Furthermore, respondent replaced one toxic drug for another toxic drug, Restoril, in the treatment regimen.

Dr. Franklin explained that the use of high-dose benzodiazepines standing alone is toxic unless there is careful documentation that explains why a patient cannot take other modalities. Respondent failed to provide such documentation. In fact, Dr. Franklin was required to review the CURES data and compare that data with Patient 1's medical record to determine the dosages of her controlled substances.

Dr. Brose disagreed with Dr. Franklin and opined that the prescriptions for Restoril and Fiorinal (as opposed to Fiorinal C with codeine which would be toxic) was not excessive or dangerous and was within the standard of care. According to Dr. Brose, Patient 1 received therapeutic benefits from the combined drugs with no evidence of harm to the patient or that the medications caused increased anxiety. A patient's perceived benefits are a factor used in a clinician's decision to modify or discontinue a drug. Dr. Brose noted that respondent had discussions with the patient and respondent concluded that there was no evidence of rebound headaches. On cross-examination, Dr. Brose testified that when respondent said he was unaware that Fiorinal could cause rebound headaches, this was a deficiency in his knowledge. Dr. Brose acknowledges that a finding of harm to a patient is not required to establish a departure from the standard of care.

Dr. Brose opined that if a physician accepts a patient with established diagnoses and treatment, then the physician does not need to include his reasoning in his medical notes when the physician has accepted the prior physician's determinations. Once the physician and the patient develop a rapport, this allows the physician to shift to an optimal patient plan. According to Dr. Brose, ideally a physician must document

a clinically justifiable reason to continue with the treatment plan, but the physician is not required to do so to meet the standard of care. Dr. Brose opined that, in this case, respondent had a conditional acceptance of Patient 1's treatment plan and continued with it, which was within the standard of care and allowed respondent to continue even when he lacked experience with prescribing some of the medications.

Dr. Farrell opined that prescribing the combination of drugs in high doses over a lengthy period of time was within the acceptable standard of practice as Patient 1 had been on that dosage for years and was tolerating the medication.[8] Dr. Farrell agreed that Patient 1 was on an atypical medication regimen, but opined that respondent managed Patient 1 by being attentive to her medical needs at his regular monthly visits and that he followed her clinically. According to Dr. Farrell, "if it is working, even if unorthodox, then don't change it." Under different circumstances it could be a dangerous combination of drugs if not monitored regularly, but in this instance, regular monitoring of Patient 1 minimized the risk and danger. Also, respondent replaced the Ambien with Restoril and decreased the dose to 15 mg daily. Dr. Farrell opined that there were no documented adverse effects to Patient 1, so respondent's care was within the standard of practice.

54. The opinion of Dr. Franklin that respondent's conduct constituted an extreme departure from the standard of practice was more persuasive and supported by the evidence. Respondent's reliance on Patient 1's prior history with the dangerous combination of drugs and the patient's assurances that she was well controlled on the

[8] At hearing, Dr. Farrell acknowledged that to come to his conclusion in his report, he reviewed the FDA insert for Fiorinal C which contains codeine which was not the same Fiorinal that respondent prescribed.

medication regimen was improper. Respondent failed to document in the medical record a clinically justifiable reason for continuing with the dangerous combination of medications. Patient 1 continues to be respondent's patient on the same combination medication regimen, except that respondent has reduced the prescriptions for Ativan and Fiorinal.

PATIENT 1'S REFUSAL TO FOLLOW TREATMENT RECOMMENDATIONS

55. Dr. Franklin opined that it was an extreme departure from the standard of practice to allow Patient 1's reluctance to follow respondent's recommendations for laboratory testing and consultations to influence his decision to continue to prescribe dangerous medications. Respondent's failure to use his power as the prescriber to taper and then discontinue the harmful combination of Ativan, Restoril, and Fiorinal was an extreme departure from the standard of practice. A patient who insists on certain medications inhibits a physician from prescribing medications that are safe and effective which is the standard of practice. Dr. Franklin acknowledged that the standard of practice does not require a physician to require testing for Restoril.

Dr. Brose disagreed with Dr. Franklin and opined that the power hierarchy between a doctor and patient is "old fashioned and paternalistic." Instead, the doctor should work with a patient in shared decision-making. Dr. Brose considered respondent's treatment of Patient 1 as empathetic and demonstrative of shared decision-making.

Dr. Farrell opined that respondent was within the acceptable standard of practice when he continued to prescribe the medications despite Patient 1's refusal of laboratory testing and consultations. Patient autonomy allowed her the right to refuse tests, recommendations and treatment. Dr. Farrell opined that Patient 1's refusals

"handcuffed" respondent in managing the patient and he had no options and "could not precipitate a withdrawal crisis." According to Dr. Farrell, respondent "did the best he could" in treating Patient 1 with her phobias and underlying medical conditions. Dr. Farrell does not believe that Patient 1 was in violation of the pain management agreement because the only pain issue was for her migraine and a physician does not need laboratory tests for pain management of migraine. Dr. Farrell agreed that more frequent testing would have provided more clinical information about the patient. According to Dr. Farrell, respondent was "practicing the art of medicine where the textbooks do not afford black-and-white clinical guidance."

56. The opinion of Dr. Franklin that respondent's conduct was an extreme departure from the standard of practice was more persuasive and supported by the evidence. Respondent continued prescribing the dangerous combination without regular laboratory testing and consultations with a psychologist, psychiatrist, or neurologist. The fact that Patient 1's previous primary physician did not have laboratory testing performed was not a reason to attempt to influence the patient to have testing. Respondent continued to prescribe benzodiazepines which are highly habit-forming and common drugs of abuse, despite his belief that Patient 1 is habituated to benzodiazepines and knowing that she was resistant to changing her medication regimen. He did not initiate a tapering process to determine the efficacy of reducing her medication regimen. He did not himself consult a psychologist or psychiatrist. He did not require the patient to adhere to the pain management agreement. Dr. Brose and Dr. Farrell's opinions, although in good faith, are not persuasive because they appear to embrace elevating the patient's desires above respondent's experience, training, and knowledge. Despite Dr. Farrell's opinion, respondent did not "do the best he could" because he had several options up to and

including discharging the patient. Essentially, respondent abdicated his responsibility and allowed the patient to take control and manage her own care.

DOCUMENTATION OF ALCOHOL USAGE

57. Dr. Franklin stated in his report that alcohol abuse is common in people who are dependent on benzodiazepines or barbiturates. Dr. Franklin opined that respondent's "failure to clearly document an exhaustive effort to exclude alcohol use or abuse by [Patient 1] placed her at grave risk for the potentially lethal effects of combining alcohol with benzodiazepines and barbiturates" and constituted an extreme departure from the standard of practice. It was an extreme departure from the standard of practice to fail to document strenuously warning her to avoid any consumption of alcohol while taking Ativan or Restoril or Fiorinal.

In his testimony, Dr. Franklin confirmed that Patient 1's 2015 and 2016 medical records were not provided for his review when he wrote his report. He acknowledged that the patient initially denied any alcohol use in 2016. This did not change his opinion that respondent departed from the standard of practice, which requires a physician to ask in future sessions about alcohol use because the patient's intent could change over time and it is necessary to obtain the clinical reality.

Dr. Brose opined that respondent would not be required to repeatedly document that he asked the patient about her alcohol consumption because of Patient 1's cultural belief about alcohol and to repeatedly ask "could be seen as confrontational." This opinion appeared to be in response to a statement respondent made in his interview about the patient's cultural beliefs.

Dr. Farrell opined that respondent was within the standard of care because respondent obtained information about Patient 1's alcohol consumption in his initial

intake assessment and the patient signed a pain management agreement acknowledging that she should avoid/minimize the consumption of alcohol. Additionally, the sole laboratory test showed that Patient 1 had an isolated mild elevation of her ALT (alanine aminotransferase), which is not a typical pattern of liver test elevations in a patient who consumes alcohol. The typical patient who consumes alcohol would have an elevated AST (aspartate aminotransferase) and Patient 1's AST level was normal.

58. The opinion of Dr. Franklin that respondent's conduct constituted an extreme departure from the standard of practice was more persuasive and supported by the evidence. The evidence established that respondent, in the initial intake in 2016, documented that Patient 1 stated that she did not drink alcohol. At that time, he met the standard of practice. Respondent testified that he annually asked Patient 1 about her alcohol intake and she indicated that she did not drink. This evidence negates Dr. Brose's opinion that respondent did not ask her about her alcohol consumption because of Patient 1's cultural belief. Nevertheless, respondent did not document in the medical record that he asked about her alcohol use after 2016. Neither did he document that he warned Patient 1 about the potentially lethal effects of combining alcohol with benzodiazepines and barbiturates.

PROLONGED USE OF HIGH-DOSE IBUPROFEN

59. Dr. Franklin opined that it was an extreme departure from the standard of practice to fail to monitor Patient 1's renal function while she was receiving high-dose ibuprofen. It was also an extreme departure from the standard of practice to treat Patient 1 with high-dose ibuprofen for a prolonged period of time, given that she had a history of PUD and symptomatic GERD. It was also an extreme departure from the standard of practice to fail to recommend an endoscopy when Patient 1's anemia was

discovered in her sole laboratory test. According to Dr. Franklin, if a patient declines blood testing, the only way to avoid harming the patient would be to decline prescribing a known nephrotoxic medication to a hypertensive patient who is at risk for hypertensive nephropathy. Instead, respondent continued with maximum dose treatment with ibuprofen over multiple years and only monitored renal function once. Dr. Franklin also considered respondent's decision to prescribe ibuprofen to Patient 1 who had a history of PUD and GERD symptoms as unjustified. The only safe course of action for Patient 1 who refused colonoscopy and would have likely refused endoscopy was to discontinue ibuprofen. Also, Fiorinal, which contains aspirin, another agent that can cause PUD, should have been discontinued.

Dr. Farrell agreed that an internist is responsible to monitor for renal failure for a patient on maximum ibuprofen. However, Dr. Farrell opined that the Board's Accusation is "presumptuous" because respondent is a board-certified gastroenterologist and no one asked respondent if he considered PUD or symptomatic GERD while treating the patient with ibuprofen. Dr. Farrell appeared to base his opinion on his review of the medical records believing that there was no mention that the patient had a history of PUD, and he was perplexed by the allegations in the Accusation. However, the medical record from December 7, 2018, referred to a patient history of PUD. Dr. Farrell also questioned why no one from the Board asked respondent if he recommended that Patient 1 have an endoscopy.

Dr. Farrell also opined that a physician can prescribe ibuprofen concomitantly with other medications to be used with caution to mitigate the risk of GERD. In this case, respondent was aware of Patient 1's medical history, advised her to take the ibuprofen with food, and he concomitantly treated with pantoprazole, which is indicated to prevent the harmful effects of ibuprofen on the digestive tract. Dr. Farrell

concluded that respondent's actions were within the standard of practice for a gastroenterologist.

60. The opinion of Dr. Franklin that respondent's conduct was an extreme departure from the standard of care was more persuasive and supported by the evidence. Despite Dr. Farrell's beliefs that the Board should ask respondent about his reasoning for the patient's care, his opinion is not persuasive. The standard of practice requires that any physician reviewing the medical record should be able to ascertain the treating physician's clinical justifications for the care provided. In this case, respondent failed to indicate in the record that he had considered her history of PUD and symptomatic GERD while prescribing high-dose ibuprofen over multiple years. He did not monitor for renal failure as required and he did not, at a minimum, recommend an endoscopy when the patient was found to be anemic. He showed have discontinued prescribing high-dose ibuprofen that the patient was using on a daily basis. The record is unclear if Patient 1 continues to take ibuprofen daily.

SIMVASTATIN-RELATED LIVER TOXICITY

61. Dr. Franklin opined that it was a simple departure from the standard of practice to fail to consider simvastatin-related liver toxicity when Patient 1's elevated liver function was discovered. With Patient 1's refusals to undergo testing, it was not within the standard of care to continue to prescribe simvastatin.

Dr. Farrell opined that respondent was within the standard of practice with the limited dose of simvastatin at 20 mg, which minimized potential side effects. The mild elevation in Patient 1's liver function while on simvastatin was within a tolerable range and not an indication to discontinue treatment. Dr. Farrell questioned why the Board

did not ask respondent if he considered possible simvastatin liver toxicity as an explanation for her mildly elevated liver test.

62. The opinion of Dr. Franklin that respondent's conduct was a simple departure from the standard of practice was more persuasive and supported by the evidence. Respondent did not document in the medical record, as required, that he considered the potential toxicity of continuing to prescribe simvastatin. Dr. Farrell appears to be more concerned about the Board asking respondent about his actions; however, the standard requires that any physician reviewing the medical record should be able to ascertain the treating physician's clinical justifications for the care provided. Respondent failed to document his clinical justifications for continuing to prescribe simvastatin when Patient 1's test result indicated elevated liver function.

LISINOPRIL MONITORING

63. Dr. Franklin opined that it was an extreme departure from the standard of practice to prescribe lisinopril to Patient 1 knowing that she would likely to refuse to undergo appropriate monitoring of electrolytes and renal function. Even though the record only indicated one prescription for lisinopril, the medical record did not establish when the treatment started or stopped. According to Dr. Franklin, there was no reason that a rational clinician who knew the patient would refuse blood testing to monitor renal function and electrolyte status would treat with lisinopril when there are other agents available to treat hypertension that do not require blood tests in order to be safe to use. Dr. Franklin noted that during his interview, respondent was unable to discuss the risk/benefit ratio of prescribing medications without monitoring the appropriate blood tests.

Dr. Farrell opined that the prescription for lisinopril for one month in February 2019, was appropriate and within the standard of care. Furthermore, he noted that Patient 1's laboratory test in April 2019 revealed normal electrolytes and renal function.

64. The opinion of Dr. Franklin that respondent's conduct was an extreme departure from the standard of practice was more persuasive and supported by the evidence. The evidence only established that respondent prescribed lisinopril for one month; however, with its level of toxicity respondent should not have prescribed the medication knowing that the patient would refuse to undergo required monitoring of electrolytes and renal function.

AMLODIPINE MONITORING

65. Dr. Franklin opined that it was an extreme departure from the standard of practice to prescribe amlodipine to a patient taking simvastatin who was known to refuse to allow appropriate monitoring of liver function and creatinine kinase levels. It was an extreme departure from the standard of practice to prescribe amlodipine with simvastatin without careful documentation of the discussion of the risks and benefits. According to Dr. Franklin, if the combination of amlodipine and simvastatin is used, it is mandatory to monitor creatinine kinase and liver function tests as well as to warn the patient to report any symptoms of hepatitis or rhabdomyolysis. Dr. Franklin concluded that it was not rational for respondent to prescribe amlodipine.

Dr. Farrell found that Patient 1 was only on amlodipine for one month and the FDA package insert does not recommend routine laboratory testing. Dr. Farrell acknowledged there are potential risks in prescribing amlodipine and simvastatin, and there is a need to monitor because of toxicity which can lead to liver injury. However,

Dr. Farrell opined that respondent was within the standard of practice to prescribe both medications concomitantly given that respondent prescribed the recommended dosage. Additionally, her laboratory tests showed her ALT within a tolerable range which refuted the argument that respondent was not exercising caution by not checking her liver functions when he prescribed simvastatin. Neither did Patient 1 complain of muscle pain in her monthly visits which would have indicated elevated creatinine kinase levels suggesting inflammation of the muscles. Dr. Farrell also noted that respondent discussed the side effects with Patient 1 in office visits on March 8, 2019 and April 8, 2019.

66. The opinion of Dr. Franklin that respondent's conduct was an extreme departure from the standard of practice was more persuasive and supported by the evidence. Respondent prescribed amlodipine while Patient 1 was also taking simvastatin knowing that she would refuse appropriate monitoring of her liver function. This deprived him of the ability to monitor the toxicity. Furthermore, respondent did not specifically document in the record that he discussed the associated risks and benefits of taking amlodipine with simvastatin. Neither did he document in the record that he discussed the necessity of regular laboratory testing to monitor her creatinine kinase and liver function.

FIORINAL USE FOR TREATMENT OF MIGRAINES

67. Dr. Franklin opined that it was an extreme departure from the standard of practice to prescribe four-times-daily Fiorinal to control migraines for an extended period. Dr. Franklin noted respondent's admitted lack of knowledge that Fiorinal can cause rebound headache and is approved only for short-term use. Dr. Franklin acknowledged that the Fiorinal FDA insert does not expressly prohibit long term use. According to Dr. Franklin, Fiorinal contains caffeine which is helpful for migraines;

however, if used regularly, the "abortive affect rapidly wanes and the caffeine often become[s] a trigger for migraine." Also, butalbital has an abortive effect on migraines only if used rarely and intermittently and regular use limits its abortive effect on migraines. Dr. Franklin noted respondent's responses during his interview demonstrating his limited experience with Fiorinal.

Dr. Farrell acknowledged that long term use of Fiorinal is not a common practice and may be unorthodox, but respondent had inherited the patient and the medication was working. The use of medications containing butalbital should be carefully monitored and respondent's monthly clinic visits sufficed as careful monitoring. According to Dr. Farrell, the FDA package insert does not say to avoid long-term use, but states to take as-needed and no more than six tablets daily and Patient 1 was taking four tablets daily. The FDA package insert also does not limit the amount of time the medication should be taken. Dr. Farrell opined that it was not unreasonable to continue the treatment of her migraine with Fiorinal in this clinical context because it was effective. Dr. Farrell opined that a reasonable clinician would have taken the same approach. He acknowledged that the patient refused a neurology consultation which might have offered other treatment recommendations.

68. The opinion of Dr. Franklin that respondent's conduct was an extreme departure from the standard of practice was more persuasive and supported by the evidence. The unorthodox medication regimen was compounded by respondent's lack of awareness of the efficacy of the treatment or the potential for making Patient 1's migraines worse, especially as she continued to experience headaches. Furthermore, respondent did not provide a discussion of his rationale for continuing to prescribe Fiorinal in the medical record.

69. No expert opinion was presented to support the allegations of incompetence in respondent's treatment of Patient 1.

Patient 2

70. Patient 2 has been under respondent's care for approximately 10 years. Patient 2's previous treating physician had established a regimen of high-dose opioid treatment for severe chronic back pain. Patient 2 also had hypertension, GERD, diverticulosis, hyperlipidemia, and depression. Respondent saw Patient 2 on a monthly basis and was able to reduce the number of narcotics by eliminating his prescriptions for SOMA and oxycontin.[9]

71. Throughout his care with respondent, Patient 2 has had blood pressure readings well above safe levels. Respondent provided medical records from 2015 and 2016 indicating that Patient 2 monitored his blood pressure at home. Also, an EKG taken in June 2016 revealed no evidence of strain on the patient's heart.

During his Board interview, respondent stated that Patient 2 had no "cardiac symptoms" and that he attributed the high blood pressure readings to "white coat" hypertension and recommended home blood pressure monitoring. "White coat" hypertension is a form of labile hypertension in which people exhibit elevated blood pressure in a clinical setting, but do not exhibit elevated blood pressure it in other

[9] In his report, Dr. Franklin concluded: "No departure from the standard of practice is present in [respondent's] management of [Patient 2's] chronic nonmalignant pain" except as it relates to his treatment of Patient 2's hypertension and his medical record keeping.

settings. Respondent did not document in the record that he suspected Patient 2 had "white coat" hypertension.

72. The medical records provided to the Board starting in 2017 indicated that Patient 2 continued to have blood pressure readings well above safe levels. For example, on June 20, 2019, Patient 2's blood pressure was elevated with a reading of 165/91, and respondent advised a low salt diet and home monitoring, and suggested that he might need anti-hypertensive medications if his blood pressure remained elevated. On August 21, 2019, Patient 2's blood pressure was elevated with a reading of 145/89, and on September 18, 2019, his blood pressure reading was 164/103. There was no notation in the medical record that respondent discussed these readings with the patient. The assessment/plan indicated "essential hypertension (primary encounter diagnosis)," with no indication that respondent had diagnosed "white coat" hypertension. On October 16, 2019, Patient 2's blood pressure was elevated with a reading of 155/86. There was no notation in the medical records that respondent discussed the reading with the patient or that he had Patient 2 conduct home blood pressure monitoring.

73. On November 14, 2019, Patient 2's blood pressure reading was 149/83. Respondent wrote the following in the medical record: "Hypertension Mild Advised home monitoring and a low salt diet. Advised that if BP remains persistently elevated he will need a medication for BP." During his monthly visits, Patient 2's blood pressure readings continued to be elevated with the last reported reading of 166/90 on March 11, 2020. After the onset of the COVID-19, there were no other blood pressure readings because the patient only had phone appointments.

Respondent's Testimony Regarding Treatment of Patient 2

74. According to respondent, Patient 2's blood pressure fluctuated, but most times it was within normal range which is a symptom of "white coat" hypertension. "White coat" hypertension is not treated with medication because it may lower blood pressure too much and create a reduction in the heart flow precipitating a heart attack, as well as erectile dysfunction. Respondent was not concerned about Patient 2's high blood pressure readings because he "knows the patient's background." Respondent testified that he discussed a low salt diet with Patient 2 as a "hygiene measure because of a lurking suspicion of high BP."

75. Respondent believes that his treatment of Patient 2 met the standard of care in all respects. Patient 2 continues to be respondent's patient and he has not prescribed any blood pressure medications. Respondent provided additional medical records to his experts and at the hearing. These documents were not reviewed by the Board's expert prior to issuing his written report.

Experts' Opinions Regarding Care of Patient 2

76. Complainant alleges that Patient 2's medical record contains no results of home blood pressure monitoring and respondent failed to document his rationale for treatment or non-treatment of Patient 2's hypertension. However, the medical records from 2015 and 2016 documented home blood pressure monitoring. There was no other documentation of home blood pressure monitoring.

Documentation of Non-Treatment of Hypertension

77. Dr. Franklin opined that it was a simple departure from the standard of practice for respondent to fail to document his treatment or non-treatment of Patient

2's hypertension. He based his decision on the medical records provided to the Board Dr. Franklin acknowledged that medical records in 2015 and 2016 confirmed respondent's discussion with Patient 2 regarding hypertension. However, Dr. Franklin opined that in those records respondent did not document a plan to address Patient 2's hypertension, so he did not meet the standard of practice. If respondent determined that Patient 2 had "white coat" hypertension, then the standard of practice is to develop a plan for management which respondent did not do.

Dr. Farrell does not treat patients with hypertension and refers them back to their primary care providers. Dr. Farrell disagrees that a treater must on each occasion indicate in the medical record whether he is treating the hypertension or not. Dr. Farrell characterized the Board's allegation as "false" and noted that respondent documented his management when he discussed home monitoring, when the EKG indicated no uncontrolled hypertension in 2016, when he recommended a low salt diet for Patient 2, and when there was no altered kidney function revealed in the laboratory testing. According to Dr. Farrell, respondent's monthly close monitoring of Patient 2's blood pressure was within the standard of practice.

78. The opinion of Dr. Franklin that respondent's conduct was a simple departure from the standard of practice was more persuasive and supported by the evidence. Respondent failed to document his non-treatment of Patient 2's hypertension, including "white coat" hypertension.

HOME BLOOD PRESSURE MONITORING

79. Dr. Franklin opined that it was a simple departure from the standard of practice for respondent to fail to document the results of Patient 2's home blood pressure monitoring or to document that home blood pressure monitoring was not

done as instructed. After 2016, there was no evidence in the record that respondent documented any home blood pressure readings or whether Patient 2 had conducted the home blood pressure monitoring.

Dr. Farrell opined that respondent met the standard of practice. Dr. Farrell stated that respondent recommended home blood pressure monitoring in 2015, and on June 20, 2019, and November 14, 2019, when he advised Patient 2 to consume a low salt diet and that he may need treatment with an anti-hypertensive medication. Dr. Farrell also relied on a letter from Patient 2 dated February 10, 2021.[10]

80. The opinion of Dr. Franklin was more persuasive and supported by the evidence. Again, Dr. Franklin acknowledged that medical records in 2015 and 2016 confirmed the documented results of home blood pressure monitoring. However, respondent did not document a plan to address Patient 2's hypertension, including "white coat" hypertension. Respondent's failure to continue home blood pressure monitoring constituted a simple departure from the standard of practice.

RATIONALE FOR NON-TREATMENT OF HYPERTENSION

81. Dr. Franklin opined that it was a simple departure from the standard of practice for respondent to fail to document in the medical record his rationale for treatment or non-treatment of Patient 2's hypertension. Also, respondent's initial belief that Patient 2 had "white coat" hypertension appeared to have been subsiding. He testified that by September 2019, he began to suspect hypertension, but he did not prescribe an anti-hypertensive medication.

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[10] This letter was not included in the evidence in this administrative proceeding.

Dr. Farrell opined that respondent did not depart from the standard of practice. Dr. Farrell characterized the Board's allegation as "false." Dr. Farrell opined that as respondent monitored Patient 2's blood pressure monthly and his diastolic reading was never greater than 100, it is reasonable to conclude that Patient 2 had "white coat" hypertension.

82. The opinion of Dr. Franklin was more persuasive and supported by the evidence. Respondent's failure to document his rationale for non-treatment of Patient 2's hypertension constituted a simple departure from the standard of practice.

Medical Records for Patients 1 and 2

83. The standard of care requires providers to maintain adequate and accurate documentation of the care and treatment provided to a patient in order to provide other providers with sufficient information so that they can adequately treat the patient. The experts' opinions diverged as to the extent of detail necessary to meet the standard of care for medical record keeping.

DR. FRANKLIN

84. Dr. Franklin described respondent's medical records as "a confusing mess" that lacked a clear and understandable list of medications prescribed to the patients. Overall, the medical records lacked a comprehensive history and physical examination, at any time, or in the aggregate, for either patient. None of the conditions treated by respondent were supported by an adequate discussion of the treatment, the basis for the treatment, or the decisions made by respondent over the course of treatment.

Dr. Franklin opined that even after respondent switched to Epic electronic records, he did not accurately describe which medications were prescribed at visits, at what doses, with what frequency, in what quantity, or for what problem. According to Dr. Franklin, a physician should remove old medication entries in Epic to accurately reflect the current status of prescriptions. Dr. Franklin observed that respondent's Epic entries for 2019-2020 appear to have been largely cut and pasted, without discussion of the actual clinical presentation on the dates in question.

Dr. Franklin opined that because both patients were treated with potentially dangerous combinations of medications, every failure of the record to outline the details of that treatment and the historical and physical findings upon which it is based, as well as his rationale for prescribing, represented an extreme departure from the standard of practice. No single progress note in either medical record met the basic standard of practice for medical record keeping; therefore, every single progress note in both records represents an extreme departure from the standard of practice.

85. Regarding Patient 2, Dr. Franklin opined that Patient 2's medical records were inconsistent with his complaint and the conditions respondent described in his interview. Respondent did not document his decision not to treat Patient 2's hypertension which amounts to inadequate and inappropriate medical record keeping. For example, Patient 2's medical record did not reflect that respondent performed an examination of Patient 2's back. Patient 2's medical record indicated a normal physical examination; however, Patient 2's severe spinal problems should not have resulted in a normal physical examination. Patient 2's medical record contained no documentation of a knee examination, but in December 2018, a dermatology referral was made for skin lesions on the knee. Patient 2's medical record contained no documentation of

respondent's examination of Patient 2 consistent with the chronic back pain, numbness, and unstable gait as described by the patient in a questionnaire.

DR. BROSE

86. Dr. Brose acknowledged that he asked respondent to transcribe the medical records that were illegible and "not wholly clear." After reviewing the transcribed notes, Dr. Brose concluded that the medical records were adequate and accurate. He concluded that since the "vast majority" of the content in the progress notes were "mostly legible," the records met the standard of practice.

DR. FARRELL

87. Dr. Farrell acknowledged that respondent provided him with typewritten notes of his handwritten medical records. Dr. Farrell opined that the medical records were adequate and he could pick up the records and continue with the patients' care based on information provided in the medical records. Dr. Farrell acknowledged that the records were "not the most thorough." Dr. Farrell noted that respondent assessed each patient at each visit and an assessment occurred whether respondent documented it or not and he would adjust any prescriptions as necessary. Dr. Farrell states that a physician does not need to list indicators or rationale at each visit for every prescription, and that each practitioner has a different approach to medical documentation.

Dr. Farrell opined that the list of medications was clear and understandable and he knew what medication the patients were on at any given time. However, under cross-examination, when asked to provide the correct prescription for Patient 1 for Fiorinal in the record for August 2019, he testified that he was not sure. Dr. Farrell

acknowledged that a subsequent treater would have to review chart entries, handwritten prescriptions, and electronic medication list to get a clear picture.

Dr. Farrell opined, in regard to Patient 2, that respondent did not have to perform a reexamination of patient's back at every visit as the neurological assessment of his reflexes and gait on each visit were sufficient. In his report, Dr. Farrell referred to an office visit on June 20, 2019, as an example during visits respondent completed a 13-organ review of systems and physical examination with an assessment and treatment plan during a 35-minute thorough and comprehensive follow-up visit. Dr. Farrell stated that respondent provided the same type of comprehensive follow up visit for Patient 1, and provided an example from a visit on July 8, 2019. Dr. Farrell described respondent's care of the two patients as exemplary and it is rare in his experience to see patients followed so consistently and attentively.

Dr. Farrell concluded in his report: "The Medical Board Accusation contains assertions, statements and assumptions that are factually incorrect. The Medical Board was mistaken in not spending more time in conversation with [respondent] to clarify matters. These deficiencies led the Medical Board to erroneous conclusions. The Medical Board's foundation for praying for discipline against [respondent] is flawed and misrepresents the medical records and facts."

88. The opinion of Dr. Franklin was more persuasive and supported by the evidence. It is clear that necessary elements of respondent's assessment and treatment were not documented in the patients' charts, thereby making it difficult for others to understand what actions he took and why. This was even to the extent where respondent had to transcribe the medical records for his own experts to understand his treatment and prescribed medications. Respondent's medical record keeping was

inadequate and inaccurate and constituted an extreme departure from the standard of practice.

Failure to Report Felony Indictment

89. On October 6, 2020, a felony indictment entitled "*United States of America v. Bhupinder Bhandari*, Case 3:20-cr-00374-CRB" was filed against respondent in the United States District Court for the Northern District of California. The criminal proceedings are pending.

90. Business and Professions Code section 802.1 provides that a physician shall make a written report to the Board within 30 days of the bringing of a felony indictment against the physician.

91. Respondent confirmed that he did not make a written report to the Board within 30 days of the felony indictment on October 6, 2020. According to respondent, his first criminal defense attorney said that she did not know if he was required to disclose the felony indictment to the Board. According to respondent, his second criminal defense attorney contacted the Board and was told that respondent did not need to report the felony indictment and only convictions had to be reported.

Respondent believes that the Board was aware of the felony indictment during his interview on November 20, 2020. However, respondent only disclosed his arrest and did not disclose that a felony indictment had been filed against him. Also, a verbal disclosure at the interview does not equate to a written report to the Board.

Respondent's explanations do not absolve him of his responsibility to make a written report to the Board within 30 days of October 6, 2020, of the felony indictment filed against him.

Additional Evidence Pertaining to Rehabilitation/Mitigation

92. Respondent has received praises and accolades over the years. In 2008, he received the 20th Assembly District Unity award. Respondent received the 2013 Jefferson Award presented by a local television station for outstanding community service in offering free medical services to those in need. He was the recipient of the 2019 Alameda County Excellence in Human Relations Award. He has volunteered at the Sikh Temple for over eight years providing free medical consultations for attendees and he has organized health care camps.

93. Respondent has taken ethics and medical recordkeeping courses.

94. The following individuals testified and/or submitted letters:

a. Li Kuo Kong, M.D., is the president of the medical staff at St. Rose Hospital in Hayward. Dr. Kong testified that she has known respondent since 2004, when Dr. Kong joined the medical staff, and became a member of the leadership in 2008. Dr. Kong has consulted with respondent on cases. Dr. Kong described respondent as providing faithful and excellent service as the primary gastroenterologist at St. Rose Hospital, and they relied upon him during the COVID-19 crisis. According to Dr. Kong, respondent is very well respected, provides medical direction and leadership in his area of expertise, and has had no deficiencies or major peer review concerns.

b. Romesh Japra, M.D., is a cardiologist and testified that he has known respondent since 1995. They have referred patients to each other and Dr. Japra has been satisfied with respondent's services. Dr. Japra described respondent as intelligent, caring, honest, and trustworthy; otherwise, he would not send his patients to respondent.

c. Pradeep Kumar, M.D., has practiced internal medicine in Fremont since 2000. He testified that he has worked with respondent at Washington Hospital and St. Rose Hospital for approximately 21 years and they consult each other. Dr. Kumar has had no issues with respondent's judgment or medical management of patients. He described respondent as honest and trustworthy and one who serves Medi-Cal patients which other providers refuse to treat. Dr. Kumar has referred his family members to respondent for treatment.

d. William Lowery, M.D., Chairman of Medicine, Alameda Hospital, wrote a letter of support confirming that respondent served as the sole gastroenterology specialist from March 2019 to September 2020, in an active emergency room and during the COVID pandemic, and continues to maintain privileges. Dr. Lowery vouches for respondent's gastroenterology work and supports him without reservation.

e. Najia Hamid, Executive Director/Founder of Afghan Elderly Association (AEA) wrote a letter of support. The AEA provides health education and other services to elderly Afghan refugees. Hamid has known respondent over 25 years. Over the past seven years, respondent has volunteered for AEA providing care and treatment to consumers. Hamid described respondent as having a pleasant personality, talented and a prominent figure of exceptional and admiral character.

f. Harinderpal Singh, Director of the Gurdwara Sahib Sikh Temple in Fremont, wrote a letter verifying that respondent has volunteered for the past seven years by giving free medical advice to members, particularly those without medical insurance.

95. Respondent is married with two children under the age of three.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App.3d 853, 856.)

2. Unprofessional conduct is grounds for discipline of a physician's Certificate pursuant to Business and Professions Code sections 2227,[11] 2234, and 2266. Pursuant to Business and Professions Code section 2234, a licensee may be subject to discipline for committing unprofessional conduct, which includes violating the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), committing repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)),[12] demonstrating incompetence (Bus. & Prof. Code, § 2234, subd. (d)), and failing to maintain adequate and accurate patient records relating to the provision of services (Bus. & Prof. Code, § 2266).

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[11] Business and Professions Code section 2227 authorizes the Board to take disciplinary action against licensees who have been found to have committed violations of the Medical Practice Act.

[12] Under the statute, in order to be repeated negligent acts there must be two or more separate and distinct negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

First Cause for Discipline (Gross Negligence/Repeated Negligent Acts/Incompetence)

3. An extreme departure from the standard of care constitutes gross negligence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) Complainant established by clear and convincing evidence that respondent's treatment of Patient 1 constituted an extreme departure from the standard of practice and was grossly negligent and repeatedly negligent.[13]

In particular, respondent prescribed a dangerous combination of benzodiazepines and a barbiturate, some in extremely high doses, over a lengthy period of time; continued to prescribe this dangerous combination of medications despite Patient 1's refusal to follow his recommendations for laboratory testing and consultations; failed to document an appropriate alcohol use history and failed to document warnings of the risks of alcohol consumption while taking the prescribed medications; failed to consider the effect of prescribing high-dose ibuprofen in conjunction with her other medical conditions; prescribed a medication knowing that the patient would refuse required monitoring of electrolytes and renal function; prescribed medications without documenting discussions of the associated risks; and prescribed a medication without an awareness of the efficacy of the treatment or potential for worsening her condition as set forth in Factual Findings 11-36, and 50-68.

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[13] It is noted that complainant's expert found that it was a simple departure from the standard of care in respondent's failure to consider simvastatin related liver toxicity when Patient 1's liver function test was elevated.

Cause for discipline exists pursuant to Business and Professions Code sections 2227 and 2234, subdivisions (b) and (c).

4. The Accusation also alleges that respondent's conduct constituted incompetence pursuant to Business and Professions Code section 2234, subdivision (d). In *Kearl, supra,* 189 Cal.App.3d at pp. 1054-1055, the Court of Appeal explained the criteria for determining whether conduct constitutes incompetence in professional licensing matters:

> The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Pollack v. Finder* (1978) 85 Cal.App.3d 833, 837.) Incompetency is distinguishable from negligence, in that one "may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.*, at p. 838.)

As no expert opinion was presented to support the allegations of incompetence, no finding can be made that respondent was incompetent in connection with his care of Patient 1. (Factual Finding 69.) Accordingly, cause for license discipline based on incompetence does not exist pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d).

Second Cause for Discipline (Repeated Negligent Acts)

5. Complainant established by clear and convincing evidence that respondent's treatment of Patient 2 departed from the standard of practice and he was repeatedly negligent in that respondent failed to document his treatment or non-treatment (or his rationale) of Patient 2's hypertension, and he failed to follow

through on or monitor his recommendation for home blood pressure monitoring, or confirm that Patient 2 performed home blood pressuring monitoring (except for the time period in 2015 and 2016) as set forth in Factual Findings 11-12, 69-73, and 76-82. Cause for discipline exists pursuant to Business and Professions Code section 2234, subdivision (c).

Third Cause for Discipline (Failure to Maintain Adequate and Accurate Records)

6. Complainant established by clear and convincing evidence that respondent's conduct established an extreme departure from the standard of practice and was unprofessional conduct, grossly negligent, and repeatedly negligent in that he failed to maintain adequate and accurate medical records for Patient 1 and Patient 2 as set forth in Factual Findings 11-12, 83-88. Cause for discipline exists pursuant to Business and Professions Code sections 2234, subdivisions (b) & (c) and 2266.

Fourth Cause for Discipline (Failure to Report Felony Indictment)

7. Complainant established by clear and convincing evidence that respondent failed to make a timely written report of the felony indictment filed against him in the United States District Court on October 6, 2020, as set forth in Factual Findings 89-91. Cause for discipline exists pursuant to Business and Professions Code section 2234, subdivision (a),[14] as it relates to section 802.1.

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[14] Business and Professions Code section 2234, subdivision (a), provides that unprofessional conduct includes "Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any

Disciplinary Determination

8. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (12th ed., 2016),[15] recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's misconduct under Business and Professions Code section 2266. In closing argument, complainant suggested that a three-year period of probation be imposed with a requirement to take continuing education courses on prescribing medications and recordkeeping. Respondent believes that his treatment met the standard of care and discipline is unwarranted.

In exercising its disciplinary functions, protection of the public is the Board's paramount concern. (Bus. & Prof. Code, § 2229, subd. (a).) At the same time, the Board is charged with taking disciplinary action that is calculated to aid the rehabilitation of the licensee whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

9. Respondent undoubtedly has provided good and caring treatment to many patients over the course of his 30-year career and has accepted patients that other physicians might reject. However, respondent committed grossly negligent and repeated negligent acts in connection with two different patients (one on an

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provision of this chapter." This provision is cited in the jurisdiction section of the First Amended Accusation.

[15] The Board's Disciplinary Guidelines are incorporated in California Code of Regulations, title 16, section 1361.

unorthodox and dangerous combination of drugs over a long period of time) which raises concerns about his technical skills and clinical judgment.

It is also concerning that he was too empathetic when Patient 1 refused to comply with his recommendations. Instead, he continued on without changing course, without requiring psychological or psychiatric care, without regular laboratory testing, and without consulting with other practitioners when he ventured outside his expertise. Respondent never broached the subject of the possibly terminating the relationship or conditioning future prescriptions on other treatment modalities with Patient 1. Even more concerning is respondent's inaccurate and inadequate recordkeeping for both patients. Importantly, respondent continues to defend his actions in the treatment of the two patients and does not acknowledge that he deviated from the standard of practice in any respect.

However, the facts in the instant case warrant a deviation from the Disciplinary Guidelines for several reasons: First, while respondent's medical documentation was wholly inadequate, he has voluntarily taken a medical recordkeeping course. Second, he has had a long and successful career over 30 years as a gastroenterologist and has no disciplinary history. Third, his professional integrity, generosity and expertise are highly regarded by physicians who are familiar with his work and know him well and by members of the community. Lastly, in both cases, there was no evidence that either patient suffered harm as a result of respondent's unprofessional conduct.

Under the circumstances, a three-year period of probation, including taking courses in prescribing practices and medical recordkeeping, will protect the public by ensuring that respondent possesses the skills and judgment to practice within the standard of care.

ORDER

Physician's and Surgeon's Certificate No. A 50058, issued to respondent Bhupinder Nath Bhandari, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for three years under the following terms and conditions:

1. 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the First Amended Accusation, but before 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 if 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 15 calendar days after successfully completing the course or not later than 15 calendar days after the effective of the Decision, whichever is later.

2. 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended 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 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

4. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

5. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current

version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

10. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender her certificate. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

14. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense

and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

DATE: October 8, 2021

Regina Brown

REGINA BROWN

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **BHUPINDER NATH BHANDARI, M.D.** 3755 Beacon Avenue Fremont, CA 94538 Physician's and Surgeon's Certificate No. A 50058, Respondent.	Case No. 800-2017-039428 **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 October 22, 1991, the Medical Board issued Physician's and Surgeon's Certificate Number A 50058 to Bhupinder Nath Bhandari, M.D. (Respondent). The certificate is renewed and current, with an expiration date of December 31, 2022. An Accusation was filed against Respondent's Certificate on November 30, 2020.

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 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 provides, in pertinent part:

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

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

(b) Gross negligence.

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

(d) Incompetence.

6. Section 2266 of the Code provides that 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.

7. Section 802.1 of the Code provides that a physician and surgeon shall make a written report to the Board within 30 days of the bringing of a felony indictment against him/her.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence)

8. Between 2017 and 2020, Respondent, a primary care physician, saw Patient 1[1] at regular, usually monthly, intervals. Patient 1 presented with a number of medical problems,

[1] To preserve patient confidentiality, the subject patients are identified herein as Patient 1 and Patient 2. The patients' full names will be provided to Respondent upon request.

including anxiety, hypertension, hyperlipidemia, migraine headache, insomnia, gastroesophageal reflux disease (GERD) with a history of peptic ulcer disease (PUD), and hypothyroidism.

9. Over the course of treatment, Respondent regularly prescribed a variety of medication. Respondent treated Patient 1's anxiety and insomnia by prescribing Ativan[2] at a steady dosage of approximately 8 mg per day. From January 2017 until June 2018, Respondent also prescribed Ambien[3]. In July 2018, Respondent replaced Ambien with Restoril[4] at an initial dosage of 30 mg per day, then decreased to 15 mg per day. Throughout, Respondent treated Patient 1's migraine headache with Fiorinal[5] (four times daily) and ibuprofen at the maximum dosage of 800 mg, three times a day. He prescribed levothyroxine to treat Patient 1's hypothyroidism, metroprolol to treat hypertension, pantoprazole to treat GERD, and simvastatin to treat hyperlipidemia.

10. Patient 1 reported a needle phobia and declined to undergo regular laboratory testing. Patient 1 declined psychiatry and neurology consults, and would not undergo routine testing such as pap smears or colonoscopy. Respondent noted several times that Patient 1 declined recommended medication changes or dosage adjustments.

11. Respondent treated Patient 1 with a combination of multiple and large dosages of sedative benzodiazepines for anxiety and insomnia, while at the same time prescribing the stimulant Fiorinal, in an amount sufficient to induce anxiety and significantly interfere with sleep.

12. Respondent stated in his Board interview that Patient 1 did not use alcohol. However, there is no indication in the medical record that an alcohol use history was ever taken or that alcohol use was ever discussed with Patient 1. In April 2019, Patient 1 underwent her only documented laboratory tests, which revealed an elevated liver function test, a common indicator

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[2] Ativan, a trade name for lorazepam, is a benzodiazepine and a controlled substances. It is a central nervous system depressant. Benzodiazepines are highly habit forming.

[3] Ambien, a trade name for zolpidem, is a benzodiazepine. It is a centrally acting sedative-hypnotic drug, a central nervous system depressant, and a controlled substance.

[4] Restoril (a trade name for temazepam) is another benzodiazepine hypnotic agent and a controlled substances.

[5] Fiorinal is a combination of the barbiturate butalbital, aspirin and caffeine. It is a controlled substance, and a sedative-hypnotic agent that has synergistic toxicity with other sedative agents, particularly benzodiazepines and opioids. A similar drug, Fioricet, is identical, except acetaminophen replaces the aspirin. Respondent prescribed Fioricet on one occasion.

of alcohol abuse. Respondent took no steps to ascertain whether Patient 1 was using alcohol, which would have been extremely dangerous given her use of benzodiazepines and barbiturates. Respondent also failed to consider the possibility of liver toxicity from simvastatin.

13. Respondent prescribed ibuprofen to his hypertensive patient, in the maximum dosage, even when she did not agree to undergo the laboratory testing necessary to assess her renal function, and even as the patient complained about current GERD symptoms, and even after her single blood test revealed anemia in April 2019.

14. Respondent prescribed lisinopril to treat Patient 1's hypertension. He added another anti-hypertensive, amlodipine, in February 2019. Respondent's record does not document any discussion of the risks associated with prescribing amlodipine along with simvastatin, or the necessity of regular laboratory testing to monitor creatinine kinase and liver function.

15. Respondent continued to prescribe Fiorinal to treat Patient 1's migraine headache, with the understanding that Patient 1 took Fiorinal on a daily basis. Respondent's record contains no discussion of the rationale for prescribing a medication not indicated or approved for long-term treatment of migraine, and when asked during his interview, Respondent revealed that he was unaware that Fiorinal can cause rebound headaches and is only indicated for short term use.

16. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 1, and is subject to disciplinary action under sections 2234, and/or 2234(b), and or 2234(c), and or 2234(d) of the Code, in that Respondent committed gross negligence, and/or repeated negligent acts, and/or demonstrated incompetence, including but not limited to the following:

A. Respondent prescribed a dangerous combination of drugs, some in extremely high doses, including Ativan, Restoril, Ambien and Fiorinal, over a lengthy period of time.

B. Respondent continued to prescribe dangerous medications to Patient 1 in spite of her refusal to follow treatment recommendations such as laboratory testing and consultations.

C. Respondent failed to undertake and/or document an appropriate alcohol use history, and failed to provide and/or document a warning of the risks of alcohol consumption while taking the prescribed medications.

D. Respondent treated Patient 1 with high dose ibuprofen for a prolonged period of time, without consideration of her PUD and symptomatic GERD, and without recommending endoscopy when the patient was anemic.

E. Respondent failed to consider simvastatin related liver toxicity when Patient 1's liver function test was elevated.

F. Respondent prescribed lisinopril to Patient 1 knowing that she would likely refuse to undergo appropriate monitoring of electrolytes and renal function.

G. Respondent prescribed amlodipine to Patient 1, who was also taking simvastatin and who was known to refuse testing for liver function and creatinine kinase levels, and without documenting a discussion of the risks associated with the prescription.

H. Respondent prescribed four times daily Fiorinal for migraine over a prolonged period, without an awareness of the efficacy of the treatment or the potential for making the patient's migraine worse.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

17. Respondent treated Patient 2 beginning in approximately 2010. Patient 2 came under Respondent's care already on high dose opioid treatment for severe chronic back pain which was not relieved by surgical and other interventions. Patient 2 also had hypertension, GERD, diverticulosis, hyperlipidemia, and depression. Due to insurance and worker's compensation issues, Respondent was unsuccessful in referring Patient 2 to pain medicine specialists.

18. Respondent treated Patient 2 for his pain and other medical issues, and was able to reduce the number of narcotics the patient was taking.

19. Over the course of treatment, Patient 2 had blood pressure readings well above safe levels. Respondent did not prescribe any treatment, and there is virtually no discussion of the patient's hypertension in the medical record. During his Board interview, Respondent stated that the patient had no "cardiac symptoms" and that he attributed the high blood pressure readings to

"white coat"[6] hypertension. Respondent stated that he recommended home blood pressure monitoring, but his record contains no results of that monitoring.

20. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 2, and is subject to disciplinary action under sections 2234, and or 2234(c), in that Respondent committed repeated negligent acts, including but not limited to the following:

A. Respondent failed to document treatment or non-treatment of Patient 2's hypertension.

B. Respondent failed follow through on or monitor his recommendation for home blood pressure monitoring, or to confirm that Patient 2 performed home blood pressuring monitoring.

C. Respondent failed to document the rationale for treatment or non-treatment of Patient 2's hypertension.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

Patient 1/Patient 2

21. Respondent's medical records lack a comprehensive history and physical examination, at any time, or in the aggregate, for either Patient 1 or Patient 2. None of the conditions treated by Respondent for either patient is supported by an adequate discussion of the treatment, the basis for the treatment, or the decisions made by Respondent over the course of treatment.

22. Respondent's records, even after he switched to an electronic medical record, do not accurately describe which medications were prescribed at visits, at what doses, with what frequency, in what quantity, or for what problem.

23. Respondent's medical records for Patient 2 are inconsistent with the Patient's complaints and the conditions Respondent described in his interview. For example, for all of 2017, Respondent's record reflects no examination of Patient 2's back, when back pain was the prevailing complaint. Patient 2 is consistently described in the medical record as having a normal

[6] White coat hypertension is a form of labile hypertension in which people exhibit elevated blood pressure in a clinical setting, but do not exhibit it in other settings.

physical examination, when it is known that Patient 2 suffered from severe spinal problems that would not result in a normal physical examination. Throughout 2018, Respondent's record contains no documentation of a knee or back examination, but in December 2018, a dermatology referral was made for skin lesions on the forehead and knee. Respondent's medical record contains no documentation of examination of Patient 2 consistent with the chronic back pain, numbness, unstable gait described by the patient in a questionnaire and by Respondent during his interview. Respondent's electronic medical records for 2019-2020 appear to have been largely cut and pasted, without discussion of the actual clinical presentation on the dates in question.

24. Respondent's medical record for Patient 1 and Patient 2 do not include a complete assessment of the patients' presenting condition, an assessment of the patient, the rationale for prescribing, or response to treatment. Respondent's records regularly state that a medication was prescribed for the patient, but do not state the medical indication or rational for the prescription. Respondent's records for each patient lack a clear and understandable list of medications prescribed, and it is impossible to determine what medication the patients were on at any given time.

25. Respondent's record for Patient 1 does not contain even a cursory discussion of the rationale for prescribing benzodiazepines in large quantities, for adding a second benzodiazepine, or for prescribing multiple sedatives while simultaneously prescribing a drug containing a significant amount of caffeine.

26. Patient 1's record contains no alcohol history, and no consideration of or discussion with Patient 1 regarding the significant risk alcohol use would pose given the combination of medications prescribed to the patient.

27. Respondent is guilty of unprofessional conduct and/or gross negligence, and/or repeated negligent acts, and subject to discipline for violation of Sections 2234(b), and/or 2234(c), and/or 2266 of the Code based on his failure to maintain adequate and accurate medical records for Patient 1 and Patient 2.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Report Felony Indictment)

28. A felony indictment entitled "*USA v. Bhandari,*" No. 3:20cr374, was filed against Respondent in the United States District Court for Northern California on October 6, 2020. These criminal proceedings are pending. Respondent has subjected his Physician's and Surgeon's certificate to disciplinary action for failure to make a timely written report of that indictment to the Board, as required by Code section 802.1.

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 50058, issued to Bhupinder Nath Bhandari, M.D.;

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

3. Ordering Bhupinder Nath Bhandari, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUL 06 2021

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

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