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

In the Matter of the Accusation Against: Robert Bruce Dozor, M.D. Physician's and Surgeon's Certificate No. G 48771 Respondent.	Case No. 800-2019-055155

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 3, 2022.

IT IS SO ORDERED January 27, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

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

In the Matter of the Accusation Against: **ROBERT BRUCE DOZOR, M.D.** **175 Concourse Blvd** **Santa Rosa CA 95403-8217** **Physician's and Surgeon's Certificate No. G 48771** Respondent.	Case No. 800-2019-055155 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

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

2. ROBERT BRUCE DOZOR, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about August 30, 1982, the Board issued Physician's and Surgeon's Certificate No. G 48771 to Respondent. The Physician's and Surgeon's Certificate was in full force and

effect at all times relevant to the charges brought in Accusation No. 800-2019-055155 and expired on November 30, 2021.

JURISDICTION

4. Accusation No. 800-2019-055155 was filed before the Board, and it is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 15, 2021. A copy of Accusation No. 800-2019-055155 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2019-055155. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2019-055155, agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. G 48771 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

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

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

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 48771, issued to Respondent ROBERT BRUCE DOZOR, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If he ever applies for licensure or petitions for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Respondent must comply with all the

laws, regulations and procedures for licensure in effect at the time the application or petition is filed, and all of the charges and allegations contained in Accusation No. 800-2019-055155 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the application or petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2019-055155 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/11/2021

Robert Bruce Dozor MD

ROBERT BRUCE DOZOR, M.D.
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 12-27-21

Respectfully submitted,

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

HAMSA M. MURTHY
Deputy Attorney General
Attorneys for Complainant

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Stipulated Surrender of License and Order - stipulated surrender Dozor.docx

Exhibit A

Accusation No. 800-2019-055155

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

In the Matter of the Accusation Against: **ROBERT BRUCE DOZOR, M.D.** **175 Concourse Blvd.** **Santa Rosa, CA 95403-8217** **Physician's and Surgeon's Certificate No. G 48771,** Respondent.	Case No. 800-2019-055155 **ACCUSATION**

PARTIES

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

2. On or about August 30, 1982, the Board issued Physician's and Surgeon's Certificate Number G 48771 to Robert Bruce Dozor, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2021, unless renewed.

JURISDICTION

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

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

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

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

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

"(b) Gross negligence.

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

"(d) Incompetence.

". . ."

6. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this

subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"..."

7. Section 2242(a) of the Code states, in relevant part, that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

8. Section 2266 of the Code states 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.

9. Section 725(a) of the Code states, in relevant part, that repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, as determined by the standard of the community of licensees, is unprofessional conduct.

FACTUAL ALLEGATIONS

10. At all times relevant to this matter, Respondent was licensed and practicing medicine in California. In 2001, Respondent founded Integrative Medical Clinic which is a multi-specialty group including, among others, physicians, naturopaths, a chiropractor, an acupuncturist, a physical therapist, and a massage therapist. He describes his practice as "holistic" pain management with his role as "the one writing the opioids."[1]

PATIENT A[2]

11. On March 11, 2016, Patient A came to the Integrative Medical Clinic (Clinic) for pain management[3] related to low back pain and sciatica, as his doctor was retiring. During the intake process, Patient A wrote his treatment goal to be "???." The initial treatment plan was to

[1] Respondent's quotes are taken from his Board interview and his subsequent emails to the Board.

[2] The patients are designated in this document as Patient A, B, and C to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[3] Since 2013, Patient A had been on a stable dose of oxycodone (30 milligrams: 4 times daily) and Soma (350 milligrams). Oxycodone is a narcotic analgesic and is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

continue Patient A on 180 milligrams of oxycodone[4] and Soma[5] three times daily without any documentation, or apparent necessity for such a large dose of opioids in combination with a muscle-relaxant. During the course of treatment, Patient A was treated at the Clinic for sciatica, cervical radiculopathy, polyneuropathy, sleep apnea, and colon cancer.

12. Respondent kept very poor medical records related to his care and treatment of Patient A. For example, on April 6, 2016, Respondent documented only a history of "tired and sore" and the physical examination, assessment, and plan portions of the records were blank. Respondent prescribed Patient A pain medications including oxycodone without, at times, documenting any discussion of pain. (Example, May 31, 2016.) The first time Respondent documented Patient A's vital signs was on September 20, 2016, which was Patient A's eighth appointment with Respondent.

13. On December 11, 2017, Patient A was diagnosed with metastatic colon cancer after experiencing worsening low abdominal pain, unintentional weight loss, and back pain. By December 22, 2017, Respondent noted that Patient A's oxycodone prescription was 30 milligrams (2 tablets every 4 hours.)

14. By January 15, 2018, Patient A's pain was not well-managed; he had run out of medications and had begun taking one to two Valium[6] a day. Respondent's plan was to increase methadone[7], refill Patient A's oxycodone, and do alternative medicine. On June 7, 2018, Respondent noted that the pharmacy would not fill his prescriptions and Patient A began to exhibit some red flags of aberrant drug behavior: "a few days early" (7/27/2018); early refill of oxycodone authorized (9/28/2018); "may need meds early" (10/26/2018); "early refill" and "lost

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[4] Oxycodone is more potent than morphine and has an MME of 1.5. So, for example, 180 milligrams of oxycodone translates into 270 MME, which is three times the maximum dose per CDC guidelines.

[5] Soma is a muscle-relaxant and a sedative and is both a dangerous drug under section 4022 and a Schedule IV controlled substance.

[6] Valium is the trade name for diazepam and is a psychotropic drug used for the management of anxiety disorder, or the short-term relief of the symptoms of anxiety. It is a dangerous drug under section 4022 and a Schedule IV controlled substance.

[7] Methadone is a narcotic analgesic and is both a dangerous drug under section 4022 and a Schedule II controlled substance.

Soma" (2/6/2019); and thought he was "out of meds" over a week early but "missing med" found (2/26/2019.)

15. By March 6, 2019, Respondent documented that Patient A needed to start "tapering" medications and will be "by guideline" by July 1, 2019. On May 14, 2019, Respondent documented giving "last" opioid prescription "from me"; and again stated "last refill" (5/28/2019); refused on June 10, 2019 to refill oxycodone, but then did so anyway on June 11, 2019, stating "100% the last one I will write."

16. CURES[8] records show that from April 6, 2016 to May 28, 2019, Respondent prescribed oxycodone to Patient A with dosages from 202.5 MME[9] (4/13/2016) to 2,250 MME (2/6/2019). On January 15, 2018, Respondent began prescribing 10 milligrams of methadone, with the additional MME dosage of anywhere from 440 MME (4/13/2018) to 1,371.6 MME (09/18/2019). Respondent prescribed Soma (350 mg tablets three per day) from April 6, 2016 to June 5, 2019 and Valium (5 mg/3 times per day) from December 22, 2017 to May 6, 2019.

17. Patient A signed a pain agreement with Respondent that stated only a single pharmacy could be used; this requirement is commonly used to protect patients from dangerous accidental errors in prescriptions, and to help to identify aberrant drug behavior. And yet, Patient A changed from CVS to Tuttle's pharmacy. Respondent stated in his subject interview and subsequent emails with the Board[10] that he "didn't care" which pharmacy Patient A went to, and did not even know that his own pain agreement limited the pharmacy to only one. Respondent ignored the fact that CVS refused to fill his prescriptions for the extremely high doses of opioids he prescribed to Patient A.

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[8] CURES stands for Controlled Substance Utilization Review and Evaluation System which is a monitoring system used to record which controlled substances are being prescribed to a patient, in what doses, and by whom.

[9] MME stands for morphine milligram equivalents and is used to describe opioid dosage per day given to a patient. The standard of practice since March 2016 has been to limit opioid dosage to less than 50 MME per day in almost all patients for treatment of chronic pain, and to not exceed 90 MME per day except in unusual circumstances, and only with the most careful documentation.

[10] Respondent's subject interview was conducted on December 15, 2020 and his statements regarding Patients A, B, and C were obtained both on that date and from emails Respondent sent to the Board to further address his care related to Patients A, B, and C.

18. Although Respondent adamantly claimed he calculated the MME for every prescription of opioids he wrote, and that "every single one" is documented in the electronic medical record; in fact, it is impossible to determine the number, dose and instructions for the controlled medication he prescribed to Patient A (or, Patient B or C, as discussed more fully below.)[11]

19. Respondent failed to document the specific treatment he provided to Patients A, B, and C. He often used the word "counseling" without further description. Respondent stated counseling could mean discussing depression or anxiety; or opioid risks; or analgesic rebound effect[12] but the medical records do not accurately and sufficiently document the "counseling" provided.

20. Respondent demonstrated a lack of knowledge related to the need to obtain EKGs when prescribing methadone to Patients A and B. High dosages of methadone, when combined with other opioids, can cause heart arrhythmia. Respondent inaccurately believed that the individual dosage of methadone necessitated an EKG.[13]

21. Respondent prescribed a dangerous combination of controlled substances, without adequate evaluation and management, to Patients A, B, and C that could have interacted in potentially deadly outcomes. For more than three years, Patient A received both oxycodone and Soma; the Soma therapy was continued after Patient A developed cancer, and then Patient A was given the additional prescriptions of methadone and Valium. Although Respondent admits understanding the inefficacy of opioids in the treatment of chronic pain, as well as the risks of overdose, and that benzodiazepines and Soma are "depressing, bad drugs," he claims he was only managing the drugs that Patients A, B, and C were already taking when they came to him for treatment. Respondent failed to explain, or document, why he re-started Patient A on Soma after it was discontinued during a hospitalization at the end of 2017, and why Respondent also

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[11] The details related to each patient's treatment and care by Respondent will be discussed separately.

[12] Analgesic rebound effect is a term used to describe the cycle of headaches that can result from overuse of analgesics.

[13] Despite Respondent's belief that Patient A and B needed to have EKGs with the methadone levels he was prescribing, he failed to ensure that either patient received an EKG.

substantially increased Patient A's opioid dosage after the hospitalization. Nor does Respondent explain, or document, why he treated Patient A with Soma for cancer pain, despite that Soma tablets "have a role for acute back spasms" but "no role at all in chronic pain." Respondent admits he knew Patient A was addicted to Soma and that he needed to reduce his dosage but that he encountered "resistance" from Patient A. So, Respondent continued to prescribe Soma despite knowing it "was a bad medication" that was not appropriate for chronic pain while knowing Patient A was addicted to it. And, after Patient A was given Valium for his cancer treatment, he continued to inappropriately prescribe Soma, which is a dangerous, and potentially deadly combination of controlled substances. Respondent neither remembers, nor did he document, why he continued to prescribe Valium to Patient A.

PATIENT B

22. On April 16, 2014, Respondent first prescribed controlled substances to Patient B for migraines, temporomandibular joint disorder, low back pain, panic disorder, bipolar disorder, and dental disorder. For more than three years, Respondent prescribed Patient B various combinations of oxycodone, methadone, and morphine[14] along with Soma and Xanax[15]. The only treatment documented for the migraines were opioids, despite the fact that opioids were known by Respondent to be counterproductive in the management of migraines.

23. Respondent's medical records related to his care and treatment of Patient B were also inadequate: sparse notes and minimal documentation of treatment plans or physical examinations. Respondent also failed to document the specific treatment he provided.

24. Respondent failed to monitor for aberrant drug behavior by Patient B. In fact, when a toxicology screen showed the presence of non-prescribed controlled substances in combination with an absence of the prescribed medications, Respondent failed to diagnose and address this aberrant drug behavior. For example, on May 31, 2017, toxicology results were negative for

[14] Morphine sulfate is a potent opioid used for the relief of moderate to severe pain. It is a dangerous drug as defined in section 4022, and a Schedule II controlled substance.

[15] Xanax is the trade name for alprazolam, which is a benzodiazepine used for the management of anxiety disorders or for short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

oxycodone, despite being prescribed oxycodone for "chronic pain;" this negative test would be consistent with the possibility of drug diversion. During his subject interview, Respondent stated he usually performed toxicology screens annually, however, cost to patients was a barrier. Respondent acknowledged he had difficulty getting toxicology screens from Patient B, and then when he did get one, Respondent ignored the indication of drug diversion by Patient B and trusted his own "judgment" (Email to Board dated 12/29/2020.) Respondent also failed to recognize and/or document that Patient B's pulse rate of 130 on October 30, 2015 was a possible symptom of aberrant drug behavior; or that the presence of Valium without a prescription was evidence of aberrant drug behavior.[16] Respondent also missed other red flags of Patient B's possible drug abuse, and should have diagnosed by December 2015 that Patient B also suffered from polysubstance use disorder. Indications for polysubstance use disorder included: absence of withdrawal symptoms when Patient B dramatically reduced his opioid dosage; and sudden bladder shyness when asked to give drug screens.

25. On September 11, 2015, Respondent doubled the opioid dosage prescribed to Patient B when Patient B developed acute dental pain. Respondent continued that treatment for over five days. Despite Patient B's report of extreme dental pain, Respondent failed to refer Patient B for an emergency dental evaluation.

26. Eventually, Respondent referred Patient B to a pain medicine specialist for chronic pain, and in that referral Respondent references that Patient B had suffered from an altered mental status on January 11, 2017, although there is no such documentation in the medical records. From April 16, 2014 to June 12, 2019, Respondent initially prescribed oxycodone with an MME of 144.6 (4/16/2014) which was tapered down to a low of 112.5 MME (1/31/2016) ending at 144.6 MME (3/22/2018). In addition, Respondent prescribed MS-Contin[17] which varied from 31 MME (4/7/2017) to 48.2 MME (7/2/2016). Also, he prescribed Soma from October 16, 2015 to June 12, 2019 (350 milligrams, 4 times a day). On April 8, 2016, Respondent began to taper

[16] Patient B and Patient C were a couple who lived together. Patient C was prescribed Valium, yet Respondent failed to consider that Patient C was diverting some of the Valium to Patient B.

[17] MS-Contin is a trade name for morphine sulfate controlled release tablets. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

Patient B's opioid dose to the CDC guideline target, and then increased it again exhibiting his inability to manage Patient B's opioid usage.

PATIENT C

27. In April 2014, Patient C was a 27-year-old woman with a history of fibromyalgia and low back pain when she sought treatment from Respondent. By the time Patient C was 32 years old her problem list included, among other conditions: migraine, chronic fatigue syndrome, irritable bowel syndrome, sleep paralysis, major depression, tachycardia, obsessive-compulsive disorder, and agoraphobia with panic disorder.

28. CURES data documents that Respondent prescribed OxyContin[18] to Patient C from April 1, 2014 to October 31, 2015 in MME dosages of between 60 MME (10/15/2015) to 90 MME per day (10/31/2015). Concurrently at times, Respondent prescribed Norco[19] 10/325 from April 10, 2014 to May 31, 2019 in MME dosages of between 37.5 (4/17/2017) and 55.6 MME (1/8/2019). On November 20, 2015, Respondent prescribed MS-Contin 30 milligrams to replace the OxyContin with MME dosages per day of between 87.1 MME (4/26/2017) and 100 MME (6/29/2018). For more than five years, Respondent prescribed Patient C various combinations of oxycodone, morphine, and Norco, along with Soma[20] and various combinations of Valium[21], Xanax[22], and Ambien.[23]

29. Although Respondent was treating Patient C with high-dose opioids combined with multiple sedatives, he failed to conduct interval assessments of the safety and efficacy of Patient

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[18] OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets which are opioids used for the treatment of pain. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

[19] Norco is the trade name for hydrocodone bitratrate with acetaminophen which is a narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

[20] Soma 350 milligrams (4 per day) prescribed from September 8, 2016 to May 8, 2019.

[21] Valium 5 milligrams (3 per day) prescribed from November 7, 2016 to February 19, 2018.

[22] Xanax 1 milligram (3 per day) prescribed from March 3, 2018 to May 2, 2019.

[23] Ambien is the trade name for zolpidem tartrate and is used for short-term treatment of insomnia. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance. Respondent prescribed Ambien 10 milligrams per day from September 16, 2016 to June 18, 2019.

C's treatment. The only documentation in her records related to adverse effects occurred on December 13, 2017, when Patient C described that the medication allows her to do things she could not do otherwise, however, the adverse effect is "constipation." Respondent failed to set objective benchmarks, and then assess whether the prescribed treatment was meeting the goals. Respondent prescribed opioids for Patient C despite her history of migraines; and despite his admitted knowledge that opioids are counterproductive in the treatment of migraines.

30. Respondent kept insufficient medical records related to his care and treatment of Patient C, including, but not limited to, inadequate physical examinations and assessments, and inadequate patient history. For example, from September 24, 2015 through November 20, 2015, Respondent increased Patient C's opioid dosage while documenting that he reduced it; and he was imprecise in the opioid dosages given during tapering by as much as 10%. On March 2, 2018, Respondent inaccurately documented that he had switched Patient C to Ativan.

31. Respondent acknowledged that his medical records related to Patients A, B, and C were inadequate: "there was a lot of computer work"; "the medical record suffered very much"; and "I do not have the personal resources to do that." The standard of care requires that the medical records of each patient, taken as a whole, support the patient care provided, and Respondent's medical records failed to do so.

32. Respondent also failed to make proper referrals for Patient C's conditions: he failed to offer cognitive behavioral therapy and graded exercise for chronic fatigue syndrome; on October 11, 2016, he failed to refer her to psychiatric care after she voiced suicidal ideation; and on June 15, 2018, he failed to diagnose and follow-up Patient C's complaint of leg weakness and tingling.

33. On December 15, 2020, Respondent admitted that he was deficient in his standard of care, however, he made several excuses in his subject interview, and his emails to the Board, for not following the standard of practice including that his patients did not have the economic resources to get proper care, that he was too busy to keep adequate medical records, and/or Patient A, B, and C's medical records were an anomaly and inconsistent with his general practice because "maybe, my sadness about their cases depressed me."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Improper and Excessive Prescribing/Failure to Conduct Adequate Physical Examination/Incompetence/Failure to Maintain Adequate Medical Records: Patient A)

34. Respondent Robert Bruce Dozor, M.D. is subject to disciplinary action under sections 2234, subdivisions (a) and/or (b) (gross negligence) and/or (c) (repeated negligent acts) and/or (d) (incompetence) and/or 2242 (prescribing without proper history or physical examination) and/or 725 of the Code (improper and excessive prescribing) and/or 2266 of the Code (failure to maintain adequate records), as further described above in Paragraphs 11 through 33, in that Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient A and:

A. Failed to conduct and/or document adequate medical history to support treatment of high-dose opioids and/or sedative-hypnotics.

B. Failed to conduct and/or document an adequate physical examination.

C. Failed to conduct and/or document a detailed treatment plan that analyzed the impact of pain on Patient A's life and the effectiveness of treatment.

D. Failed to obtain and/or document informed consent for the use of high dosage opioids and/or sedatives.

E. Failed to create and/or document specific objective goals and/or consider alternative treatment modalities for Patient A.

F. Failed to modify treatment plan based on periodic review of safety and efficacy.

G. Failed to conduct and/or document a diligent search for aberrant drug behavior of Patient A. And, once aberrant drug behavior was detected, Respondent failed to rapidly respond by considering tapering and/or referral to an addiction medicine specialist and/or increasing the level of monitoring of Patient A.

H. Respondent inappropriately prescribed Soma to Patient A, which was a dangerous, counterproductive medication both because Patient A was addicted to Soma, and because it did

not address Patient A's chronic pain issues. Respondent continued to prescribe Soma after Patient A was also prescribed Valium, which was a dangerous and potentially deadly combination.

I. Prescribed Valium without medical indication and/or failed to document medical indication to prescribe Valium. Failed to obtain any written communication from Patient A's oncologist as to the medical indication for the prescription of Valium to Patient A.

J. Excessively prescribed controlled substances in dangerous combinations and failed to document the prescriptions in the medical records.

K. Lack of knowledge and/or incompetence related to necessity of obtaining an EKG in the care and treatment of Patient A.

L. Lack of knowledge and/or incompetence by prescribing high dosages of opioids in combination with Soma, despite Patient A's lack of a stated treatment goal.

M. Failed to discontinue Patient A's Soma prescription and/or taper Patient A's dosage of oxycodone.

N. Lack of knowledge and/or failure to document oxycodone dosages in his care and treatment of Patient A.

O. Lack of knowledge and/or incompetence in continuing the prescriptions of another provider for high dosages of opioids and Soma in the care and treatment of Patient A.

P. Lack of knowledge and /or incompetence by his inaccurate belief and/or statement that Kaiser refused to prescribe pain medication to Patient A after he was diagnosed with cancer.

Q. Respondent's dosage increase to Patient A in December 2017 from 600 MME to more than 900 MME and/or Respondent's subsequent dosage increase (danger of overdose) and decrease (danger of withdrawal) in MME without proper medical indication and/or documentation.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Improper and Excessive Prescribing/Failure to Conduct Adequate Physical Examination/Incompetence/Failure to Maintain Adequate Medical Records: Patient B)

35. Respondent Robert Bruce Dozor, M.D. is subject to disciplinary action under sections 2234, subdivisions (a) and/or (b) (gross negligence) and/or (c) (repeated negligent acts) and/or (d) (incompetence) and/or 2242 (prescribing without proper history or physical examination) and/or 725 of the Code (improper and excessive prescribing) and/or 2266 of the Code (failure to maintain adequate records), as further described above in Paragraphs 22 through 26, in that Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient B and:

A. Failed to conduct and/or document adequate medical history to support treatment of high-dose opioids and/or sedative-hypnotics.

B. Failed to conduct and/or document an adequate physical examination.

C. Failed to conduct and/or document a detailed treatment plan that analyzed the impact of pain on Patient B's life and the effectiveness of treatment.

D. Failed to obtain and/or document informed consent for the use of opioids and/or sedatives.

E. Failed to create and/or document specific objective goals and/or consider alternative treatment modalities for Patient B.

F. Failed to modify treatment plan based on periodic review of safety and efficacy.

G. Failed to conduct and/or document a diligent search for aberrant drug behavior of Patient B. And, once confronted with a toxicology screen confirming aberrant drug behavior possibly indicative of drug diversion, Respondent failed to respond to address the findings on the test and continued to prescribe controlled medications to Patient B.

H. Lack of knowledge and/or incompetence related to necessity of obtaining an EKG in the care and treatment of Patient B.

I. Lack of knowledge and/or incompetence in prescribing opioids for an indication of migraine headaches in Patient B.

J. Lack of knowledge and/or incompetence that he had to either turn Patient B away from treatment or continue high dosage opioid therapy, Xanax, and Soma.

K. Doubled the prescription of oxycodone dosage for acute dental pain, and continued that treatment beyond five days, without a referral of Patient B for an emergency dental evaluation.

L. Exhibited a lack of knowledge and/or incompetence in his inability to manage Patient B's opioid dosage.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Improper and Excessive Prescribing/Failure to Conduct Adequate Physical Examination/Incompetence/Failure to Maintain Adequate Medical Records: Patient C)

36. Respondent Robert Bruce Dozor, M.D. is subject to disciplinary action under sections 2234, subdivisions (a) and/or (b) (gross negligence) and/or (c) (repeated negligent acts) and/or (d) (incompetence) and/or 2242 (prescribing without proper history or physical examination) and/or 725 of the Code (improper and excessive prescribing), and/or 2266 of the Code (failure to maintain adequate records)as further described above in Paragraphs 27 through 33, in that Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient C and:

A. Failed to conduct and/or document adequate medical history to support treatment of high-dose opioids and/or sedative-hypnotics. Exhibited a lack of knowledge of the necessity of obtaining an adequate history in order to prescribe high-dose opioids and/or sedative-hypnotics.

B. Failed to conduct and/or document an adequate physical examination.

C. Failed to conduct and/or document a detailed treatment plan that analyzed the impact of pain on Patient C's life and the effectiveness of treatment.

D. Failed to obtain and/or document informed consent for the use of opioids and/or sedatives.

E. Failed to create and/or document specific objective goals and/or consider alternative treatment modalities for Patient C.

F. Failed to modify treatment plan based on periodic review of safety and efficacy.

G. Failed to conduct and/or document a diligent search for aberrant drug behavior of Patient C. Respondent continued to prescribe controlled medications to Patient C after learning about the possibility of diversion from Patient C to Patient B. Exhibited a lack of knowledge of inability to recognize aberrant drug behavior in Patient B and C.

H. Exhibited lack of knowledge and/or incompetence in prescribing opioids for an indication of migraine headaches in Patient C.

I. Failed to offer Patient C cognitive behavioral therapy and graded exercise in the care and treatment of Patient C's chronic fatigue syndrome.

J. Prescribed opioids to Patient C to treat fibromyalgia.

K. Respondent kept inadequate and inaccurate medical records for Patient C: from September 24, 2015 to November 20, 2015; he increased Patient C's opioid dosage while documenting that he reduced it; he failed to document the opioid doses given while tapering Patient C; and he inaccurately documented switching Patient C to Ativan.

L. Replacing Valium with Xanax on March 2, 2018.

M. Prescribed benzodiazepines in combination with Ambien in combination with high doses of opioids.

N. Failed to refer Patient C to psychiatric care on October 11, 2016 when she voiced suicidal ideation.

O. Failed to diagnose and follow-up on Patient C's complaint of leg weakness and tingling on June 15, 2018.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Lack of Knowledge/Excessive Prescribing in Dangerous Combinations: Pattern of Practice: Patients A, B, and C)

37. Respondent Robert Bruce Dozor, M.D. is subject to disciplinary action under sections 2234, subdivisions (a) and/or (b) (gross negligence) and/or (c) (repeated negligent acts) and/or (d) (incompetence) and/or 725 of the Code (improper and excessive prescribing), as further outlined above in Paragraphs 11 through 33, in his care and treatment of Patients A, B, and/or C in that Respondent:

A. Excessively prescribed high dosage controlled substances in dangerous combinations as a pattern and practice to Patients A, B, and/or C without adequate evaluation and management of care.

B. Exhibited a lack of knowledge/incompetence in his care and treatment of Patients A, B, and/or C by excessively prescribing high dosages of controlled substances in dangerous combinations without adequate evaluation and management of care.

C. Prescribed Soma to Patients A, B, and/or C despite knowing that the combined therapy of Soma, benzodiazepines, and opioids is dangerous; and, despite his express understanding that Soma was not indicated in any of the three cases.

D. Continued to prescribe opioids despite ineffectiveness for some of the indications for which he prescribed them in his care and treatment of Patients A, B, and C.

E. Exhibited incompetence and/or lack of knowledge that the standard of care is determined by Patient A, B, and/or C's economic resources.

F. Exhibited incompetence and/or lack of knowledge that failure to keep adequate and/or accurate medical records related to Patients A, B, and/or C is excused by Respondent's lack of time.

G. Failed to ensure that Patients A, B, and/or C received proper care and treatment by transfer of care and/or arrangement of proper resources to adequately treat them.

H. Failure to perform and/or document adequate history and physical examinations of Patients A, B, and/or C to support the care rendered.

I. Failure to analyze the effect of Patient A, B, and/or C's pain on quality of life and/or formulate a treatment plan with objective goals that would reduce pain's impacts.

J. Failure to document a recognized indication for the treatment of high dosage opioids and/or sedative-hypnotics and/or the combination of both in the care and treatment of Patients A, B, and/or C.

K. Failure to obtain and/or document informed consent prior to treatment with opioids and/or sedative-hypnotics in the care and treatment of Patients A, B, and/or C.

L. Failure to engage in a diligent search for aberrant drug behavior and/or to address it effectively when detected in the care and treatment of Patients A, B, and/or C.

M. Lack of knowledge of the provisions of the pain agreement he utilized in the care and treatment of Patients A, B, and/or C.

N. Failure to document the prescribed quantity of controlled medications, including exact number, dose, and instructions for use, in the medical records related to Patients A, B, and/or C.

O. Failure to document the specific interventions, such as the type of counseling given, and for what purpose, to Patients A, B, and/or C.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records: Patients A, B, and C)

38. Respondent Robert Bruce Dozor, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records, as further described above in Paragraphs 11 through 33, in relation to his care and treatment of Patient A, B, and/or C.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 48771, issued to Respondent Robert Bruce Dozor, M.D.;

2. Revoking, suspending or denying approval of Respondent Robert Bruce Dozor, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Robert Bruce Dozor, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: OCT 15 2021

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

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Robert Dozer, M.D. Accusation