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

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| In the Matter of the Accusation and Petition to Revoke Probation Against:<br><br>Kent Walter Lehman, M.D.<br><br>Physician's and Surgeon's Certificate No. G 38595<br><br>Respondent. | Case No.: 800-2021-078937 |

## DECISION

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

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

IT IS SO ORDERED: June 3, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
GIOVANNI F. MEJIA
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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation and Petition to Revoke Probation Against:<br><br>**KENT WALTER LEHMAN, M.D.**<br>**999 N Tustin Ave Suite 222**<br>**Santa Ana, CA 92705-6506**<br><br>**Physician's and Surgeon's Certificate No. G 38595,**<br><br>Respondent. | Case No. 800-2021-078937<br><br>OAH No. 2022010140<br><br>**STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER** |

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

## PARTIES

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

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2. Kent Walter Lehman, M.D. (Respondent) is represented in this proceeding by attorney Michael A. Taibi, Esq. whose address is: Taibi & Associates, APC, 401 West A Street, Suite 1810, San Diego, California 92101.

3. On or about December 21, 1978, the Board issued Physician's and Surgeon's Certificate No. G 38595 to Kent Walter Lehman, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation and Petition to Revoke Probation No. 800-2021-078937 and will expire on December 31, 2022, unless renewed.

## JURISDICTION

4. Accusation and Petition to Revoke Probation No. 800-2021-078937 was filed before the Board, and is currently pending against Respondent. The Accusation and Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on October 7, 2021. Respondent timely filed his Notice of Defense contesting the Accusation and Petition to Revoke Probation. A copy of Accusation and Petition to Revoke Probation No. 800-2021-078937 is attached as Exhibit A and incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2021-078937. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation and Petition to Revoke Probation; 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.

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

## CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2021-078937, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 38595 to disciplinary action. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G 38595 for the Board's formal acceptance with an agreed-upon effective date of June 1, 2022, or as soon thereafter as the Board may order.

9. Respondent understands that by signing this stipulation he enables the Board, or the Executive Director of the Board on the Board's behalf, to issue the below Disciplinary Order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

10. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2021-078937 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

## CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b) provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. This stipulation shall be subject to approval by the Executive Director of the Board on behalf of the Board. Respondent agrees that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it.

By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Board, considers and acts upon it.

13. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understand and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director or the Board, or both, may receive oral and written communications from its staff or the Attorney General's Office, or both. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, or any member thereof, or any other person, from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by other party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director, Respondent will assert no claim that the Executive Director, the Board or any member thereof, was prejudiced by its/his/her review, discussion or consideration of this Stipulated Surrender of License and Disciplinary Order, or of any matter or matters related hereto.

## ADDITIONAL PROVISIONS

14. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Executive Director of the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order on behalf of the Board:

**ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 38595, issued to Respondent Kent Walter Lehman, M.D., is surrendered and accepted by the Board, effective June 1, 2022 or as soon thereafter as the Board shall order.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2021-078937 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $6,472.50 prior to issuance of a new or reinstated license.

6. 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 and Petition to Revoke Probation, No. 800-2021-078937 shall be deemed to be true, correct, and admitted by Respondent

for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

## ACCEPTANCE

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

DATED: Apr 5 2022 Kent Walter Lehman MD

KENT WALTER LEHMAN, M.D.
*Respondent*

I have read and fully discussed with Respondent Kent Walter Lehman, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 4/6/2022

MICHAEL A. TAIBI, ESQ.
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: April 6, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

GIOVANNI F. MEJIA
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation and Petition to Revoke Probation No. 800-2021-078937**

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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation & Petition to Revoke Probation Against:<br><br>**KENT WALTER LEHMAN, M.D.**<br>**999 N. Tustin Ave., Ste. 222**<br>**Santa Ana, CA 92705-6506**<br><br>**Physician's and Surgeon's Certificate No. G 38595,**<br><br>Respondent. | Case No. 800-2021-078937<br><br>**ACCUSATION AND PETITION TO REVOKE PROBATION** |

## PARTIES

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

2. On or about December 21, 1978, the Board issued Physician's and Surgeon's Certificate No. G 38595 to Kent Walter Lehman, 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 December 31, 2022, unless renewed.

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## JURISDICTION

3. This Accusation and Petition to Revoke Probation is brought before the Board under the authority of the following laws, and the Board's Decision and Order in the case entitled *In the Matter of the Accusation Against Kent Walter Lehman, M.D.*, Board case No. 09-2012-225474, a true and correct copy of which is attached hereto as exhibit A and hereby incorporated by reference as if fully set for the herein. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

## STATUTORY PROVISIONS

4. Section 2004 of the Code states, in pertinent part:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

....

5. Section 2227 of the Code states, in pertinent part:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

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

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

....

6. Section 2234 of the Code states, 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 omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

....

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

## FIRST CAUSE FOR DISCIPLINE

### (Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate to disciplinary action under section 2234, as defined by section 2234, subdivision (b), of the Code in that he committed gross negligence. The circumstances are as follows:

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9. In or around 2010 to 2016, Patient A[1] received medical care and treatment from Respondent on multiple occasions for ailments including, but not limited to, pain in Patient A's back or other areas of the body.[2]

10. In or around September 2015, Patient A applied for public disability benefits.

11. On one or more occasions thereafter, Patient A, or a requestor duly authorized to receive a copy of Patient A's medical records, requested from Respondent a copy of Patient A's medical records for the purposes of the public disability benefits application. Respondent failed to provide a copy of Patient A's medical records in response to one or more such requests.

12. As early as on or about June 27, 2019, if not sooner, Respondent received a written request from the California Health and Human Services Agency, Department of Social Services (DSS) for Patient A's medical records. Among other things, the request stated:

> Your patient has applied for disability...benefits under the Social Security Act. Your records are essential to our determination. This is not a request for an examination but a request for existing information.
>
> ...
>
> Please note that this is a request for all records during [August 2014 to present], and is not limited to records pertaining to the alleged impairments listed below.
>
> Alleged impairments:
> [H]ip muscle damage; arthritis left hip; lower back pain; knee cartilage damage.

13. The June 27, 2019 written request for Patient A's medical records was accompanied by a copy of an authorization to disclose medical information executed by Patient A.

14. Respondent failed to promptly provide a copy of Patient A's medical records in response to any duly authorized DSS request for Patient A's medical records.

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[1] A pseudonym is used in the instant Accusation and Petition to Revoke Probation in the place of any patient's true name to preserve patient confidentiality. The true name and identity of any such patient is known to Respondent or will be disclosed to Respondent following Complainant's receipt of a duly-issued request for discovery pursuant to Government Code section 11507.6.

[2] Any acts or omissions alleged to have occurred more than seven years prior to the filing of the instant Accusation and Petition to Revoke Probation are pleaded for informational purposes only, and not as a basis for disciplinary action.

15. On or about April 14, 2020, Respondent produced a certified copy of his medical records for Patient A to a Board investigator. The certified medical records produced by Respondent included only records for appointments between approximately January 2015 and August 2016, and failed to contain records for the complete course of Respondent's care and treatment of Patient A.

16. Respondent committed gross negligence in the course of his care and treatment of Patient A including, but not limited to, failing to promptly provide copies of Patient A's medical records to Patient A or one or more other duly authorized requestors.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

17. Respondent has further subjected his Physician's and Surgeon's Certificate to disciplinary action under section 2234, as defined by section 2234, subdivision (c), of the Code in that he committed repeated negligent acts. The circumstances are as follows:

18. Paragraphs 8 through 16, above, are hereby incorporated by reference as if fully set forth herein.

19. Respondent also committed negligence in the course of his care and treatment of Patient A including, but not limited to, failing to adequately maintain complete and accessible medical records for Patient A.

**THIRD CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

20. Respondent has further subjected his Physician's and Surgeon's Certificate to disciplinary action under section 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records relating to the provision of services to Patient A as more particularly alleged in paragraphs 8 through 19, above, which are hereby incorporated by reference as if fully set forth herein.

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## FOURTH CAUSE FOR DISCIPLINE

**(Violation of the Medical Practice Act)**

21. Respondent has further subjected his Physician's and Surgeon's Certificate to disciplinary action under section 2234, as defined by section 2234, subdivision (a), of the Code, in that he violated or attempted to violate one or more provisions of the Medical Practice Act as more particularly alleged in paragraphs 8 through 20, above, which are hereby incorporated by reference as if fully set forth herein.

## CAUSE TO REVOKE PROBATION

**(Failure to Obey All Laws)**

22. At all times after the effective date of Respondent's probation, condition 11 of Respondent's probation stated:

> 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.

23. Respondent's probation is subject to revocation because he failed to comply with condition 11 of his probation, as more particularly alleged in paragraphs 8 through 21, above, which are hereby incorporated by reference as if fully set forth herein.

## DISCIPLINARY CONSIDERATIONS

24. To determine the degree of discipline, if any, to be imposed on Respondent's Physician and Surgeon's Certificate, Complainant alleges that on or about August 13, 1992, in a prior disciplinary action titled *In the Matter of the Accusation Against Kent Walter Lehman, M.D.* before the Board, in case No. D-4373, Respondent's license was suspended for a period of one year and placed on probation for a period of ten years for committing unprofessional conduct including, but not limited to, acts of dishonesty or corruption substantially related to the duties of a physician and surgeon, excessive prescribing of drugs, treatment, or use of diagnostic or treatment procedures or facilities, and presenting a false or fraudulent claim for payment of services to an insurance company. That Decision is now final and is incorporated by reference as if fully set forth herein.

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25. To determine the degree of discipline, if any, to be imposed on Respondent Kent Walter Lehman, M.D., Complainant alleges that on or about May 6, 2004, in a prior disciplinary action titled *In the Matter of the Accusation and Petition to Revoke Probation Against Kent Lehman, M.D.* before Board, in Case No. D1-1990-1604, Respondent's license was suspended for a period of 90 days and placed on probation for a period of five years for committing unprofessional conduct and violations of Respondent's then in effect probation including, but not limited to, gross negligence, repeated negligent acts, incompetence, dishonesty and falsifying medical records, prescribing dangerous drugs or controlled substances without a prior good faith examination, excessive prescribing or administering of drugs, dispensing misbranded drugs, failure to maintain adequate and accurate medical records, and failing to obey all laws and rules governing the practice of medicine in California. That Decision is now final and is incorporated by reference as if fully set forth herein.

**PRAYER**

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 38595, issued to Respondent Kent Walter Lehman, M.D.;

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

3. Ordering Respondent Kent Walter Lehman, 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: OCT 07 2021

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

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# Exhibit A

**Decision and Order**

**Medical Board of California Case No. 09-2012-225474**

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

| | |
|---|---|
| In the Matter of the Accusation Against: | |
| KENT WALTER LEHMAN, M.D. | Case No. 09-2012-225474 |
| Physician's and Surgeon's Certificate No. G 38595 | |
| Respondent | |

## DECISION

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

This Decision shall become effective at 5:00 p.m. on November 18, 2016.

IT IS SO ORDERED: October 20, 2016.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, JD, Chair
Panel A

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.

S. Woods
Signature
For Custodian of Records
Title
8/23/2021
Date

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
RANDALL R. MURPHY
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California Department of Justice
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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>KENT LEHMAN, M.D.<br>999 North Tustin Ave, #222<br>Santa Ana, CA 92705<br><br>Physician's and Surgeon's Certificate No. G 38595,<br><br>Respondent. | Case No. 09-2012-225474<br><br>OAH No. 2016010891<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant)" is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Randall R. Murphy, Deputy Attorney General.

2. Respondent KENT LEHMAN, M.D. ("Respondent") is represented in this proceeding by attorney William Behrndt, whose address is:

William Behrndt, Esq.
2913 El Camino Real, #219
Tustin, CA 92782

3. On or about December 21, 1978, the Medical Board of California issued Physician's and Surgeon's Certificate No. G 38595 to Kent Lehman, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 09-2012-225474, and will expire on December 31, 2016, unless renewed.

JURISDICTION

4. Accusation No. 09-2012-225474 was filed before the Medical Board of California ("Board"), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 11, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 09-2012-225474 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 09-2012-225474. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 09-2012-225474, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 09-2012-225474 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

CONTINGENCY

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

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

///

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

## DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 38595 issued to Respondent Kent Lehman, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for eight (8) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for the Schedule III drugs of Phendimetrizine and Testosterone, the Schedule IV drugs of Phentermine and Nuvigil/Provigil and Schedule V drugs. At the end of the fourth year of probation, Respondent may request that the restrictions listed in this paragraph be lifted. The Board or its designee, after reviewing all aspects of Respondent conduct on probation and exercising its discretion, may grant Respondent's request.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. 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.

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

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 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.

5. 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 equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education

Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 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.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations ("CCR") section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

7. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program") (such as the CPEP Program, at the Center for Personalized Education for Physicians, located in Denver, Colorado). Respondent shall successfully complete the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully

completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after Respondent has successfully completed the clinical training program, Respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

8. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3)

calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program ("PEP") equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent's participation in a PEP would be at Respondent's own expense during the term of probation if he chooses that option.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the 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.

10. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

11. 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.

12. 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.

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13. 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 thirty (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.

14. 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.

15. 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 (2) years.

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

Periods of non-practice 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; and General Probation Requirements.

16. 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.

17. 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.

18. 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 his or her license. 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.

19. 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.

ACCEPTANCE

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

DATED: 7-18-16

Kent Lehman MD

Kent Lehman, M.D.
*Respondent*

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

DATED: 7/12/16

William Behrndt
*Attorney for Respondent*

ENDORSEMENT

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

Dated:

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

RANDALL R. MURPHY
Deputy Attorney General
*Attorneys for Complainant*

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

DATED: _____

_____
William Behrndt
*Attorney for Respondent*

ENDORSEMENT

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

Dated: 8/12/14

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

RANDALL R. MURPHY
Deputy Attorney General
*Attorneys for Complainant*

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**Exhibit A**

Accusation No. 13-2012-225474

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
RANDALL R. MURPHY
Deputy Attorney General
State Bar No. 165851
California Department of Justice
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*Attorneys for Complainant*



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

| | |
|---|---|
| In the Matter of the Accusation Against:<br>KENT LEHMAN, M.D.<br>999 North Tustin Avenue, #222<br>Santa Ana, California 92705<br>Physician's and Surgeon's Certificate G 38595,<br>Respondent. | Case No. 09-2012-225474<br>ACCUSATION |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 21, 1978, the Medical Board issued Physician's and Surgeon's Certificate Number G 38595 to Kent Lehman, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2016, unless renewed.

3. In a disciplinary action entitled *In the Matter of the Accusation Against Kent Lehman, M.D.*, Case No 04-1990-001604, the Board issued a decision, effective September 12,

1992, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's license was placed on probation for a period of ten years with certain terms and conditions. A copy of that decision is attached as Exhibit A and is incorporated by reference.

4. In a second disciplinary action entitled *In the Matter of the Accusation and Petition to Revoke Probation Against Kent Lehman, M.D.*, Case No D1-1990-001604, the Board issued a decision, effective May 6, 2004, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's license was placed on probation for a period of five years with certain terms and conditions. A copy of that decision is attached as Exhibit B and is incorporated by reference.

## JURISDICTION

5. 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.

6. The Medical Practice Act ("Act") is codified at sections 2000-2521 of the Business and Professions Code.

7. Pursuant to Code section 2001.1, the Board's highest priority is public protection.

8. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . ."

9. Code section 2227, subdivision (a), provides as follows:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

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

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

10. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

11. Section 2238 of the Code states: "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

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12. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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

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

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

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

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

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

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

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

14. Health & Safety Code section 11154 states:

"(a) Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division."

15. Health & Safety Code section 11173 states in relevant part:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division."

## FACTS

PATIENT L.A.

16. Respondent began treating L.A. on June 25, 2010, for chronic pain related to rheumatoid arthritis. He continued to treat L.A. until at least February 7, 2014.

17. Respondent's initial progress note dated June 25, 2010, indicates that L.A. had previously received treatment for pain from another physician, whom Respondent identified. He indicated the prior physician had terminated L.A. from his practice because L.A. tested positive for "meth." (The documentation suggests it was methadone as opposed to methamphetamine.) There are no other details about L.A.'s prior pain management.

18. Respondent's June 25, 2010 note is brief, provides little detail regarding L.A.'s presenting pain symptoms and includes almost no evidence of any physical examination. Respondent's diagnosis was that L.A. suffered from kyphoscoliosis and also had severe rheumatoid hands. There is no documentation concerning L.A.'s substance abuse history apart from a medical history form included in the records that does not have a name or date but appears to be L.A.'s form, because it indicates a prior history of rheumatoid arthritis. On the form, L.A. indicates that he did not have an alcohol or drug problem. There is no indication in the chart that Respondent checked a urine drug screen or a CURES report prior to prescribing opioids to L.A. The diagnoses are listed as arthritis, back pain, scoliosis and fatigue-malaise. There is no

treatment plan apart from a prescription for OxyContin 80 mg #90[1] and hydrocodone/ acetaminophen 10/325, #120. Respondent appears to have assumed responsibility for prescribing medications L.A. was previously receiving from another physician. Specifically, OxyContin 240 mg and hydrocodone 40 mg daily (although quantities are not indicated). There is no record of informed consent by L.A. for the high dose opioid therapy.

19. On August 12, 2010, Respondent requested a consultation from a physical medicine and rehabilitation specialist for help with managing L.A.'s right knee. The records do not indicate the results of this consultation.

20. Respondent's records do not indicate that a history or physical examination commensurate with the circumstances of L.A.'s initial visit was ever done and no records exist showing that it was subsequently performed, to the extent warranted by L.A's presenting complaint.

21. Respondent does not appear to have actually assessed the nature and extent of L.A.'s complaints of pain or the impact of the pain upon L.A.'s functioning. Respondent did not inquire about previous pain treatment and any history of substance abuse.

22. Respondent's records show that he did not establish a legitimate medical indication for the use of a controlled substance for L.A. Respondent's records do not reflect development of a treatment plan with specific treatment objectives.

23. Respondent's records show that he did not discuss with L.A. common potential risks and benefits relative to the use of the prescribed controlled substance in order to allow L.A. to give an informed consent.

24. Respondent's records show that he did not see L.A. periodically in order to monitor the controlled substances therapy. Thus, Respondent was unable to assess L.A.'s progress toward treatment objectives, assess L.A.'s adherence to the controlled substances treatment regimen, and assess whether L.A. was having any adverse effects from the controlled substances. Thus,

[1] All prescription notations follow the form of drug prescribed (OxyContin), dosage (80 mg), and number of tablets prescribed (#90).

Respondent was unable to determine whether treatment of L.A.'s pain with controlled substances should be continued or modified.

25. Respondent's notes are generally written on a monthly basis. The records contain little information concerning whether L.A. was benefiting from this high dose opioid therapy. When Respondent rated L.A.'s pain, it was generally severe with one exception in a note dated June 22, 2012, indicating, "Finally patient getting good pain relief on 5x/d OxyContin otherwise pain 10/10 neck/back." A subsequent note dated August 16, 2012, indicates L.A. stated that he was getting excellent pain relief from the current regimen.

26. Respondent's records show that he failed to ask L.A. about any side effects common with the substances being prescribed, such as constipation and falls. The records show that L.A. had difficulty walking and required use of a walker, suggesting that he was at an increased risk for falling independent of the opioid therapy. Respondent's note of January 6, 2012, indicates that L.A. had occasional falls, was weak and "unstable," but there is no indication that Respondent considered altering the medication treatment plan (although no plan is actually contained in the records) as a result of this observation. Due to the paucity of information in the medical records, it is unclear whether L.A. had any cognitive side effects from the drugs. It is also unclear whether L.A. was advised not to drive, if he was driving and whether the medications potentially impacted his driving safety, which when coupled with his noted physical conditions requiring use of a walker could present a public safety hazard.

27. Respondent's records indicate that he was treating L.A. for hypogonadism with testosterone supplementation, which might have reflected an unnoted side effect of the long-term opioid therapy.

28. Although there is little or no reference to any physical examination after the initial very limited physical examination reflected in the June 25, 2010 note, it does appear that Respondent made a minimal effort to monitor L.A.'s adherence to treatment with the opioids. Respondent's September 28, 2012 note indicates that he "collected urine to monitor narcotic levels." However, no urine drug screen results are in the medical records corresponding with this date.

29. Respondent's records contain a treatment agreement signed by L.A. on January 11, 2013. There is also a consent for chronic opioid therapy, although the date on the form is covered. There are several CURES reports in the front of the file that Respondent obtained on August 29, 2013 (with minor notations in Respondent's handwriting), September 16, 2013, and January 20, 2014.

30. Respondent wrote an extensive progress note on April 15, 2013, detailing L.A.'s pain and noting that L.A. was scheduled for an ankle fusion with the orthopedist. However, the physical examination was very limited and the diagnoses were very general consisting of arthritis, neck pain, back pain, and foot pain. Respondent indicated that L.A. had tried gabapentin, presumably in an effort to treat the pain, but it "didn't work," and Cymbalta was too expensive. Respondent refilled L.A.'s prescription for OxyContin 80 mg #120.

31. Respondent's November 4, 2013 notes reflect the results of a drug screen showing that L.A. tested positive for amphetamine, marijuana, "met," and benzodiazepine. However, Respondent did not indicate how these findings impacted his treatment of L.A., although the notes indicate that the results were unexpected, including the positive result for marijuana and the positive result for a benzodiazepine. What is meant by the term "met" is unclear from the records.

32. Respondent's records do contain notes from the orthopedist who performed an ankle fusion on L.A. in 2013. These notes corroborate the notes showing that L.A. suffered from severe rheumatoid arthritis and had a history of bilateral hip and knee joint replacement surgeries.

33. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

34. The CURES reports show that L.A. filled 40 prescriptions from Respondent for OxyContin 80 mg from June 25, 2010 through December 15, 2013. L.A. averaged 376 mg of oxycodone daily during this period.

35. The CURES reports show that L.A. filled 31 prescriptions from Respondent for hydrocodone/acetaminophen during the time covered by the three CURES reports. He averaged

67 mg of hydrocodone daily during this period. This constitutes high-dose oral opioid therapy, which warrants closer monitoring than low-dose therapy by virtue of the increased risk for adverse effects, which can include overdose and death.

**PATIENT D.A.**

36. Respondent's records contain a number of progress notes from March 15, 2004 through July 18, 2012. The records include laboratory test results, imaging study results, including a report from a lumbar spine x-ray dated August 25, 2010, showing 50-60% compression fractures at L1 and L4. There is a chest x-ray from August 25, 2010, and an electrocardiogram from August 24, 2010. There is a consultation dated September 2, 2010, from a specialist in physical medicine and rehabilitation, Dr. S., although page one is missing. Dr. S. diagnosed D.A. with lumbar disc degeneration, osteoarthritis, and an acute lumbar compression fracture. Dr. S. also recommended specific treatments, however, the notes do not reflect that such treatments ever took place.

37. Respondent's records contain a history and a physical examination pertaining to D.A.'s hospital admission on January 10, 2011, for placement of a cardiac pacemaker, which notes were signed by a Dr. G.

38. Respondent last wrote D.A. a prescription for a controlled substance (hydrocodone) on August 24, 2010. Respondent's progress notes describe D.A. as having "arthritis pains" impacting his back and knees. Respondent noted that D.A. voiced a complaint of anxiety, or "nervousness," that at times impacted his sleep. Respondent also diagnosed D.A. with gout and prescribed anti-inflammatory medication, including Naprosyn.

39. Respondent's notes are handwritten and provide limited information concerning the nature and extent of D.A.'s complaints, such as back pain, anxiety, and insomnia. For example, the November 11, 2009 progress note indicates that D.A. had back pain and stiffness with intensity 6/10 without medication as well as ankle swelling, arthritis, hypertension, and anxiety, but nothing further. Furthermore, there is a note for D.A. dated September 21 without a year, showing a diagnosis of dementia.

40. On August 24, 2010, Respondent noted that D.A. had fallen twice and injured his back but did not remember falling. Respondent described D.A.'s heart rate as irregular at that visit. Respondent also diagnosed syncope, arrhythmia, anemia, benign prostatic hypertrophy, and back pain, ordering laboratory testing, a chest x-ray and a lumbar spine x-ray. Respondent prescribed hydrocodone/APAP 10/325 #120. No indication of Respondent's response if any to the range of issues is reflected in the notes except the prescription.

41. On November 28, 2011 Respondent diagnosed D.A. with Alzheimer's disease and prescribed Namenda as a cognitive enhancer. However, the notes do not indicate whether D.A. was benefiting from use of the pain and antianxiety medications. Neither do the notes indicate whether D.A. was having any adverse effects from the pain and anti-anxiety medications.

42. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009, through August 13, 2012, December 19, 2011, through December 19, 2012, and December 5, 2012, through December 15, 2013.

43. The CURES reports show that D.A. filled seven prescriptions from Respondent for diazepam 10 mg #30, four prescriptions for alprazolam 2 mg #30, two prescriptions for zolpidem 10 mg #30, and eight prescriptions for hydrocodone/acetaminophen #60 in either the 7.5 mg or 10 mg formulations from August 13, 2009 through August 13, 2012.

PATIENT C.A.

44. Respondent's initial visit with C.A. took place in May 2004 (although the date is not clear in the records) when she presented for treatment of obesity with a request to begin diet pills. At the initial visit C.A. weighed 254 pounds on her 66-inch frame. Respondent documented a brief history and a problem focused examination.

45. Respondent's records show that he began treating C.A. with phentermine and continued to treat her until at least March 20, 2012. During that time Respondent provided C.A. with numerous prescriptions for hydrocodone and alprazolam with some additional prescriptions for carisoprodol and zolpidem, in addition to the anorexic drug phentermine. A handwritten note on the front of the chart indicates that C.A. died on August 17, 2012, without further explanation. It is unclear if the note was written by Respondent.

46. Respondent's records include a note dated October 19 that appears to be from 2009 (based upon its location within the chart) indicating that C.A. had "right knee pain-no cartilage right knee, worse when driving car or cold." There is no further description of the pain nor is there any indication of previous pain treatment.

47. Respondent's records contain no documentation of a substance use history apart from a form entitled "Patient's Check List for Medical History" in a different section of the file, but that form does not have a patient's name and is undated. There is no record of a physical examination of C.A's knee.

48. Respondent indicated "knee pain/arthritis" and prescribed C.A. 60 tablets of Vicodin. However, there is no indication of discussion of treatment options other than the opioid analgesic.

49. Respondent continued to prescribe C.A. hydrocodone over the next two and one-half years.

50. Respondent's documentation in support of his continuing prescription of hydrocodone to C.A. is incomplete. On January 6, 2010, he noted C.A.'s chief complaint to be "continued back pain-stiffness." However, there was no physical examination noted in the records. Eight months later, on August 16, 2010, there is a more detailed note describing C.A. as having "arthritis pains" in her neck "with radiculopathy into both hands." Respondent noted C.A. was taking Lyrica. They indicate a reduced cervical range of motion and brisk reflexes at the elbows. Respondent's diagnosis was neck pain and arthritis. He prescribed Norco 10/325 #60 and Soma 350 mg #60 each with one refill.

51. On September 17, 2010, Respondent issued C.A. a prescription for alprazolam (Xanax) 2 mg #45. There is no indication in the progress note as to why he prescribed her this drug.

52. Respondent's October 7, 2010 note indicates that C.A. had "continued neck pains" and an x-ray showed degenerative changes in her cervical spine. Interestingly, the x-ray report is, dated February 5, 2009, and was ordered by another physician. Furthermore, there was no physical examination apart from her weight and a diagnosis of neck pain. Notwithstanding the

lack of an examination and the singular diagnosis, Respondent prescribed Xanax 2 mg #60, Norco 10/325 #90, Soma 350 mg #120, and Neurontin 300 mg #90.

53. Respondent's notes of November 4, 2010, state that C.A. was having "really bad back pains also knees really bad." He described her posture as kyphotic and diagnosed back pain and arthritis. Respondent prescribed her Xanax 2 mg quantity #60, Vicodin ES #120, and Soma #120.

54. On December 24, 2010, Respondent noted that C.A. had "dropped Xanax," but that statement is unexplained in the notes. However, on January 28, 2011, Respondent notes that C.A. had "lost-misplaced Xanax." He further noted "anxiety" as a diagnosis with nothing further. He then prescribed Xanax 2 mg #60 with instruction to take one tablet twice daily as needed. He also prescribed Prozac 20 mg #60 with instruction to take one daily as needed. However, Prozac is not prescribed on an as needed basis.

55. There is very little data contained in the medical records indicating how C.A.'s symptoms of pain and anxiety were responding to treatment with these drugs. In addition, there is very little information concerning how she was actually using the medications and whether she was using them as directed or having any adverse effects from the drugs.

56. Respondent's medical records dated April 22, 2011 indicate that C.A. had not taken her Vicodin (hydrocodone/acetaminophen) because it kept her awake. Nonetheless, Respondent prescribed her more hydrocodone/acetaminophen on that visit. The apparent adverse effect of the drug should have prompted an investigation by Respondent into the symptom and consideration of switching the medication.

57. Respondent's notes provide very little information concerning whether C.A. was having difficulty controlling her use of the medication. A note on April 29, 2011, indicates Respondent talked with C.A. about "too many Xanax," although there is no further explanation of this statement and he continued prescribing her Xanax. His Xanax prescriptions for C.A. subsequent to that visit ranged from 10 tablets to 60 tablets per prescription.

58. A neurological consultation dated June 1, 2011, was ordered because C.A. reported having progressive weakness in all four limbs with abnormal reflexes. Notes from the neurologist

indicate an eventual diagnosis with multiple sclerosis and cervical myelopathy due to cervical spine stenosis.

59. On July 11, 2011, Respondent noted that C.A. had been diagnosed with multiple sclerosis. He continued prescribing her Norco, Xanax, Ambien, and Prozac. There is no mention of any symptoms in Respondent's notes and there is no physical examination reflected in the note. Neither is there a treatment plan relative to the prescription of controlled substances.

60. On October 17, 2011, Respondent noted he had spoken with C.A. and her speech was "very slurred." His notes indicate that she "wanted more Xanax," but that he told C.A. that it sounded like she had taken too much Xanax, which was dangerous. According to the medical records, Respondent advised C.A. that "[i]n order to get more meds, she would need some responsible [sic] to monitor her meds." C.A. appears to have agreed to the monitor and said she would come in supposedly to set up a monitoring plan. However, the records contain no documentation indicating how or if this monitoring was ever effected.

61. There are no CURES reports in the medical records but a listing in the back of the chart from Well Point pharmacy dated October 16, 2009, indicated that C.A. had received prescriptions for Vicodin and Soma from other physicians during the summer of 2009. This was during the time Respondent began prescribing C.A. hydrocodone. The medical records do not indicate any discussion as to whether C.A. was tolerating the controlled substances or having significant adverse effects from them. The sole instance, referenced above was when C.A. had slurred speech, suggesting she may have been misusing her medication.

62. In terms of diagnostic testing, there are a number of laboratory reports found in the chart. There are copies of brain and cervical MRI scans dated June 3, 2011, ordered by another physician to evaluate C.A. for possible multiple sclerosis. There is no evidence that Respondent ever ordered or checked a urine drug screen.

63. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

64. The CURES reports show that C.A. filled 27 prescriptions from Respondent for hydrocodone/acetaminophen from October 20, 2009 through March 20, 2012. The quantity of tablets per prescription ranged from 30 to 180, and he prescribed her an average of 45 mg of hydrocodone daily during that time.

65. The CURES reports show that C.A. filled 35 prescriptions for alprazolam from Respondent from September 17, 2010 through August 10, 2012. The quantity of tablets per prescription ranged from 10 to 60, with an average of 5.4 mg of alprazolam prescribed daily during that time.

PATIENT K.A.

66. Respondent began treating K.A. on September 9, 2009 and continued to treat her up until at least August 9, 2013. Respondent's notes indicate that he was treating her for back pain and anxiety and in the initial visit the notes indicate that K.A. presented with a request for prescriptions.

67. At the initial September 9, 2009 visit, Respondent described K.A. as having anxiety and stress and also reported that she had fallen and hurt her tailbone area. Respondent did not delineate the nature and extent of her pain in the progress note. Included in the medical records is a Brief Pain Inventory form that better describes the location and severity of the pain, but it is not dated, so it is unclear whether K.A. completed this form at the time of the initial visit. The records also contain an anxiety symptom questionnaire but again without a date. There is no reference to K.A.'s prior treatment. There are no old records within the file to understand her prior treatment.

68. There is no delineation of K.A.'s substance use history apart from a medical history form dated September 9, 2009, upon which K.A. denied having an alcohol or drug problem. However, K.A. also denied having any mental problem or history of nervous breakdowns, which seems inconsistent with the progress note from this same date stating she suffered from anxiety and stress.

69. Respondent's physical examination of K.A. was limited. The only musculoskeletal reference indicates reduced range of motion in her back in forward flexion

and no indication that K.A.'s lower back or sacral region was palpated. Furthermore, there is no documentation of neurological testing of K.A.'s lower limbs and no diagnostic testing to determine whether K.A. had a fracture to account for pain in the sacrococcygeal region[2] despite her complaints of back pain. There is no urine drug screen connected with the initial visit.

70. There is no CURES report in Respondent's medical records. There is no indication of a treatment plan or discussion of treatment options other than documentation that Respondent prescribed her Xanax 2 mg #30, Vicodin ES #60, and what appears to be a B vitamin "cocktail."

71. There is no informed consent from K.A. documented with the initial visit. The file contains a consent for chronic opioid therapy and a treatment agreement for the use of controlled substances in the treatment of chronic pain, which were signed on February 14, 2012, over two years after the initial visit.

72. Respondent treated K.A. for several years and saw her on a regular basis, but his progress notes contain little information concerning her symptoms and examination findings. A representative entry for March 18, 2010, indicates that K.A. "threw back out," yet the physical examination indicates only that K.A. was well developed and well nourished. However, Respondent prescribed her more Vicodin, Xanax, and Prozac on that visit.

73. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

74. The CURES reports indicate that K.A. filled 36 prescriptions from Respondent for hydrocodone/acetaminophen 7.5 mg from September 9, 2009 through April 23, 2013, for an average of 2.5 tablets daily during the period. The CURES reports indicate that K.A. filled 43 prescriptions from Respondent for alprazolam 2 mg from September 9, 2009 through July 2, 2013, averaging 1.6 tablets daily during that period.

[2] There is a report of a lumbar x-ray that Respondent ordered, but this was not done until May 31, 2013 (4 years after the initial visit) and was normal with only mild degenerative spurs.

75. Respondent's notes dated March 24, 2011 indicate that Respondent discussed K.A.'s back pain, stating that "Medication allows her to continue work and normal activities of daily living." However, the physical examination was again limited, although he mentions that K.A. had "some tender areas" in her back, but no diagnosis is included with that observation. He also questioned whether she had arthritis, but apart from refilling her prescriptions there is no clear treatment plan reflected in the records.

76. On June 28, 2011 Respondent noted that K.A. returned "early" for refill of her medication, which he attributed to her having increased back pain due to an increased workload and he noted that she was taking three pain pills daily. On that visit he actually performed a physical examination and noted tenderness in the lumbosacral region and over the coccyx. As a result, he prescribed her more Vicodin #90 and suggested use of a doughnut cushion for sitting and nonsteroidal anti-inflammatory medication.

77. On August 22, 2011, Respondent noted that the medication helped reduce K.A.'s pain intensity and provided some quantification of the pain intensity. However, there is no physical examination record apart from listing her weight.

78. On October 18, 2011, Respondent had a follow-up and noted K.A.'s pain intensity was 10/10. However, again there was no physical examination apart from noting that she appeared "distressed" and walked in a "guarded" fashion and a recorded weight. He refilled her Vicodin and Xanax, recommended nonsteroidal anti-inflammatory drugs and a topical pain patch. The progress notes do not indicate how K.A. would utilize her medications. Furthermore, there is no indication Respondent asked K.A. whether she had trouble controlling her use of the medications and no indication that he checked a CURES report.

79. Respondent's note dated August 9, 2013, indicates that K.A. was seeing a chiropractor for treatment of her pain. Respondent performed a limited physical examination including assessing her cervical range of motion and palpating for tenderness in her back. He prescribed Xanax 1 mg #30, ibuprofen 600 mg #60, and Robaxin 500 mg #30. However, despite his many prescriptions of Xanax for K.A. for the treatment of anxiety and his note that she might

have a bipolar disorder, there is no indication that he ever considered referring her for a mental health consultation with either a psychologist or psychiatrist.

PATIENT R.A.

80. R.A. died on March 31, 2011, at age 43 of an accidental overdose reported as an acute polydrug intoxication due to the combined effects of methadone, morphine, codeine, carisoprodol, meprobamate, sertraline, and alprazolam. The coroner's report indicates he had a prior drug history.

81. The Drug Worksheet in the coroner's report indicates that there were prescriptions to R.A. from Respondent for Tylenol with codeine (seven prescriptions) and carisoprodol (five prescriptions).

82. On June 14, 2011, Respondent reported seeing R.A. regularly for back pain, including a visit on February 1, 2011, when he prescribed R.A. hydrocodone and Tylenol with codeine.

83. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

84. The CURES reports indicate Respondent gave four prescriptions to R.A. for Tylenol with codeine 300/60 mg #90 on December 14, 2010 and December 17, 2010. In addition, Respondent gave four prescriptions to R.A. for Tylenol with codeine 300/60 mg #180 on January 7, 2011 and February 1, 2011.

85. Respondent had no medical records for R.A. despite a history of providing him prescriptions as evidenced by the CURES reports.

PATIENT M.A.

86. Respondent treated M.A. for back pain with an initial note in the file dated February 18 with no year indicated, making it unclear when treatment began. In addition, M.A.'s patient information form, usually completed on the initial visit, is undated. Respondent continued to treat M.A. until at least May 24, 2012.

87. Respondent failed to provide a year on the first two notes in M.A.'s medical records, with the second note date only March 23. However, the first note of February 18 indicates a chief complaint of "back pain" and states that M.A. hurt his back while at work. There is neither further discussion as to how M.A. was injured nor any documentation of the nature and extent of the pain beyond characterizing it as back pain.

88. Respondent's records from the initial visit fail to include any past medical history, social history or substance abuse history. There is no CURES report or urine drug screen connected with the initial visit. The physical examination at the initial visit is limited and from a musculoskeletal standpoint consists only of documented tenderness in the lumbosacral region and a positive "straight leg," although it is unclear whether M.A. had unilateral or bilateral abnormal straight leg raise testing. There is no neurological examination, such as lower limb strength, reflex, or sensory testing documented in the records. The records contain no recommendation for diagnostic testing.

89. Respondent's diagnosis at the initial visit is simply "back pain," and the "treatment plan" consists of prescriptions for Vicodin ES #60 and Valium 10 mg #20. Treatment objectives are unclear, and there is no evidence of informed consent.

90. At the March 23 visit, noted above with no year indicated, Respondent noted that M.A. had back pain with an intensity 8/10. There is no physical examination documented, apart from a weight. The diagnosis is back pain/arthritis. Respondent prescribed M.A. Vicodin, Valium, and Xanax.

91. Respondent's notes indicate that M.A.'s next visit was on April 28 (again no year is noted). No history or examination is reflected in the notes. However, the note does not indicate if Respondent actually saw M.A. on that date.

92. Respondent saw M.A. again on June 30 (again no year is noted) and documented "continued low back pain" with tenderness in the lumbosacral region. He ordered an x-ray of the lumbar spine, though there is no evidence that this x-ray was ever done. He prescribed M.A. Xanax, Vicodin, and Soma, and also gave M.A. an injection of Toradol. Respondent's treatment objectives are not stated in the notes and are unclear.

93. Respondent's next note is dated August 24, 2009, with M.A.'s chief complaint listed as the need for a prescription refill. The medical records indicate that M.A. had continued low back pain that was worse due to physical lifting and bending at work. There was no physical examination reflected in the notes except for blood pressure, weight, and a notation that M.A. was well dressed and well-nourished. Respondent's diagnosis was now "back pain/myalgia/anxiety." He prescribed the patient Vicodin, Xanax, and Soma.

94. Respondent's progress reports generally provide little or no information about the nature and extent of the M.A.'s pain with little or no physical examination. There does not appear to be any inquiry concerning whether M.A. was tolerating the medications and taking them as directed.

95. Respondent's November 23, 2009 notes again recommended a lumbar x-ray, but again there is no evidence in the file that this was ever done. However, there is a report in the file of a lumbar MRI from February 26, 2010, which showed normal alignment of the spine with mild degenerative changes at L4-L5 and L3-L4 and a small disc protrusion causing narrowing of the right neuroforamina at L3-L4. It is unclear who ordered the study, because Respondent does not mention the MRI order or otherwise refer to it in his progress notes until May 14, 2010, suggesting that he did not order the study.

96. Respondent's records contain no coherent treatment plan other than the prescription of controlled substances. There is no indication he considered nonpharmacologic interventions, such as a home exercise program or physical therapy. Neither is there adequate attention to whether M.A. was adhering to treatment with controlled substances that were being prescribed nor is there any evidence of a urine drug screen test.

97. Respondent's notes from March 26, 2010, indicate that M.A. was "trying to cut back on 'narcotic' pain meds." There is a notation on May 14, 2010, that M.A. "was taking too many Vicodin-hurts stomach." However, there is never any indication of any inquiry into M.A.'s substance abuse history.

98. On August 9, 2010, Respondent saw M.A. to refill his prescriptions for oxycodone, Vicodin, Xanax, and Soma. There was no clear treatment plan for prescription of

these controlled substances. Respondent indicated that M.A. had suffered a work injury and had been seen at Kaiser, but there is no further discussion of that event, the nature of the injury, the Kaiser diagnosis or any other facts as to that injury.

99. Respondent completed some disability forms for M.A. on August 10, 2010, in which he described M.A. as having severe low back pain due to herniated disk and radiculopathy.

100. On November 18, 2010, Respondent noted that M.A. had been "flagged by DEA," but indicated "patient states that it's not him." However, there is no further discussion of this issue in the notes and the files do not indicate a CURES report was run or any other follow up was performed. There is no physical examination at that visit apart from describing him as well dressed and well nourished. Respondent proceeded to prescribe him more oxycodone 30 mg #120 and Norco 10/325 #90, which were intended to be a 30 day supply of medication. Respondent then instructed M.A. "to seek new pain management group," which infers that he no longer planned to prescribe M.A. controlled substances.

101. Despite the above-referenced indication that Respondent had instructed M.A. to seek another pain management group, in a visit on June 1, 2011, where M.A. presented apparently for a request for a prescription, Respondent prescribed M.A. 120 Soma tablets without performing an examination or a history.

102. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

103. The CURES report from August 13, 2009 through August 13, 2012 indicates that Respondent prescribed M.A. controlled substances, including multiple prescriptions for hydrocodone, oxycodone, alprazolam, and zolpidem plus a single prescription for diazepam during this time.

104. The CURES reports show that M.A. filled 13 prescriptions from Respondent for hydrocodone/acetaminophen from August 24, 2009 through February 4, 2011. The quantity

of tablets per prescription ranged from 60 to 150, and he prescribed M.A. an average of 32 mg of hydrocodone daily during that time.

105. The CURES reports show that M.A. filled eight prescriptions from Respondent for oxycodone 30 mg from April 22, 2010 through November 18, 2010. The quantity of tablets per prescription ranged from 20 to 120, with an average prescription of 102 mg of oxycodone daily during that time.

106. The CURES reports show that M.A. filled 11 prescriptions from Respondent for alprazolam 2 mg #30 from August 24, 2009 through July 8, 2010. He prescribed M.A. an average of 2 mg of alprazolam daily during that time.

107. The CURES reports show that M.A. filled eight prescriptions from Respondent for zolpidem either in the 10 mg or 12.5 mg formulations from August 24, 2009 through February 19, 2010. Respondent prescribed M.A. an average of 19 mg of zolpidem daily during that time.

108. The CURES data shows that Respondent prescribed M.A. a one-month supply of alprazolam 2 mg (30 tablets) on August 24, 2009, September 1, 2009, and again on September 14, 2009.

109. The last medical records included in M.A.'s chart include a CURES report from October 27, 2009 through October 27, 2010 that was faxed to Respondent from a "Mike." The CURES report does not appear to have been generated at Respondent's request. That report shows that M.A. was obtaining controlled substances from multiple providers during this period.

PATIENT V.B.

110. Respondent initially treated V.B. for injuries stemming from an automobile accident. In V.B.'s medical records there is a Patient Information Sheet and a medical history checklist both dated October 22, 2007. However, the first progress note is dated almost a year later on October 20, 2008, and recounts her history of having been involved in an auto accident and suffering a concussion, cervical strain, and lumbar strain.

111. At the October 20, 2008 visit, Respondent performed an appropriate prior examination before prescribing her Vicodin ES #20 and carisoprodol #20. The records include subsequent visit notes dated November 10, 2008, December 11, 2008, January 9, 2009, January 28, 2009, February 13, 2009, March 6, 2009 and April 7, 2009.

112. V.B.'s medical records were not together in records recovered from Respondent, but rather were located in two separate areas within the files. This itself makes it difficult to understand how Respondent could properly track V.B.'s progress. Respondent's handwritten notes start on the entry for January 2, 2008, and notes that he gave V.B. a hormone injection. A later note (date uncertain) describes V.B. as having a prior history of a "traumatic incident" and previous treatment with antidepressant medicines. Respondent described V.B. as having anxiety and depression and prescribed Xanax and Prozac.

113. Respondent's note dated January 9 and found in the second set of records in the files does not include a discernible year. However, it is likely 2009 because the first set of records found includes a visit on January 9, 2009. That note indicates that V.B. had "migraines" without further elaboration. Respondent prescribed her Fioricet with codeine and Prozac. There was no evident physical examination performed on that visit. Respondent's handwritten notes in the second section of the file are brief and none contain information about a physical examination, except that weight is often recorded but no blood pressure or other relevant information.

114. Respondent's note dated April 7 without a discernible year (likely 2009 because of another visit on April 7, 2009 in the separated file) indicates that V.B. complained of pain in the region of her right sacroiliac joint and extending down her leg with an intensity of 9/10. A physical examination noted only that V.B. was tender over the right sacroiliac joint. Respondent's diagnosis was sciatica, though there was no documentation of a neurological examination with lower limb strength, reflexes, or straight leg raise testing to reach that diagnosis. Respondent gave her an injection of Toradol and prescribed hydrocodone/acetaminophen 10/325 #60.

115. A note dated May 8 without a year indicates V.B. had "continued headaches ... migraines." Respondent prescribed Fioricet, Prozac and Xanax.

116. Respondent's note dated September 9, 2011, enters a diagnoses of migraine and fibromyalgia. Again, there is no history or physical examination other than her weight.

117. Respondent's note dated November 21, 2012, indicates that V.B. was "no longer taking Xanax-Soma," but there is no explanation as to why V.B. had stopped those medications. Respondent described V.B. as having "continued migraines/fibromyalgia" and prescribed her more Fioricet and Vicodin.

118. Respondent's note dated March 29, 2013, indicates only that V.B had returned for a refill and had continuing neck pain with "daily migraines" and depression. Her pain intensity was 7/10, and Respondent described her as worse following an auto accident that occurred two weeks prior to the visit. Although there is an entry in the objective section of the note it is illegible.

119. Respondent's note dated April 26, 2013 indicates that V.B. had migraines since an auto accident in 1986. In addition to prescribing her Vicodin, Fioricet, and Prozac, Respondent also prescribed her 10 tablets of amitriptyline 10 mg and gave her samples of Lyrica as well.

120. Respondent's note dated May 26, 2013, indicates that V.B. had continued migraines with complaints of insomnia and also bilateral hip pain and left-sided knee pain. Respondent also noted that she took over-the-counter preparations but he did not delineate what over the counter preparations she had taken, which is necessary to determine if there was any potential for adverse drug-drug interactions with the medications Respondent himself prescribed her.

121. Respondent's note dated June 21, 2013, includes a "post-it note" attached to the page indicating "phase off pain Rx," with nothing further. Considering the later prescriptions provided to V.B., it is difficult to determine what is meant by the post-it note and if it refers to V.B. at all.

122. Respondent's note dated August 6, 2013, indicates that V.B. had a left hip x-ray at his request, and the study was normal. In a follow up on August 16, 2013, Respondent reviewed the x-ray results with V.B. and ordered laboratory testing to include a complete blood count, chemistry panel, and sedimentation rate. He prescribed her more Fioricet and Vicodin.

123. Respondent's note dated September 19, 2013, reiterated V.B.'s various pains and associated pain intensities. However, the physical examination consisted only of her weight and neck range of motion in lateral rotation. Interestingly, Respondent also indicated the results of

V.B.'s urine drug screen (the order for which is not in the records) in which she tested positive for barbiturate, benzodiazepine, THC, opioid, and something else that is illegible. It is unclear if or how he integrated this urine drug screen result into her treatment plan.

124. Respondent's last note dated February 19, 2014, describes V.B. as having "really bad migraines" that she believed were secondary to an old neck injury. The physical examination consisted only of describing her as a white female in moderate distress. This note reads as though Respondent had no recollection of this patient. He prescribed her more Fioricet, Vicodin, ibuprofen, and BuSpar.

125. V.B's chart contains a medical history checklist dated October 22, 2007, on which V.B. indicated she had a history of some type of mental problem, although it is unclear as to the nature of the problem. Respondent later notes V.B as having depression and anxiety. V.B. endorsed severe headache as a symptom and also endorsed night sweats, ankle swelling, and loss of appetite. V.B. denied having an alcohol or drug problem. There is no other indication in the file concerning whether or not V.B. had a substance abuse problem despite Respondent prescribing her several controlled substances over an extended period of time and indications that V.B. was misusing her Fioricet.

126. V.B had a history of migraine as shown by the charts. She also had anxiety and depression, which increased her risk for misuse of the controlled substances Respondent prescribed her. There is no documentation in the medical records indicating that Respondent ever talked with V.B. about how she was taking the medications.

127. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

128. V.B's CURES reports suggests she had difficulty controlling her use of Fioricet.

129. During the periods reflected in the CURES reports, V.B. first filled a prescription from Respondent for a controlled substance, Fioricet with codeine, on August 24, 2009. V.B. filled a total of 66 prescriptions for Fioricet with codeine during the time from August 24, 2009

through December 2, 2013. The quantity for each of these prescriptions varied between 30 and 100 capsules, but was generally either 60 or 90 capsules per prescription.

130. During the first year that Respondent prescribed her Fioricet, he prescribed her an average of 7.2 capsules daily, which is a very high dose. V.B. frequently filled prescriptions for Fioricet and sometimes filled them just days apart. For example, V.B. filled a prescription for 60 tablets on December 4, 2009, only to fill another prescription for 60 tablets on December 7, 2009. The CURES report also shows that during this first year V.B was filling the prescriptions at two different pharmacies, often indicative of a desire not to raise suspicion about the quantity of medication she was receiving.

131. Fioricet is an analgesic that combines in a single tablet a low dose of an opioid (30 mg of codeine), a barbiturate (50 mg of butalbital), acetaminophen, and caffeine. It is used for the acute treatment of headache with the recommendation not to exceed a total daily dose of six capsules. It is not intended to be taken daily or even frequently in one month because of its habit-forming potential and its potential to make a person's headache condition worse.

132. The CURES reports indicate that V.B. filled 27 prescriptions from Respondent for hydrocodone/acetaminophen 7.5 during the time covered by the three CURES reports. V.B. averaged 1.6 tablets daily during this period. The CURES reports indicate that V.B. filled 18 prescriptions for alprazolam 2 mg from Respondent during the time frame covered by the three CURES reports. She averaged 0.4 tablets daily during this period.

133. The CURES reports indicate that V.B. filled four prescriptions for carisoprodol from Respondent during the time frame covered by the three CURES reports. She filled these prescriptions between June 4, 2012 and November 29, 2012.

134. V.B's file contains an opioid therapy consent form that is signed and dated April 26, 2013, several years after she began receiving prescriptions for controlled substances from Respondent. There is also a controlled substances treatment agreement that is signed but not dated. A Brief Pain Inventory was completed by V.B on April 26, 2013 and a Pain Anxiety Symptom Scale was completed, which is not dated.

135. No record exists of Respondent checking a CURES report in order to monitor V.B.'s adherence to treatment instructions despite the length of time he prescribed her controlled substances.

136. Respondent's notes dated September 19, 2013, indicate that V.B.'s urine drug screen tested positive for barbiturate, benzodiazepine, THC, opioid, and something else that is illegible in the records. It is unclear how he integrated this urine drug screen result into her treatment plan, if at all.

137. V.B's progress notes have little or no history and little or no physical examination. They do list the medications he prescribed for her, but there is no indication as to how she was tolerating the medications and generally no information as to whether they were helpful in treating her symptoms.

138. Respondent's treatment objectives are unclear in the medical record. Despite V.B.'s continuing complaint of severe headache, there is no evidence Respondent considered referring her for consultation to a headache specialist, such as a neurologist. His physical examination documentation is inadequate and should contain more details regarding her neurological functions, since the differential diagnosis for chronic headache includes conditions other than migraine.

139. There is no indication that Respondent monitored V.B. for potential adverse effects from the analgesics, such as liver damage, until he recommended laboratory testing in his note dated August 16, 2013. However, there are no laboratory testing results in the file. Such testing should be done on a periodic basis when routinely prescribing analgesics that contain acetaminophen.

**PATIENT S.B.**

140. Respondent began treating S.B. in 2006 (although the date is uncertain due to deficiencies in the medical records) for weight loss and continued to treat her for other problems including chronic pain and anxiety at least through October 17, 2013. Respondent treated S.B. for chronic pain and anxiety and wrote S.B. multiple prescriptions for controlled substances, including hydrocodone, alprazolam and carisoprodol.

141. The initial note in S.B.'s chart is very brief, indicating a chief complaint of "diet pill" and indicating "father: ETOH." There is a notation that "phen before worked." There is a brief physical examination followed by notation that he prescribed her phentermine 37.5 mg #30, Xanax 2 mg #20, Prozac 20 mg #30, and Ambien 10 mg #20. There is no indication in the chart why all of these controlled substances were prescribed for a chief complaint of "diet pill."

142. Respondent's next note is dated "April 17", but again there is no year indicated. Respondent indicates that S.B. complained of low back pain with intensity 7/10 without medication. There is no further description of the symptom in the progress note, though a medical history checklist completed by S.B. on May 7, 2007 (a significant amount of time after the initial visit which, based on the overall records, occurred in early summer of 2006) indicated symptoms of tingling, numbness, limited motions, and disturbance in walking without specifying the body part to which the symptoms referred. Neither discussion of prior pain treatment nor any indication of questions concerning any history of substance abuse (other than the medical history checklist where she denied a history of alcohol, drug and/or mental problems) is contained in the note. The note also indicates "anxiety insomnia" without further explanation.

143. The "April 17" note contains no indication that Respondent performed any physical examination pertaining to S.B's back pain apart from noting her weight of 240 pounds. No musculoskeletal or neurological examination to evaluate her spinal condition is shown. There is no diagnosis or treatment plan other than the prescription of medications, including Vicodin ES #60, Xanax 2 mg #30, Ambien 10 mg #30, and Prozac 20 mg #60. However, there is no indication of informed consent relative to these drugs and there is no treatment objective listed in the note.

144. Three CURES reports were obtained during the investigation of Respondent. The reports cover the time from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

145. The CURES reports indicate that Respondent provided 49 prescriptions to S.B. for hydrocodone/acetaminophen from November 16, 2009 through November 15, 2013. The

quantity of tablets per prescription ranged from 60 to 240, and he prescribed the patient 5,580 tablets during that time.

146. The CURES reports indicate that Respondent provided 25 prescriptions to S.B. for alprazolam from August 4, 2009 through June 17, 2013. The quantity of tablets per prescription ranged from 15 to 45, and Respondent prescribed S.B. 1,475 tablets during that time, for an average dose of 2.4 mg daily.

147. The CURES data shows that Respondent provided 22 prescriptions to S.B. for carisoprodol from January 25, 2012 through November 15, 2013. The quantity of tablets per prescription ranged from 30 to 90, and he prescribed S.B. 1,590 tablets during that time, for an average of 2.7 tablets daily.

148. Respondent saw S.B. on multiple occasions throughout the course of his treatment of her. However, his notes provide little information about the nature and extent of S.B.'s symptoms, only her complaints of low back pain and anxiety. Respondent's note of October 15, 2009, indicates that S.B's low back pain was worse in the mornings. His note of February 18, 2010, suggests exercise exacerbated her low back pain. His note of August 20, 2010 notes that S.B.'s pain intensity was "8/10 at times without medicine," but there is no indication concerning the impact medication had upon her pain or her ability to function. Respondent's notes prior to 2011 are devoid of any examination pertinent to the evaluation of S.B.'s low back pain apart from two entries. The first, on October 15, 2009, indicates that S.B.'s back was "tender, tense, stiff" in the lumbosacral region. The second, which appears to be on March 18, 2007 (legibility makes the date uncertain), indicates that S.B.'s lower back was "tender." Thus, for 5 years, through the end of 2010, S.B.'s medical records fail to adequately describe the nature of her symptoms and the details of any physical examination findings, indicating that no physical examinations had occurred.

149. Respondent's note dated January 13, 2011, is entitled "interim note-pain management." In this entry, Respondent goes into greater detail about S.B.'s history and indicates that he did not actually start treating her back pain until 2009. This is striking because earlier notes in the medical record appear to date back as far as 2006 and at least 2007.

150. Respondent's note dated January 13, 2011, delineates minimal treatment objectives relative to S.B's low back pain and her use of pain medicine. Respondent discusses information germane to informed consent and precautions typical of a pain treatment agreement with S.B. He said it appeared the pain medications were "allowing her to live with a tolerable level of pain" and "to function at a reasonable level at work and at home." There is a minimal physical examination indicated on this note with weight, blood pressure, and a reference that S.B's back was "tight" with a questionable reduction in range of motion. Respondent recommended that S.B. have a lumbar x-ray. A copy of a lumbar x-ray report dated March 8, 2011 is in the file. The x-ray showed that S.B. had mild degenerative changes at the L5-S1 disc.

151. Respondent's note dated March 11, 2011 indicates that he assessed her lumbar bending, because S.B. was "unable to bend/fingers to knees." There is no indication as to how Respondent assessed her lumbar bending.

152. Respondent's note dated April 28, 2011 indicates that S.B. had a negative "straight leg." However, there was no evaluation of her lower limb strength or reflexes reflected in the notes, or any other indication as to how Respondent arrived at that conclusion.

153. Respondent's note dated August 3, 2011, indicates that S.B. was "taking more meds for relief." There was no indication as to whether she was having difficulty controlling her use of the drugs, or if the fact that she was "taking more meds for relief" was considered a positive or negative treatment point, or any other conclusion.

154. Respondent's note dated August 29, 2011, indicates that S.B. was "very anxious," and describing job-related stress. Her pain was 10/10. Her anxiety was 10/10. It is not indicated what plan of treatment Respondent developed for these complaints other than the continued prescription of controlled substances.

155. Respondent's note dated September 30, 2011, indicates that S.B. was "still visibly anxious" and fidgety. Respondent continued to prescribe her Xanax, Vicodin, Ultram, and Soma. There is no indication that he ever considered referring her for mental health care, even though he noted in his March 18, 2010 entry (18 months prior) that she had "bipolar" disorder.

156. Respondent's note dated February 23, 2012, indicates that he was unable to determine whether or not S.B. was bipolar and that he felt it would be wrong to diagnose her with that condition "without an expert evaluation." He added, "[i]t seems that it is sufficient to treat empirically." S.B.'s medical records contain a consent for chronic opioid therapy, which S.B. signed and dated on August 23, 2012, approximately 6 years after Respondent first began prescribing her medications covered by that consent. There is also a treatment agreement for the use of controlled substances in the treatment of chronic pain, which S.B. signed and dated on February 23, 2012, approximately 6 years after respondent first began prescribing her medications covered by that consent.

157. Respondent continued to prescribe S.B. Vicodin, Xanax, Soma, and Ultram throughout 2012 without consideration of alternative approaches to treating her symptoms. There is no indication of a referral for physiotherapy or consultation with a pain specialist or orthopedist. There are ambiguous suggestions in the progress notes that S.B. was taking more medication than directed. Respondent made a comment in his January 13, 2013 note suggesting that was a problem, writing, "also aware of concerns over Xanax and Soma and narcotics ... will reduce slowly?"

158. Respondent's note dated April 11, 2013, indicates that he talked with S.B. about reducing her medications, and that she agreed to a gradual reduction. For the first time Respondent recorded the results of S.B.'s urine drug screen in which she tested positive for opiate, cannabis, and benzodiazepine.

159. Respondent's note dated June 23, 2013, finally indicates consideration of an MRI, pain consultation, and laboratory studies to evaluate for possible arthritis. Laboratory results from August 13, 2013, show S.B. to be within normal limits, including comprehensive metabolic panel, complete blood count, and sedimentation rate.

160. Respondent's note dated October 17, 2013, is the last note in the chart (and was after the investigation into Respondent's practices had been initiated), and contains components of the neurological examination, including sensory and reflex testing in S.B.'s limbs. The notes indicate that Respondent considered S.B. a candidate for permanent disability. There is also a notation

indicating "forms filled," though it is unclear what forms are referenced. A Brief Pain Inventory and an anxiety symptom scale are in the chart with the notes for October 17, 2013, but neither of which are dated, making it possible that these are the forms referenced although he could also have been referring to disability forms.

161. The only evidence in the chart that Respondent was monitoring whether S.B. was receiving prescriptions from other physicians occurs in the latter portion of 2013. Three CURES reports dated August 20, 2013, August 29, 2013 and October 17, 2013 are contained in the records. Thus, no inquiry regarding S.B.'s receipt of prescriptions for controlled substances from other physicians occurred until Respondent had been prescribing her controlled substances for over 7 years.

162. The August 29, 2013 CURES report has the names of two other providers who had written the patient prescriptions for controlled substances during 2013 circled.

**PATIENT T.B.**

163. Respondent began treating T.B. for back pain on November 30, 2007, and continued treating him through at least February 5, 2013. Respondent also treated T.B. for inguinal pain related to hernia.

164. Respondent's initial evaluation of T.B. was on November 30, 2007. The file contains a brief note indicating a chief complaint of back pain and a medical history indicating that T.B. had "minimal back pain" prior to injuring his back three days prior to the visit, for which he had been to a chiropractor. There is no further delineation of the nature and extent of the pain and neither is there any other discussion of prior treatment efforts. There is no review of T.B.'s substance abuse history except the medical history questionnaire completed on November 30, 2007, upon which he indicated he had no history of an alcohol or drug problem.

165. Respondent's notes indicate a limited general physical examination was performed but the only reference to T.B.'s back is a notation of tenderness in the lumbosacral paravertebral region. There is no range of motion, strength, or reflex testing documented.

166. The November 30, 2007 diagnosis was back pain. However, there is no indication whether T.B. had any symptoms of nerve root irritation, such as sciatica. A treatment plan is

reflected in the notes consisting of prescriptions of Vicodin ES #40 and Robaxin 750 mg #40 with a recommendation to continue treatment with the chiropractor.

167. Respondent first prescribed the patient Xanax on November 8, 2010. There is no documentation in the medical records to support the prescription of Xanax. Neither is there any indication that T.B. suffered from an anxiety disorder.

168. Respondent's notes dated September 25, 2011, indicate that T.B. had right shoulder pain. However, there is no further elaboration concerning the nature and extent of the pain and there is no indication of any examination of the right shoulder in the notes. Respondent continued prescribing T.B. hydrocodone and Xanax as an ongoing matter.

169. On February 5, 2013, Respondent saw T.B. to refill his prescriptions for hydrocodone and Xanax. There is a "post-it note" on the progress note that states "get off pain meds." There is no date on the post-it note and no indication of when it was placed in the file. The progress note itself has no treatment plan other than the continued prescription of drugs.

170. Three CURES reports were obtained as part of the investigation of Respondent. They cover the time periods from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

171. The CURES reports indicate that T.B. filled 19 prescriptions from Respondent for hydrocodone/acetaminophen from November 9, 2010 through February 20, 2013. The quantity of tablets per prescription ranged from 60 to 150. Respondent prescribed T.B. an average of 29 mg of hydrocodone daily during that time.

172. The CURES reports indicate that T.B. filled 19 prescriptions from respondent for alprazolam from November 9, 2010 through February 20, 2013. The quantity of tablets per prescription was either 30 or 40. Respondent prescribed the patient an average of 1.9 mg of alprazolam daily during that time.

173. Respondent saw T.B. approximately once a month. However, the progress notes contain minimal history and very little evidence of any physical examination. Other than the notes from the initial visit on November 30, 2007, there is one additional detailed assessment of T.B.'s pain in the entire chart and that consists only of a Brief Pain Inventory questionnaire T.B.

completed on February 5, 2012. There is also an anxiety symptom questionnaire in the file, but that has no date.

174. Respondent's notes have no history or examination information apart from noting that T.B. was presenting for a prescription refill. There is neither reference nor indication concerning the use of the medication to treat T.B.'s "hernia pain" or back pain.

175. Respondent's notes for the 6 years of T.B.'s treatment contain no indication evidencing any assessment of T.B.'s adherence to treatment requirements with controlled substances. T.B.'s file contains no CURES reports or urine drug screens. Neither is there any indication that Respondent ever discussed the medication with T.B., and how T.B. was taking the prescribed controlled substances to ensure that T.B. did not have a drug problem.

176. T.B.'s file contains a signed, undated treatment agreement for the use of controlled substances in the treatment of chronic pain. There is also a consent for chronic opioid therapy signed and dated February 24, 2012, approximately 6 years after Respondent first began prescribing such controlled substances to T.B.

177. Respondent's notes contain no documentation that T.B. was ever asked if he had experienced any adverse effects from the prescribed drugs.

178. Respondent's notes dated July 20, 2009, indicate that he had referred T.B. to a general surgeon. However, there is neither a surgical consultation in the file nor any record of any follow up concerning that referral or why the referral was made.

179. Respondent's notes are deficient in that they contain little or no history and little or no physical examination findings for T.B. T.B.'s pain complaints are not adequately described in the medical record. The rationale for Respondent's prescription of Xanax is nowhere found in the medical records despite that prescription being refilled regularly for several years. Overall, Respondent's treatment objectives for T.B. are unclear, unstated and unknown.

**PATIENT V.C.**

180. Respondent first saw V.C. on August 20, 2010. Her chief complaint is noted as "Rx request, pain lower back (center)" which appears to reference a request for a prescription for back pain. Respondent's notes indicate she had "residual back pain," and had pain of 9/10 intensity

without medication. The note suggests that V.C. was not taking any medications at the time she presented to Respondent. However, there is no further discussion of the nature and extent of the pain, whether there was any extension of the pain into her lower limbs, or whether there was any associated weakness or sensory disturbance.

181. Respondent's notes contain no past medical history except from what can be gleaned from a checklist that V.C. completed on the date of the initial visit. V.C. denied any history of alcohol, drug, or mental problems on that checklist. Respondent's note does not contain any discussion of her prior pain treatment efforts. However, an orthopedic consultation report dated May 27, 2010, is contained in the medical records. That orthopedic consultation report references a consultation with an orthopedist due to an automobile accident on April 24, 2010. The report indicates that orthopedist performed a comprehensive evaluation and diagnosed her with cervical sprain, lumbar sprain, blunt abdominal trauma, headache and dizziness due to concussion, and "rule out anxiety." The orthopedist recommended chiropractic treatment and neurological consultation and prescribed her Norco 10/325 #60 and Prilosec 20 mg #60.

182. Respondent's notes document a limited, general physical examination. The only mention Respondent made of any musculoskeletal or neurological finding was that her neck had reduced range of motion, although V.C. presented with a chronic, severe musculoskeletal complaint and Respondent had access to the orthopedic report.

183. Respondent's notes contain no indication that he considered diagnostic testing to evaluate V.C.'s complaints of severe pain despite four months having passed since her injury in the automobile accident. Respondent's diagnoses was simply "auto accident, cervical strain, and lumbosacral strain," with no indication of how he came to those conclusions.

184. Respondent's "treatment plan" was the prescription of Norco 10/325 #90, Xanax 2 mg #20, and Soma 350 mg with no quantity noted. There is nothing in the medical records to indicate V.C. gave informed consent until February 21, 2012, when she signed a consent for chronic opioid therapy. There is nothing in the medical records to indicate consideration of any alternative treatments apart from controlled substances.

185. Three CURES reports were obtained during the investigation of Respondent. These CURES reports are from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

186. The CURES reports indicate that Respondent provided V.C. with 42 prescriptions for hydrocodone/acetaminophen from August 20, 2010 through November 15, 2013. The quantity of tablets per prescription ranged from 30 to 240. Respondent prescribed V.C. 5,990 tablets of hydrocodone/acetaminophen during that time.

187. The CURES reports indicate that Respondent provided V.C. with 25 prescriptions for alprazolam from August 20, 2010 through April 29, 2013. The quantity of tablets per prescription ranged from 10 to 30. Respondent prescribed V.C. 530 tablets during that time frame.

188. The records indicate that Respondent historically saw V.C. every 1-2 months, prescribing hydrocodone and alprazolam on a consistent basis. In addition, on August 4, 2011, Respondent prescribed V.C. zolpidem 10 mg #30. On April 13, 2012, Respondent prescribed V.C. Soma 350 mg #60. However, these prescriptions for zolpidem and Soma were isolated and not recurring prescriptions. The hydrocodone and alprazolam were recurring prescriptions.

189. Respondent's notes do not describe the nature and extent of V.C.'s pain symptoms at any point in time. The notes do not provide examination data.

190. Respondent provided multiple prescriptions for alprazolam during his first year of treating V.C., but no reference to anxiety is mentioned in the notes until August 4, 2011, when the single word "anxiety" is entered without any further delineation of the nature and extent of V.C.'s anxiety.

191. There is no documentation explaining why Respondent prescribed V.C. alprazolam, although following the single entry on August 4, 2011, it is possible the prescription could have been for the symptom of anxiety. However, because the notes are deficient it is impossible to determine the diagnosis resulting in the prescription.

192. The single word reference to "anxiety" in the August 4, 2011 note is the only reference to anxiety in the entirety of the progress notes until Respondent notes on March 11,

2013, that V.C. was more anxious after having been involved in an automobile accident on March 11, 2013.

193. Respondent notes that on May 23, 2013, V.C.'s anxiety was "much better." A "Pain Anxiety Symptom Scale" is located in the medical records, but it was not dated, so it is unclear when V.C. completed that form.

194. Respondent began prescribing V.C. Prozac on November 21, 2012, for reasons that are unclear, Respondent indicating only that V.C. did not feel good on Xanax and could not get to sleep at night.

195. Respondent's notes dated August 21, 2012, indicate that V.C. had a history of seven prior automobile accidents. Those notes also indicate that V.C. was unable to reduce to 150 per month, although it is not stated which prescription was being referenced by that note. However, he prescribed V.C. 180 tablets of Norco that day.

196. Respondent's notes dated October 13, 2012, indicate that V.C. had been in yet another automobile accident and that he had increased her use of one of the medications (presumably Norco due to the quantity referenced) to seven tablets daily. However, the records do not indicate any concern over the number of automobile accidents that V.C. represented having been in despite the high level of controlled substances being prescribed.

197. Respondent's notes make multiple references to V.C.'s applications for disability, which he based on her difficulty concentrating due to taking medication. However, despite that reference there is no apparent attention concerning whether V.C. had any adverse effects from the drugs, such as cognitive impairment, especially in light of the frequent automobile accidents. This is particularly troubling because Benzodiazepines, such as alprazolam, have been shown to adversely impact a person's ability to drive safely.

198. Respondent's notes dated March 11, 2013 indicate that V.C. was involved in yet another automobile accident (this is the eighth reported automobile accident for V.C.). Respondent provided a few sentences of history in that March 11, 2013 note, but no examination is recorded other than noting "WM." What is meant by "WM" is unknown. Respondent's plan

was to "continue current medication" and to order an x-ray of her neck. A report of a cervical x-ray dated March 25, 2013 is in the file. The x-ray was normal.

199. V.C.'s medical records also contain reports showing normal x-rays of her neck and low back dated September 1, 2011, a normal renal ultrasound dated November 8, 2013, and laboratory testing dated September 23, 2013, comprising all of the diagnostic testing over the course of three years of treatment.

200. Respondent's pattern of prescribing indicates that V.C. may have had trouble controlling her use of the drugs. Respondent said in his May 23, 2013 note that he had "to slowly reduce her pain meds by 30" per month, although there is no evidence that this reduction occurred. Respondent's note dated May 23, 2013, states that he advised her to follow up with physical therapy, making this the first reference to consideration of physical therapy in his progress notes. There is no evidence Respondent ever ordered a urine drug screen for V.C.

201. Although Respondent appears to have ordered two CURES reports, the first dated August 29, 2013, and the second November 20, 2014, there is no indication of why these reports were ordered or what action, if any, was taken as a result of these CURES reports.

202. Respondent's notes indicate that he did not consider referring V.C. for consultation with a psychologist or psychiatrist despite her "anxiety" and his numerous prescriptions to her for alprazolam.

203. Respondent's records contain no informed consent regarding V.C.'s long-term use of opioid therapy until February 21, 2012, when V.C. signed a consent for chronic opioid therapy and a treatment agreement for controlled substances.

204. Respondent's progress notes have little or no history and little or no physical examination findings. V.C.'s pain complaints are not adequately described in the medical record and Respondent's treatment objectives are unclear.

**PATIENT B.C.**

205. Respondent first examined B.C. on June 17, 2009. The initial note indicates the B.C. presented complaining of pain in his right hand and shoulder due to sports injuries and surgeries.

However, Respondent did not further delineate the nature and extent of the patient's pain symptoms.

206. Respondent's records include records from an orthopedist who treated B.C. prior to Respondent. Those records indicate that B.C. had two surgeries on his right hand and a right shoulder surgery in the six years prior to presenting to Respondent.

207. Respondent noted that B.C. "was on Norco for pain relief also was taking marijuana," but Respondent did not elaborate as to how B.C. was using these drugs. There is no delineation of past medical history except the medical history checklist completed by B.C. on the day of the initial visit, which checklist also included the standard question as to a history of alcohol, drug, or mental problems that B.C. denied having. Respondent did not check a CURES report or request a urine drug screen.

208. Respondent's notes indicate a physical examination revealing that B.C. had a full range of motion in his "back" with a "normal curve." The examination of the right upper limb is limited. The examination also indicates that B.C. had an "equal full grip" and what appears to be a slight resting tremor in the right hand with "full dexterity." Respondent's notes also reference "arm 11 o'clock," but it is unclear what is meant by this notation. Respondent's diagnosis was right shoulder pain with impingement syndrome and brachial nerve "impin."

209. Respondent prescribed B.C. Norco 10/325 #60 and Ultram 50 mg #40. There is no evident treatment plan reflected in the notes apart from the prescription of these opioids. There is no documentation of informed consent relative to the medicines except for a consent for chronic opioid therapy, which B.C. did not sign until January 30, 2012.

210. Three CURES reports were obtained during the investigation of Respondent. These CURES reports are from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

211. The CURES reports indicate that Respondent provided B.C. with 63 prescriptions for hydrocodone/acetaminophen from September 15, 2009 through November 24, 2013. The quantity of tablets per prescription ranged from 20 to 180. Respondent prescribed B.C. 6,850

tablets during that time, which equates to an average dose of approximately 62 mg of hydrocodone daily.

212. The CURES reports indicate that Respondent provided B.C. with 24 prescriptions for alprazolam from January 30, 2012 through August 30, 2013. The quantity of tablets per prescription ranged from 10 to 30. Respondent prescribed the patient 517 tablets during that time, which equates to an average dose of about 1.9 mg daily.

213. The CURES reports indicate that Respondent provided B.C. with 25 prescriptions for carisoprodol from January 30, 2012 through November 11, 2013. The quantity of tablets per prescription ranged from 20 to 120. Respondent prescribed the patient 2,240 tablets during that time, which equates to an average dose of 4.7 tablets daily (although the actual dosage per day is difficult to discern from the records).

214. Respondent saw B.C. on a regular basis to refill the prescriptions for hydrocodone, tramadol, and carisoprodol with the later addition of alprazolam. Respondent's progress notes usually indicate a chief complaint of "Rx refill" with little or no history or physical examination. Respondent occasionally recorded a pain intensity level, as he did in his September 24, 2010 note where he indicated "pain 8/10 esp when working-lifting."

215. B.C.'s medical records include two "Brief Pain Inventory questionnaires" relative to his pain intensity and the impact of pain upon his functioning. These two questionnaires were completed on two occasions, November 21, 2012 and March 17, 2014.

216. Respondent's notes indicate that on July 28, 2010, B.C. reported "back pain, knee pains." However, there is no physical examination, nor treatment goals indicated. On that visit Respondent refilled prescriptions for hydrocodone, tramadol, and carisoprodol.

217. Respondent saw B.C. again on August 23, 2010, September 24, 2010, November 12, 2010 and December 14, 2010 to refill the medications with no indication of any physical examination. No vital signs are recorded even though there are blank spaces for the patient's weight and blood pressure on each note. There is no evidence that Respondent performed any examination or other testing on B.C. whatsoever.

218. Respondent's note dated February 7, 2011, offers some physical examination relative to B.C.'s back, indicating a reduced back range of motion and "paravertebral muscles 'tight."

219. Respondent's note dated April 21, 2011 indicates that B.C. had "continued shoulder and low back pain," which B.C. apparently attributed to "swinging hammer all day." Respondent's notes indicate that he considered whether the B.C. had arthritis, but there is no indication of any referral for diagnostic evaluation for the now chronic complaint of low back pain.

220. On May 12, 2011, Respondent noted that B.C. had been stopped by the police who took his medications, so Respondent simply prescribed him more Norco and Soma.

221. Respondent saw B.C. on June 8, 2011, July 14, 2011, July 26, 2011, August 4, 2011, August 29, 2011 and September 21, 2011, apparently solely for medication refills. The notes from those visits are devoid of any history or examination findings apart from a few measures of the patient's weight. The same is true for multiple visit notes in 2012, as set forth in the medical records.

222. Respondent began prescribing B.C. Xanax on November 30, 2012. However, there is no indication in the records as to why he prescribed B.C. Xanax, but this became a recurring prescription for small quantities of the drug. Respondent's progress notes do not indicate that B.C. complained of anxiety or made other complaints for which Xanax might be prescribed. There is a Pain Anxiety Symptom Scale form in the chart, but this is not dated.

223. Respondent's notes dated July 11, 2012, indicate that B.C. had continued left shoulder pain and was to have left shoulder surgery the following week. The physical examination consisted only of B.C.'s weight and a description of him as "WD WN WM," which appears to mean that B.C. was "well dressed, well nourished, white male."

224. A note indicating that B.C. underwent shoulder arthroscopy at Kaiser on July 18, 2012, is in the file. There is no indication in the records that Respondent coordinated his prescription of analgesic medications with the surgeon who performed the surgery in order to prevent B.C. from getting drugs from both doctors.

225. In 2013, B.C. saw Respondent for multiple visits for prescriptions with no history or physical examination findings recorded in the notes. The May 2, 2013 progress note indicates only that B.C. had right hand pain intensity 7/10. Respondent issued him prescriptions for hydrocodone, carisoprodol, alprazolam, and ibuprofen.

226. Respondent's note dated May 26, 2013, provides a slight history and a physical examination result indicating B.C.'s left arm "raises to 2 o'clock only," and his right hand was swollen. There does not appear to be a reason for that swelling

227. Respondent's note dated November 11, 2013 indicates that B.C. had left shoulder surgery on October 23, 2013, and would be starting physical therapy. However, in a previous note Respondent had stated that B.C. underwent left shoulder arthroscopy at Kaiser on July 18, 2012. There is no indication in the records as to whether or not both surgeries, one, or none actually took place. There are no records from any surgeon or any indication that Respondent had communicated with a surgeon concerning B.C. However, the note referencing July 18, 2012 surgery refers to that surgery in the past tense so it is reasonable to suggest that Respondent must have actually seen evidence of that surgery at the time he entered the information in his progress notes. However, the same is also true for the November 11, 2013 note.

228. Respondent's notes indicate that he made no effort to monitor whether B.C. was using the prescribed medications as directed until June of 2013. The first urine drug screen in the file is dated June 24, 2013, and indicates that B.C. tested positive for opiate and benzodiazepine, which is to be expected based on the prescription history, but he also tested positive for THC. A second urine drug screen documented in the March 17, 2014 progress note shows the same results. No mention of marijuana use is reflected in the progress notes after the notation in the initial visit note on June 17, 2009.

229. B.C.'s records include a signed treatment agreement for controlled substances, but there is no date on this form.

230. Respondent's records contain one CURES report Respondent accessed on B.C. dated August 29, 2013. There is no indication that Respondent took any action or otherwise made note of that report.

231. Respondent's note dated December 23, 2013, indicates that B.C. was "struggling" to decrease his use to 120 per month, apparently referring to his use of hydrocodone, as that is the only controlled substance that B.C. was taking in a quantity able to be reduced to that number. Respondent's documentation reflects no evidence that he assessed B.C. for possible adverse effects from the controlled substances that he prescribed him over the course of five years. Only one laboratory test result is in B.C.'s medical records and that was ordered by B.C.'s primary care physician at Kaiser, with results from August and October 2013. Respondent never ordered any such laboratory testing.

232. Norco is a combination of hydrocodone and acetaminophen. Daily dosing of acetaminophen raises concerns about potential liver toxicity, which is determined by laboratory testing.

**PATIENT N.D.**

233. Respondent's initial visit with N.D. was on February 8, 2007, and continued at least until February 4, 2014.

234. Respondent's note dated February 8, 2007, indicates that N.D. presented with complaints of chronic back pain and anxiety. There is no further description of her symptoms in the notes and neither is there a description of any prior treatment for pain or anxiety. The physical examination is limited, and the only detail noted with respect to her musculoskeletal and neurological examinations is back tenderness in the lumbosacral region. There is no mental status examination. Diagnoses are simply anxiety and back pain. There are no diagnostic test results noted. There is no evident treatment plan apart from prescription for medications, including Xanax 2 mg #30, Prozac 20 mg #30, Vicodin ES #30, and possibly Wellbutrin, although the record is unclear on that medication. There is no documentation indicating informed consent relative to the medications was given.

235. Past medical history can only be gleaned from the "patient's checklist for medical history" dated February 8, 2007. That checklist does not indicate any issues with muscles, joints, or nerves, and N.D. denied any history of alcohol, drug, or mental problems. There is no substance abuse history documented apart from what can be gleaned from this questionnaire.

236. Respondent's progress notes show that N.D. was generally seen on a monthly basis. However, Respondent's notes are generally devoid of history and physical examination findings apart from occasional brief references. There are occasional references to the diagnosis of migraine but without any history to support the diagnosis. In the June 20, 2008 note, the diagnoses of fibromyalgia and arthritis appear with no supporting documentation.

237. Respondent's notes from August 14, 2009, indicate a prescription for Ambien (zolpidem), but the notes make no reference to N.D. having a sleep problem until December 9, 2009, when Respondent noted "[patient] depressed-sleep problems" without elaboration.

238. Respondent's notes list a diagnosis of back pain without other diagnoses, yet at every visit he refills prescriptions for hydrocodone, alprazolam, zolpidem, and fluoxetine.

239. On August 27, 2010, Respondent began prescribing N.D. two different strengths of hydrocodone, but there is no explanation as to why this is necessary and prescribing a patient two different strengths of this drug is an uncommon practice.

240. The notes contain limited clinical information indicating that Respondent made an effort to refine the nonspecific diagnoses of anxiety and back pain. There is a report of a lumbar x-ray in the file, but that was not done until June 17, 2013, six years after Respondent began prescribing to N.D. That x-ray showed only mild degenerative changes. The only laboratory testing results in the file are dated December 22, 2012, and those were normal and included tests looking for an underlying arthritic condition, like rheumatoid arthritis.

241. Respondent's notes provide little data to determine whether N.D. benefited from taking the medications in terms of her pain, mood, and sleep. There is a pain assessment scale, the "Brief Pain Inventory," which presumably N.D. completed, but that is found on only one occasion on April 29, 2013. N.D.'s medical records contain an anxiety symptom scale (usually completed by the patient), but it is undated. The lack of clinical data makes it difficult to determine the rationale for continuing or altering treatment with the prescribed drugs.

242. Respondent's notes contain limited data to indicate that he was attentive to whether N.D. was taking the medications as directed or misusing them. There are notes from an

emergency room visit on September 17, 2010, concerning N.D.'s having had a new onset seizure, which suggests she may have been misusing her medications.

243. N.D.'s medical records contain three CURES reports Respondent apparently accessed on August 29, 2013, September 27, 2013 and January 21, 2014. These CURES reports indicate that N.D. obtained prescriptions for alprazolam and hydrocodone on multiple occasions during 2013 from other physicians. Respondent's notes on September 27, 2013, indicate that he "again spoke to patient" about not seeing another physician. However, there is no indication that Respondent altered his treatment of N.D. as a result.

244. The medical records contain the results of a single urine drug screen included in Respondent's July 3, 2013 progress note. N.D. tested positive for amphetamine, opiate, THC, benzodiazepine, PCP, and "met." No indication of any change in Respondent's treatment of N.D. as a result of these test results is contained in the file.

245. The notes contain no indication of an informed consent discussion until January 31, 2012, when N.D. signed a consent for chronic opioid therapy and also signed a treatment agreement for controlled substances.

246. Respondent's notes contain no indication that he considered referring N.D. for consultation with a psychiatrist, psychologist, or pain specialist. There is no indication he considered referring her for physical therapy or some other nonmedicinal approach to managing her symptoms, despite her long-standing symptoms and requirement for multiple medications.

247. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 12, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

248. The CURES reports indicate that Respondent provided N.D. with 92 prescriptions for hydrocodone/acetaminophen from August 14, 2009 through November 1, 2013. The quantity of tablets per prescription ranged from 30 to 180. Respondent prescribed the patient 9,470 tablets during that time.

249. The CURES data for the 92 prescriptions for hydrocodone/acetaminophen from August 14, 2009 through November 1, 2013 is peculiar because it indicates numerous instances

where N.D. filled two separate prescriptions for hydrocodone from Respondent on the same day for different strengths of the drug; one for the 7.5 mg formulation and the other for the 10 mg formulation. These prescriptions have different prescription numbers eliminating the possibility of clerical error. Furthermore, in addition to the CURES data, the medical records contain copies of prescriptions dated August 29, 2013 and June 17, 2013, dates on which Respondent prescribed N.D. two different strengths of the same drug.

250. The CURES reports indicate that Respondent provided N.D. with 54 prescriptions for alprazolam from August 14, 2009 through November 1, 2013. The quantity of tablets per prescription ranged from five to 40. Respondent prescribed N.D. an average of 2 mg of alprazolam daily during that time.

251. The CURES reports indicate that Respondent provided N.D. with 12 prescriptions for zolpidem from August 14, 2009 through January 4, 2012. The quantity of tablets per prescription was either 30 or 40. Respondent prescribed N.D. an average of 8 mg of zolpidem daily during that time.

252. Respondent also prescribed N.D. oxycodone/acetaminophen 10/325 #60 on April 29, 2013. There were no other prescriptions for oxycodone during the times covered by the CURES reports.

**PATIENT M.F.**

253. Respondent first saw M.F. on November 1, 2011. Respondent's initial note indicates that M.F. had suffered a severe injury to his right foot in a January 2011 motorcycle accident, had undergone multiple surgeries, and had severe pain with intensity 8-10/10. Respondent indicated that M.F. "was going to Kaiser and VA." He noted that M.F. stated that Norco made him sick. There is no further delineation of the pain symptom or prior treatment efforts, and there is no indication Respondent obtained prior treatment records.

254. Respondent prescribed controlled substances for the treatment of M.F.'s chronic pain condition until M.F. died of an accidental overdose on February 19, 2013. The coroner's report indicates the overdose was due to the combined effects of fentanyl, mirtazapine, alprazolam, and nordiazepam.

255. Respondent did not record a substance abuse history apart from M.F.'s medical history checklist, which does not have a name or date but appears to be M.F.'s, because it mentions a January 2011 motorcycle accident. On this checklist, the patient denied alcohol, drug, and mental problems. There is no indication that Respondent reviewed a CURES report or obtained a urine drug screen in connection with the first visit.

256. Respondent's physical examination is notable for its completeness including the report of M.F. walking with a limp and having a markedly disfigured right ankle and foot with scarring and reduced range of motion at the ankle. Respondent diagnosed right-sided foot ankle pain with history of a compound fracture at the ankle/foot. He prescribed the patient hydrocodone/acetaminophen 10/325 #60 with instructions to take one tablet twice daily as needed for pain. There is an informed consent for chronic opioid therapy the patient signed and dated on January 16, 2012. There is also a treatment agreement for long-term controlled substances therapy for chronic pain M.F. signed and dated on January 16, 2012.

257. Respondent continued to see M.F. on a monthly basis after the initial visit until his final visit with the patient on January 28, 2013. As noted above, M.F. died from an accidental overdose on February 19, 2013.

258. A CURES report for M.F. shows Respondent provided M.F. with 10 prescriptions for controlled substances from December 8, 2012 through January 28, 2013, including three prescriptions for oxycodone/acetaminophen 10/325 #60, two prescriptions for transdermal fentanyl 50 mg #15, three prescriptions for alprazolam 2 mg #20-30, and two prescriptions for hydrocodone/acetaminophen 10/325 #30. As noted above, the coroner's report indicates M.F. died from the combined effects of fentanyl, mirtazapine, alprazolam, and nordiazepam.

259. Respondent prescribed M.F., Norco 10/325 #30 on December 12, 2011. The notes from that date do not indicate why Respondent prescribed this drug to M.F. This is particularly interesting because on M.F.'s first visit with Respondent he stated that Norco made him sick.

260. Respondent's note dated January 4, 2012 is entitled "Interim Treatment Plan." Respondent provides further details about M.F.'s trauma and subsequent limb salvage surgeries. He also provided more detail about the pain and reiterated M.F.'s statement that Norco "makes

him sick." Respondent indicated that M.F. had tried physical therapy and had been encouraged to walk. He provided more description of the physical findings at the foot and ankle. He said the patient had "achieved reasonable pain relief' with a combination of Percocet and Norco, which had "allowed him to increase his standing/walking." He cautioned the patient about potential risks associated with the medication and the importance of safeguarding the medication. He asked the patient to sign a pain treatment agreement, which was subsequently signed on January 16, 2012.

261. Respondent's note, dated March 28, 2012, indicated that M.F. requested Duragesic, which he had apparently used previously. Respondent prescribed him transdermal fentanyl 125 mg, quantity unstated, in addition to Percocet, dosage unstated, #60 and Norco, dosage unstated, #30.

262. Respondent's note of April 2, 2012 indicated that M.F. did not feel the 25 mg dose of transdermal fentanyl was adequate, because his pain was 10/10 with walking. Respondent increased the dose of transdermal fentanyl to 50 mg.

263. Respondent's note of April 26, 2012, indicated that M.F. felt "'much better' on the fentanyl patches," with improvement in his sleep. Respondent noted that M.F. was still walking with a crutch and a limp.

264. Respondent's note of July 17, 2012, indicated that M.F. had complaints of anxiety and stomach upset, with nausea and vomiting. There is no indication that Respondent queried M.F. regarding his bowel function to assess whether M.F.'s nausea and vomiting might be due to bowel dysfunction from the opioid drugs, in that long-term opioid therapy can cause severe constipation. The notes do not contain a description of the nature and extent of M.F.'s anxiety. Respondent prescribed M.F. alprazolam 2 mg #20 on that visit.

265. Respondent's note of August 13, 2012, indicated that M.F.'s pain was 8/10 without medicine but reduced to 2/10 with medication. Respondent's notes indicate that M.F. had a "restless anxious feeling in leg," which Xanax helped. Respondent did not describe this symptom in any greater detail, but revised the diagnosis to "foot/ankle/leg pain and cramps and anxiety" at some point. In addition to the Xanax, Respondent continued the prescriptions for alprazolam 2

mg # 20 in addition to the transdermal fentanyl, oxycodone, and hydrocodone prescriptions previously given.

266. Respondent's notes of November 27, 2012, indicate that M.F. had taken more medication on some days, but it is unclear if that means that he had taken more than was prescribed or had taken more because the pain was greater, but still within prescription limits. A physical examination on that visit noted that M.F. "struggles markedly, walks with cane, diaphoretic, pale." He refilled the prescriptions for all four controlled substances.

267. Respondent's note of December 27, 2012, indicates that M.F. was walking more and had "adequate" pain relief but complained of increasing leg cramps and a crawling, itching, tingling sensation in his foot, especially at night. Respondent noted that Xanax helped the patient relax and decreased his breakthrough pain. There is no indication that Respondent considered prescribing M.F. a non-opioid analgesic, since the note suggests more clearly that M.F. was experiencing some neuropathic pain in the leg.

268. Respondent's note of January 2, 2013, indicates that M.F. had brought in a package of fentanyl patches that his four-year-old nephew had run through a shredder. The notes indicate that M.F. asked for replacement of the patches, but Respondent told him he could not give him a replacement prescription and that he was responsible for securing his medications. He also said he was considering referring him to specialty pain management. This incident is of particular concern, since if M.F.'s recitation is truthful, he allowed his four-year-old nephew access to the fentanyl patches, which could easily have led to the death of the child if he had been exposed to the drug. Yet other than declining to prescribe M.F. replacement patches, Respondent seems not to consider the event important.

269. Respondent's note of January 28, 2013, indicates that M.F. complained of severe pain with intensity 10/10 at the right foot and ankle. He described him as anxious, diaphoretic, and markedly distressed. In an "Annual Review" Respondent on the same date, again summarized the patient's history and performed "a brief, cursory exam" that showed the patient to be "in moderate to marked distress," to appear anxious, and to have a "labored" style of walking with a cane. He

noted marked scarring about the right foot with no edema or cellulitis. In referring to the treatment plan, he said the patient was "in agreement that we have achieved the level of pain relief that allows him reasonable [activities of daily living]." He reprised the informed consent. He indicated his plan to check a urine drug screen the following month. There is a more quantitative assessment of the patient's pain on this date, in the form of the Brief Pain Inventory.

270. Respondent's next entry in M.F.'s file is a one-page, typed summary of "Additional Facts" Respondent gathered for a postmortem analysis. He asked the decedent's wife if the decedent had seen any other doctors. His notes state that: "She told me that she was his wife, not his mother, and that he took care of his own medical problems and that she didn't get involved." Respondent further reported that he called the pharmacy where M.F. filled his prescriptions from Respondent and asked the pharmacy employee if she could run a CURES report on M.F. The employee said she could not, as "she was not set up to do those. Respondent's notes indicate that he then told the pharmacy employee that "I had tried to get set up myself since January but was never able to get a hold of anyone there when I called."

271. Respondent's medical file for M.F. contains two CURES reports dated August 23, 2013 and August 22, 2013, months after the M.F.'s death. These reports indicate the patient was obtaining prescriptions for controlled substances (opioids and benzodiazepines) from multiple doctors at multiple pharmacies.

PATIENT E.H.

272. Respondent first saw E.H. on September 23, 2007. The initial note indicates that E.H. was first treated for weight loss. He did not consistently treat her for a pain condition until April 7, 2008.

273. Respondent's first mention of prescribing E.H. Talwin is in the progress note dated April 7, 2008. The note indicates that E.H. had back pain secondary to "twist." There is no physical examination other than her weight. The diagnosis is "back pain/conjunctivitis," and Respondent prescribed her 60 Talwin tablets. Respondent's subsequent notes variously refer to E.H. as having pain in her back, right leg, right foot, neck, left hand, and also migraine. There are some references to E.H. having fallen and injured herself.

274. Respondent's, notes from June 8, 2010, that indicates that E.H. had fallen and fractured her left knee, though there was no physical examination documented to support that conclusion, or any physical examination at all noted for that visit. He prescribed her Talwin #60 with one refill. The visit notes generally indicate that he refilled her prescription for Talwin, but there is scant history and essentially no physical examination findings to support long-term prescription of the opioid.

275. Respondent's March 28, 2011 progress note indicates that he doubled the quantity of the Talwin prescription from 60 to 120 tablets. There is no explanation in the notes and there is no record in the notes to indicate a symptom of pain, any physical examination findings, or a diagnosis of pain.

276. Respondent's progress note of July 22, 2011, indicates that E.H. was prescribed Norco 10/325 #60 with one refill. There is no record of any symptom of pain. There is no physical examination apart from her weight. There is no diagnosis of pain. Despite multiple intervening visit notes, the next entry that even mentions the E.H. having pain is dated February 16, 2012, and indicates "'back pain, leg pain" without further explanation and without a physical examination. He refilled her prescription for Talwin #90 with one refill.

277. E.H. visited Respondent on multiple occasions but the next entry that concerns pain is dated March 29, 2013, when Respondent noted that E.H. had continued back pain "but better," with intensity 7-8/10. Respondent also observed that E.H. still had "bottle almost full of meds." There was no physical examination apart from weight. He indicated she had back pain, left knee pain, and left foot pain and prescribed her Talwin #90. He recommended x-rays of her left knee and right foot. There is a report for a right foot x-ray in the medical records dated September 11, 2013, showing that E.H. had degenerative joint disease at the first metatarsophalangeal joint. Oddly there is also a right foot x-ray report in the chart dated May 1, 2006 (seven years prior) that showed similar findings. No report of a left knee x-ray is contained in the medical records.

278. Respondent's April 25, 2013 progress note indicates that Respondent talked with E.H. about "alternatives to Talwin Nx." He indicated she had right foot pain that was constant with intensity 8/10, had intermittent pain in the low back with intensity 9/10, plus left knee pain at

times with intensity 7/10. There is no physical examination apart from weight. There is no assessment, and the plan consists of prescriptions for Talwin, Motrin, Elavil, and samples of Lyrica. The note suggests that either E.H. or Respondent wished to ease her off of Talwin. However, it is impossible to determine the exact facts due to the sparse documentation. It is unclear whether E.H. was having difficulty controlling her use of the drug (she was receiving numerous prescriptions for the medication) or if another reason for reduction of the medication caused the notation. There is no documentation concerning whether Respondent ever talked to her about how she was managing her use of the drug.

279. There are two CURES reports in E.H.'s medical records that Respondent accessed, but those were not accessed until August 29, 2013 and January 21, 2014. Respondent did not adequately assess E.H.'s adherence to proper use of this opioid analgesic.

280. Respondent's medical records contain a consent for chronic opioid therapy signed by E.H. on February 16, 2012. There is also a treatment agreement for long-term controlled substances therapy for chronic pain which E.H. signed but did not date.

281. Respondent's notes do not contain documentation indicating that Respondent monitored E.H. for potential adverse effects from her chronic use of pentazocine, such as sedation, dizziness, nausea, mental changes, and dependence. There is a remarkable dearth of any physical examination findings relative to E.H.'s pain symptoms in the entire file. It is impossible to determine from the documentation what the treatment objectives were with respect to the multiple prescriptions for Talwin.

282. Respondent's September 11, 2013 progress note provides additional history, indicating that E.H. had increasing right foot pain and had apparently increased the amount of medication she was taking. The pain is described as dull, throbbing, deep, and sometimes sharp and as worse with standing and walking. Again there is no physical examination except for the notation "x-ray/foot from 2006 shows [sic]." The diagnosis is merely foot pain. Respondent prescribed her Talwin #75, gabapentin, ibuprofen, and Vistaril. He noted a urine drug screen result in the left margin of the progress note, but the results are undecipherable.

283. Respondent's March 14, 2014 progress note contains little information except for indicating that E.H. presented for prescription refills. There are no symptoms documented. There was no physical examination. Respondent prescribed Norco 10/325 #120 and ibuprofen 600 mg #30. The treatment plan is unclear.

284. Respondent's medical records do not contain any systematic assessment of E.H.'s pain apart from one Brief Pain Inventory completed on January 18, 2013. On this questionnaire, she indicated the location of her pain, delineated her pain intensity, and rated the pain's impact upon her function.

285. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013. There is also a CURES report in Respondent's file that is dated January 21, 2014 and includes five additional prescriptions from Respondent that are not included on the CURES reports obtained as part of the investigation.

286. The CURES reports show that E.H. filled 128 prescriptions for pentazocine/naloxone (trade name Talwin Nx) from Respondent from September 4, 2009 through January 13, 2014. Pentazocine is a weak opioid analgesic used for the relief of moderate to severe pain. It is available as an oral agent in combination with a small amount of naloxone, and the naloxone is intended to reduce the risk of its being abused intravenously. Over slightly more than four years, Respondent prescribed her 8,951 tablets for an average dose of 317 mg of pentazocine daily. (The manufacturer recommends a total daily dose of pentazocine not exceed 600 mg.)

287. Respondent issued E.H. several other prescriptions for controlled substances from September 4, 2009 through January 13, 2014, including a prescription for Butrans 5 mg patches on May 5, 2011, prescriptions for hydrocodone on July 22, 2011 and September 30, 2013, and a prescription for codeine on November 4, 2013.

**PATIENT J.I.**

288. Respondent first saw J.I. on February 25, 2008, for an initial complaint of bronchitis and anemia. There is no history in this note and a limited physical examination. The diagnoses

were bronchitis and anemia, and a treatment plan consisted of vitamin supplementation and a testosterone injection.

289. Respondent's second visit with J.I. occurred on May, 14, 2008, at which time Respondent started prescribing J.I. Norco 10/325 #60, for a diagnosis of sinusitis. The records do not contain any description of the nature and extent of the pain nor any record of any examination other than blood pressure and weight. There was no indication of informed consent or any discussion of the possible risks associated with Norco. There is no indication as to whether the patient had a history of substance abuse apart from what can be gleaned from J.I.'s self-completed, undated medical history checklist upon which J.I. denied alcohol, drug, or mental problems. However, Respondent does comment upon the substance abuse issue four years later in a note dated January 23, 2012.

290. Respondent's January 14, 2009 note references J.I. as having continued "sinus pressure/pain." Respondent prescribed him Norco 10/325 #80. There is no documentation of an examination other than J.I.'s weight.

291. Respondent's February 12, 2009 progress note indicates that J.I. had "sinus facial pains" and was seeing an otolaryngologist. Respondent prescribed J.I. 100 Norco tablets.

292. Respondent's April 20, 2009 progress note mentions "headaches" as J.I.'s subjective complaint without further description of the symptom. Respondent prescribed J.I. Vicodin ES #100.

293. Respondent's August 11, 2009 note indicates a diagnosis of migraine for the first time. There is no further history and no examination of the neurological system. Respondent prescribed J.I. Norco 10/325 #120.

294. Respondent's January 1, 2010 progress note makes the first reference to pain intensity, noting "pain is 8-10/10 without meds." Respondent noted that he spoke with J.I. about "seeing two doctors" and indicated the patient said he would not get medicines from the other doctor without notifying Respondent. Respondent's assessment was now pain in the neck, back, and face (sinuses), and he prescribed J.I. Norco 10/325 #120.

295. Respondent's March 11, 2010 note indicates a diagnosis of trigeminal neuralgia, back pain, and cellulitis. There is no neurological examination. There is no examination of the head and neck recorded. There is no further delineation of the symptoms other than indicating the patient had "severe maxillary-face pain 9/10." Respondent prescribed J.I. Norco 10/325 #120.

296. Respondent saw J.I. on several interim occasions with no significant events recorded in the progress notes. However, on January 3, 2011 there is a note in the medical records entitled "Interim Review." In that note Respondent indicated that J.I. was "under chronic pain management" and had "not sought pain meds from another physician" since he had spoken to him the prior January when he learned that J.I. had been receiving narcotic prescriptions from both Respondent and another physician. It is unclear how Respondent discovered that information. In the January 3, 2011 note Respondent indicated that J.I. had achieved "adequate pain relief" without having to increase the amount of Norco compared with the year before. The note indicates that he cautioned J.I. about taking additional acetaminophen in over-the-counter medicines, talked with J.I. about the issue of tolerance and the option of using a long-acting medication and discussed the importance of safeguarding his medications to prevent diversion. The note also indicates that, for apparently the first time, he warned J.I. that the prescribed medications might affect his level of alertness and cause other potential side effects. Respondent concluded that J.I. "had good pain relief" and had "been able to enjoy a comfortable active lifestyle." There was no physical examination associated with this note other than recording the patient's height, weight, and blood pressure.

297. Respondent's June 21, 2011 progress note indicates that J.I. complained of constant pain with an intensity level of 10/10 that interfered with his concentration and drained his energy. The note contains some physical findings, including tenderness to percussion below the eye, though he does not indicate whether this was right-sided or left-sided. Respondent also indicated that J.I. had mild periorbital swelling. Respondent indicated that J.I. had "intractable" sinus/face pain. He prescribed him Norco 10/325 #120 with one refill and promethazine and codeine cough syrup, 8 ounces.

298. On December 20, 2011, Respondent increased the quantity of the Norco prescription from 120 to 240 tablets. The notes indicate that J.I.'s pain intensity was 7/10 without medicine but did not indicate the degree to which the medication alleviated the patient's pain.

299. Respondent's July 11, 2012 progress note indicates that J.I. was "in satisfactory comfort" and stated that the medication reduced his pain from 7-8/10 to 2-3/10. He added, "He [J.I.] appears to be handling his medications responsibly. The meds allow him to enjoy [activities of daily living] and his hobby (boating, fishing, travel)." That is the extent of the information in the note, with no additionally physical examination or objective readings.

300. Respondent's October 12, 2012 progress note indicates that J.I.'s pain is no longer controlled by the current prescriptions with a pain intensity of 9/10. Respondent prescribed him Norco 10/325 #180 and added Percocet 10/325 #60, which is another short-acting opioid/acetaminophen combination.

301. On January 23, 2012, Respondent wrote a report entitled "Periodic Review," in which he summarized J.I.'s history to a greater extent that had been done in the prior four years of seeing J.I. Respondent described J.I.'s history of pain treatment prior to coming under his care. Respondent also notes that J.I. did not have a history of drug or alcohol abuse, nor did he have history of any psychological problems. The note also included a limited physical examination. Respondent listed a treatment plan with objectives, including the objective "to make the pain tolerable so that he can enjoy a reasonable quality of life and beyond achieving normal [activities of daily living] he remains quite active." Respondent mentioned informed consent and cautioned J.I. about potential risks as well as the need to secure his medications. Respondent also noted that he was planning to do a urine drug screen, but results for this screen do not appear in the file until July 2, 2013. The file includes a consent for chronic opioid therapy and a treatment agreement for long-term controlled substances therapy for chronic pain, but J.I. did not sign and date these documents until January 23, 2013 exactly one year after the periodic review.

302. Respondent's March 1, 2013 note indicates that Respondent began prescribing J.I. transdermal fentanyl at a dose of 50 mg with instruction to change the patch every 48 hours. Respondent noted that J.I. had tried a friend's fentanyl patch with good relief. Strikingly, there is

nothing in the notes indicating the Respondent advised J.I. of how dangerous it is for one patient to use another person's fentanyl patch, because that could easily result in unintentional overdose and death in someone who is not sufficiently tolerant to opioids. Respondent also initiated treatment with the patch on a 48 hour schedule, which is not how the patch is generally dosed at the outset of treatment. However, Respondent altered the schedule at the next visit on March 29, 2013 when he instructed the patient to change the patch every 72 hours. However, the reason for altering the duration, as reflected in the notes was because J.I. stated that "his plan" would only pay for use of the patch every 72 hours.

303. Respondent's July 2, 2013 notes include the results of the urine drug testing mentioned on January 23, 2013. J.I.'s urine was positive for opiate and negative for the other substances tested, which was consistent with the prescription records.

304. Respondent's medical records for J.I. include CURES reports dated November 25, 2009, August 29, 2013 and September 2, 2013. The report of November 25, 2009 may have led Respondent to counsel J.I. on January 20, 2010 regarding the need to get pain medications from only one physician at a time.

305. Respondent's only entry in the several years represented in the file that quantitatively assesses J.I.'s pain and activity tolerance is a Brief Pain Inventory questionnaire completed on January 23, 2013. There is also one pain anxiety symptom scale in the file, but that has no date. Diagnostic testing in the file includes laboratory testing Respondent ordered for J.I. in November 2012, laboratory testing of J.I. in June 2007 that was ordered by another physician and which Respondent had faxed to his office on March 4, 2008 and laboratory testing J.I. had in early 2008, also ordered by another physician, which Respondent also had faxed to his office on March 5, 2008. It is not indicated how Respondent was made aware of these tests.

306. Respondent saw J.I. on a regular basis to prescribe and monitor his treatment with opioid analgesic medicine, usually hydrocodone and later transdermal fentanyl, but there is an inadequate description of the nature and extent of J.I.'s pain, little or no physical examinations, and no noted consideration of referring J.I. for consultation with a specialist, such as a neurologist or pain medication specialist.

307. Early in the course of Respondent's treatment of J.I., Respondent made reference to J.I, seeing an otolaryngologist, but there is no documentation to suggest he coordinated his treatment with that clinician, or what that clinician's finding were, if any. Respondent uses different terms to refer to J.I.'s pain, including facial pain, migraine, and trigeminal neuralgia, yet J.I.'s diagnosis remains unclear due to lack of adequate history and no physical examinations to differentiate these different disease entities, for which there are more specific treatments available than just long-term opioid therapy.

308. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

309. The CURES reports show that J.I. filled 54 prescriptions for hydrocodone from Respondent from September 16, 2009 through November 23, 2013. Over these four years, Respondent prescribed J.I. 7,380 hydrocodone tablets for an average of 54 mg of hydrocodone daily. Respondent also issued J.I. a few prescriptions for promethazine with codeine cough syrup, oxycodone/acetaminophen, and later during the course of treatment started him on transdermal fentanyl, in addition to the hydrocodone.

**PATIENT C.L.**

310. Respondent first saw C.L. on June 25, 2001, for treatment of C.L.'s obesity with the diet drug phentermine. There are a number of follow-up visits over the ensuing years pertaining to the prescription of this diet pill. Seven of the progress notes over the following years do not have a discernible date and most contain very limited information.

311. Respondent first prescribed C.L. an opioid analgesic on March 30, 2005, noting that C.L. had back pain as indicated by an examination revealing tenderness in the lumbosacral region. Respondent prescribed Vicodin ES #40.

312. Respondent's subsequent notes make occasional reference to C.L.'s having low back pain, but Respondent did not prescribe C.L. more Vicodin until 2007. This 2007 note's exact date is uncertain, but it indicates that C.L. had back and leg pain but did not include any further discussion of the symptoms. There is no examination of the musculoskeletal or neurological

systems. Respondent began prescribing the patient hydrocodone (e.g., Vicodin, Norco) on a more consistent basis, but the only documentation of any examination findings relative to the back are an occasional notation of back tenderness in the paraspinal region.

313. Respondent's December 5, 2008 progress note indicates that C.L. had fallen and had back pain as well as right knee pain with intensity 9/10. Respondent failed to document any examination of the back or the knee. Respondent prescribed C.L. hydrocodone/APAP 10/325 #90 with one refill. He also recommended a right knee x-ray; however, there is no x-ray of the knee in the medical records, although a report of a lumbar x-ray done on May 20, 2013 (five years after the recommendation) showed minimal degenerative changes in the lumbar spine.

314. Respondent's files include laboratory test results from August 8, 2001, August 31, 2006 and April 17, 2013.

315. Respondent's file contains a consent for chronic opioid therapy, but this was not signed and dated until February 28, 2012, and a pain management agreement of the same date.

316. Respondent's file includes a note dated July 7, without a discernible year, that indicates that C.L. had "very bad sciatica" in his left leg. There was no neurological examination noted but Respondent prescribed hydrocodone/acetaminophen 10/325 # 90 with one refill.

317. Respondent's physical examination of C.L. does not address the ongoing complaints of back and leg pain and is inadequate. There is no documentation concerning the range of motion in the back or lower limbs or muscle, reflex, or sensory testing. Neither is there any documentation of straight leg raise testing.

318. Respondent's file does not contain a pain treatment plan for several years apart from the prescription of the opioid analgesic, even though Respondent was generally seeing C.L. on a monthly basis. Respondent did prescribe C.L. ibuprofen 800 mg, but that was not until the May 16, 2012 visit. There is no indication Respondent considered alternative treatment options, such as physical therapy or injections, until he referred the patient for consultation with a pain specialist in 2012. Dr. J.'s consult report is dated August 10, 2012, and described the nature and extent of the patient's pain and examination findings.

319. Dr. J. made a diagnosis of lumbar radiculopathy and lumbar facet arthropathy and gave specific recommendations, which are outlined in his report. The notes do not reflect those recommendations being acted upon.

320. Respondent's November 23, 2012 notes show that he prescribed C.L. hydrocodone/acetaminophen 10/325 #120 and oxycodone 30 mg #120. There is no indication in the record of any reason for any prescription, but less two short-acting opioid analgesics concurrently. In C.L.'s next visit on December 18, 2012, Respondent noted that C.L. indicated that he still had low back pain and that oxycodone gave "much better relief;" however, Respondent continued to prescribe C.L. both opioid analgesics at that visit and subsequent visits on January 16, 2013, February 13, 2013 and March 4, 2013. Respondent increased the quantity of the hydrocodone from 120 to 180 tablets at the March 4, 2013 visit while reducing the quantity of the oxycodone from 120 to 60 tablets.

321. Respondent's notes indicate that on March 29, 2013, he prescribed C.L. hydrocodone #240 without a prescription for oxycodone, with no explanation.

322. Respondent's April 17, 2013 notes indicate that C.L. stated that the oxycodone was "too heavy" but hydrocodone (Norco) was "too light." Respondent's response was to prescribe C.L. oxycodone/acetaminophen 10/325 #60. The treatment plan for the opioid analgesics is unclear.

323. Respondent's May 5, 2013 note indicates that C.L. was taking approximately eight per day of something (presumably the oxycodone) and he also noted C.L. to say that "Percocet wears off too fast." C.L. rated his pain intensity as 10/10, but it does not indicate with or without medications. The notes show that Respondent did switch C.L. back from the Percocet to hydrocodone/acetaminophen 10/325 #240. However, no treatment plan is delineated and no physical examination of the neurological or musculoskeletal systems is recorded.

324. Respondent's July 26, 2013 notes indicate that C.L. had continuing low back pain with an intensity of 9/10 without medication. Respondent's notes do not indicate how C.L.'s pain intensity changed in response to the medication. Respondent also noted for what appears to be the first time that C.L. had pain at his waist radiating to the left heel. He noted that another

physician had ordered x-rays showing that C.L. had a disc problem at L4-L5. Respondent's notes indicate that he performed an examination and C.L. had back tenderness and indicated the location of that tenderness, but there was no examination of the neurological system. Respondent prescribed C.L. more hydrocodone and ibuprofen.

325. Respondent ordered a urine drug screen for C.L. on June 27, 2013, which is the first evidence of any monitoring of C.L.'s adherence to proper treatment. The results of that urine drug screen show that C.L. tested positive for opiates and negative for alcohol and illicit substances. However, on a subsequent urine drug screen dated September 18, 2013, Respondent noted that C.L. tested positive for amphetamine, opiate, benzodiazepine, and PCP. Respondent did not enter any notes showing that he discussed these findings with C.L. or that he was concerned about these findings in any way.

326. Respondent's file contains two CURES reports for C.L. dated August 30, 2013 and January 21, 2014. There is no indication that Respondent reviewed or otherwise noted those CURES reports, even in light of the urine drug screen results for September 18, 2013.

327. On December 21, 2013, Respondent began prescribing C.L. a long-acting morphine analgesic in addition to the oxycodone, hydrocodone and ibuprofen. No explanation is included in the notes for this additional prescription.

328. Respondent's January 7, 2014 notes indicate that C.L. complained that the morphine made him drowsy. Respondent prescribed him OxyContin 20 mg #60, apparently to replace the morphine, in addition to hydrocodone and ibuprofen.

329. Respondent's February 14, 2014 notes indicate that C.L. complained of increased back pain with an intensity of 10/10. Respondent indicated that C.L. was "taking more meds." Respondent appears to have examined C.L. on this occasion and noted that C.L. was in "marked distress" and unable to sit in a chair and that his back was tender. No other notation regarding any neurological or musculoskeletal examination findings are included in the notes. The noted symptoms suggest a significant change in C.L.'s condition, yet Respondent performed no appropriate physical examination. Respondent prescribed C.L. more opioid analgesics and ordered laboratory testing.

330. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

331. The CURES reports show that C.L. filled 61 prescriptions for hydrocodone from Respondent from August 19, 2009 through November 15, 2013. Over those four years, Respondent prescribed C.L. 10,380 hydrocodone tablets with an average dose of 60 mg of hydrocodone daily.

332. The CURES reports show that C.L. filled 13 prescriptions for oxycodone from Respondent from October 14, 2011 through November 15, 2013, totaling 1,400 oxycodone tablets for an average dose of 69 mg daily.

**PATIENT K.L.**

333. Respondent first saw K.L. on June 9, 2009, although the year is not discernible on the handwritten initial evaluation but can be determined by reference to a medical history checklist K.L. completed on that day. The notes indicate that K.L. had undergone left hip replacement on October 31, 2007, and presented to Respondent complaining of right hip pain without further description of the pain in the notes. Respondent noted that K.L. would probably need to have a right hip replacement and "was on OxyContin 80 mg plus oxycodone plus Norco's." There is no further delineation in the records concerning K.L's reaction to the treatment or the quantity of the medications.

334. In the notes from the initial visit Respondent listed the name of an orthopedist and the name of a pain physician who presumably were involved with K.L.'s care, but there is no indication that he coordinated his treatment of K.L. with these other physicians. There is no additional mention of prior treatment apart from reference to a prior left hip replacement.

335. K.L.'s past medical history can be gleaned from the "patient's checklist for medical history," dated June 9, 2009, on which the patient denied any history of alcohol, drug, or mental problems. There is no substance abuse history documented for K.L. The initial physical examination is limited and the only thing listed in the notes is a leg length discrepancy. Respondent's diagnosis is right hip pain, with no further explanation.

336. There are no diagnostic test results ordered for the initial visit, but there is a recommendation for bilateral hip x-rays. However, there are no x-ray results in the file. Respondent prescribed K.L. OxyContin 40 mg #45 with instructions to take one in the morning and two in the evening, Norco 10/325 #60, and Zofran 8 mg #seven. There is no treatment plan apart from the prescriptions for medications. Neither is there an informed consent related to the medications prescribed in the original progress note. There is a consent for chronic opioid therapy in the file which K.L. signed on March 7, 2012, almost three years after the initial visit.

337. Respondent's notes indicate that he next saw K.L on June 30, 2009. Respondent indicated that K.L. had just had a right hip replacement and was in for a wound dressing check and prescription refill. However, Respondent did not indicate what medications he prescribed K.L. that day or any information regarding the physician who performed the hip replacement and medications that physician may have prescribed.

338. Respondent's next note is dated "July 20" with no year indicated. Respondent indicated that K.L. was taking OxyContin 60 mg three tablets daily and without medication had hip pain intensity of 9/10. No examination appears to have occurred with only the observations noted that K.L. was in moderate distress, walked with a limp using a cane and had a weight of 228 pounds. Respondent prescribed OxyContin 60 mg #90, Norco 10/325 #120, and alprazolam 2 mg #60. There is no indication as to why Respondent prescribed K.L. alprazolam.

339. Respondent's notes generally provide a very limited description of K.L.'s pain and how the medicinal treatment was impacting that pain and K.L.'s functioning. Physical examination findings are very infrequent and provide almost no detail.

340. Respondent's October 19 note (again without a year) indicates that K.L. wished to "start cutting down on OxyContin." There is no indication as to why K.L. wished to do so. Furthermore, there is another prescription for alprazolam with no indication as to why K.L. was provided that prescription or needed alprazolam.

341. Respondent's January 15, 2010 note indicates that K.L. wanted an early refill of his medication and was having surgery on Monday, but there is no indication as to what type of

surgery he would be having, who was performing that surgery, what any preoperative orders were or any other information regarding the surgery.

342. A note in the file from another physician indicates that K.L. was hospitalized from January 20, 2010 through January 22, 2010 for hip replacement surgery. However, the records do not indicate whether K.L. was adhering to proper treatment with the prescribed medications.

343. Respondent's file contains a CURES report dated September 23, 2010, marked to the attention of Respondent. That CURES report's prescription history is suggestive of a pattern of doctor shopping, because K.L. filled prescriptions for controlled substances from multiple providers at multiple pharmacies during the four-month time frame of the report.

344. Respondent's October 8, 2010 progress note indicates that he had reviewed a CURES report but the note said nothing in addition to that notation of that review. There is no indication that the report impacted Respondent's unnoted "treatment plan" for K.L.

345. Respondent's next note is dated November 5, 2010, wherein he indicates that he had talked with K.L. about "seeing other M" [sic], without anything further documented about the discussion. This note and the next seven notes are devoid of any history and physical examination findings apart from an occasional listing of the patient's weight.

346. There is no indication of urine drug testing in the file to confirm whether K.L. was taking the medications appropriately or abusing illicit substances. The file contains a form entitled Long-term Controlled Substances Therapy for Chronic Pain, which is essentially a treatment agreement. However, K.L. signed but did not date the form.

347. Respondent's July 9, 2011 note indicates that K.L. had just had right knee surgery and had a swollen right calf. Respondent ordered a venous Doppler study.

348. Respondent's records do not indicate any clear treatment plan for the medications prescribed to K.L. There is very limited information in the progress notes to tell whether K.L. was benefiting from the drug treatment program or having side effects. Some of Respondent's notes make reference to K.L.'s pain intensity without medication, but there is no indication as to the impact the medications had upon reducing his pain. The only diagnostic testing in the file is laboratory testing from August 18, 2009 (shortly after the initial visit), which included a

comprehensive metabolic panel, complete blood count, lipid panel, testosterone and prostate specific antigen. There is one image of a prosthetic hip in the file, but it is unclear whether this is the right hip or the left hip, it is not dated and there is no patient name on the image.

349. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

350. The CURES reports show that K.L. filled 18 prescriptions for OxyContin from Respondent from August 18, 2009 through February 6, 2011. These were for the 80 mg formulation with the exception of a single prescription for the 60 mg formulation. Respondent prescribed K.L. an average of 165 mg daily of OxyContin during this time.

351. The CURES reports show that K.L. filled 24 prescriptions from Respondent for oxycodone 30 mg from December 3, 2010 through November 19, 2012. Respondent prescribed K.L. an average of 92 mg of oxycodone daily during this time.

352. The CURES reports show that K.L. filled 37 prescriptions from Respondent for hydrocodone/acetaminophen from August 20, 2009 through November 19, 2012. The quantity of tablets per prescription ranged from 40 to 360. Respondent prescribed the patient 5,860 tablets during that time frame for an average dose of 57 mg of hydrocodone daily.

353. The CURES reports show that K.L. filled 44 prescriptions from Respondent for alprazolam from August 20, 2009 through November 19, 2012. The quantity of tablets per prescription ranged from four to 180. Respondent prescribed the patient an average of 5.3 mg of alprazolam daily during that time.

354. The CURES reports show that K.L. filled 12 prescriptions from Respondent for carisoprodol, at 90 tablets per prescription during the time frames covered by the three CURES reports. K.L. filled these prescriptions between February 1, 2012 and November 19, 2012.

**PATIENT K.M.**

355. It is impossible to determine when Respondent first saw K.M. because Respondent did not maintain a medical record for K.M. However, the coroner's report prepared following

K.M.'s death following an accidental overdose indicates that Respondent prescribed her controlled substances starting on or about February 2, 2007.

356. According to the Drug Worksheet in the coroner's report for K.M., Respondent prescribed her alprazolam #30, hydrochlorothiazide 25 mg #30 and Lunesta 3 mg #30 on February 2, 2007 and butabarbital #90 and hydrocodone/acetaminophen 7.5/750 #30 on February 4, 2007. Respondent also prescribed her alprazolam #30 on March 2, 2007.

357. K.M. died at age 44 of an accidental overdose. The coroner's report indicates she died of acute morphine intoxication on March 11, 2007.

**PATIENT C.P.**

358. Respondent first saw C.P. on June 12, 2003 and continued to treat her until December 30, 2009 when he gave her prescriptions for hydrocodone/acetaminophen 10/325 #120, alprazolam 2 mg #30 and diazepam 10 mg #60. According to the coroner's report C.P. died one week later, on January 5, 2010 of an accidental overdose due to the combined effects of hydromorphone, hydrocodone, diphenhydramine, temazepam, diazepam, methadone, and sertraline.

359. Respondent's notes indicate that C.P. initially presented to him on June 12, 2003, for weight control and treatment of chronic pain related to interstitial cystitis. There is a medical history checklist that C.P. completed on June 12, 2003, followed in the file by a number of records from other practitioners pertaining to C.P.'s evaluation and treatment prior to and subsequent to Respondent's treatment of her. Respondent also ordered a number of diagnostic tests during his treatment of C.P., including multiple laboratory tests and imaging studies. Reports in the file from other physicians indicate that C.P. had a history of ulcerative colitis, diabetes, hypertension, obesity, interstitial cystitis, hyperlipidemia and coronary artery disease.

360. Respondent's progress notes suggests Respondent began prescribing the patient Norco, or hydrocodone/acetaminophen, for chronic pain due to interstitial cystitis at the initial evaluation on June 12, 2003.

361. Respondent's April 13, 2004 progress notes indicate that he prescribed C.P. a benzodiazepine, Valium. The notes indicate that the prescription was related to anxiety stemming

from being recently diagnosed with ulcerative colitis. However, the notes contain very little information as to the nature and extent of C.P.'s pain or anxiety, for which complaints Respondent prescribed her medication. Physical examination findings are seldom documented throughout the course of Respondent's treatment of C.P.

362. On several different occasions Respondent's notes contain references to C.P. having "back pain." However, there is no adequate physical examination of her low back and lower limbs documented anywhere in the records.

363. Respondent's notes for January 23, 2004, indicate that C.P. was seen by Respondent following an automobile accident. He documented more of a physical examination than he generally did, but the only reference to her back was "tender para lumbar." His diagnoses that day included lumbosacral strain, and the note indicates he recommended a lumbar x-ray. There did not appear to be any x-rays in the file regarding this recommendation.

364. Respondent's notes reflect that the next physical examination related to her back occurred on November 20, 2008. He noted her back was tender in the thoracic and lumbosacral region with no other findings. There is no mention of C.P.'s spinal range of motion, lower limb strength, reflexes, or sensation, such as tingling in her extremities or back.

365. Respondent's notes contain almost no documentation concerning C.P.'s responses to treatment with controlled substances. The records do not indicate if the hydrocodone resulted in pain reduction or increased her pain tolerance for daily activities. There is no indication why Respondent concurrently prescribed her two benzodiazepines, Valium 10 mg and Xanax 2 mg, and the records do not indicate if she was benefiting from the benzodiazepines. The records do not indicate if C.P. had any adverse effects from the controlled substances, such as drowsiness, cognitive impairment, and constipation.

366. Respondent's notes do not indicate how C.P. was controlling her use of these potentially habit-forming medications. There is no indication if Respondent ever attempted to determine if C.P. was having any difficulty controlling her use of the drugs or deviating from his instructions when taking them. The records contain a Medication Log listing medications prescribed to C.P. from October 2004 through January 2006, but nothing thereafter apart from

what can be determined from the progress notes. Respondent did not order a urine drug screen or any CURES reports for C.P.

367. C.P. died of an accidental drug overdose on January 5, 2010. C.P.'s autopsy report indicates that she died due to the combined effects of multiple drugs, including opioids and benzodiazepines. Respondent prescribed her hydrocodone, which metabolizes into Hydromorphone, which the autopsy found in her system. Respondent prescribed her diazepam, which metabolizes into temazepam, which the autopsy found in her system. Respondent prescribed her alprazolam, which the autopsy did not find in her system. Methadone was found in her system but Respondent was not prescribing her methadone.

368. Three CURES reports were obtained during the investigation of Respondent. However, only the CURES report from August 13, 2009 through August 13, 2012 reflects prescriptions for C.P.

369. The CURES report shows that C.P. filled 5 prescriptions from Respondent for hydrocodone/acetaminophen 10/325 #120 from August 18, 2009 through December 30, 2010.

370. The CURES report shows that C.P. filled 5 prescriptions from Respondent for alprazolam 2 mg #30, and five prescriptions for diazepam 10 mg four of which were for #30 and one of which was for #60 from August 18, 2009 through December 30, 2010.

371. Respondent indicated during the investigation that he treated her for interstitial cystitis and prescribed her numerous medications, including Norco, Xanax, Valium, Nexium, and Reglan. He also prescribed her Zoloft at one time but said she had stopped taking that medication.

**PATIENT J.S.**[3]

372. Respondent first examined J.S. on September 23, 2013 and saw him again on December 27, 2013 and January 27, 2014. These visits were recorded on video and audio.

373. Respondent's note from September 23, 2013, indicates that J.S. complained of right shoulder pain and anxiety associated with having recently moved from Northern California to attend a local community college. The note also references J.S.'s experiencing stress from work.

[3] This is a simulated patient who saw Respondent as part of an undercover operation during the investigation of Respondent.

The note does not contain any description of the nature of J.S.'s anxiety and if it included the panic attacks or had associated depressive symptoms. Neither is there a description of if, or how J.S.'s anxiety impacted his functioning, if at all. There is no indication in the progress note whether J.S. had a pre-existing history of anxiety or treatment for anxiety, although there is a medical history checklist, which J.S. completed and upon which he indicated he had no history of mental problems. The initial note does not indicate if J.S. had a history of substance abuse, although on the history checklist J.S. indicated he had no drug or alcohol problems.

374. Respondent's initial note does not indicate whether J.S. had a family history of any psychiatric condition. There is a brief physical examination, which Respondent noted was significant for blood pressure elevated at 150/90. The diagnosis was anxiety, shoulder pain, and increased blood pressure. Respondent prescribed J.S. alprazolam 1 mg #30 and warned J.S. to be cautious of using the drug with alcohol. The treatment plan is unclear. There is no indication that Respondent talked with J.S. about alternative treatment options for anxiety, such as a medication other than a controlled substance or counseling.

375. Respondent's notes from December 27, 2013, indicate that Respondent opened the visit with J.S. by asking him if he wished a refill of Xanax. He observed the prescription had lasted J.S. "quite a while." J.S. volunteered that he had run out of the medication but used a few of his mother's while he was visiting her, but Respondent did not respond to that statement with any criticism of that approach. Respondent talked with him about his anxiety and suggested J.S. take Prozac as a way to facilitate a reduction of Xanax. Respondent prescribed J.S. Xanax 1mg #30, Prozac 20 mg #30, and ibuprofen 600 mg #90, all with zero refills. Respondent prescribed the ibuprofen for J.S.'s complaint of shoulder pain. Respondent did not perform a physical examination during this visit.

376. Respondent's January 27, 2015 visit began with Respondent asking J.S, "More of the same for you, the Xanax and the Prozac?" Respondent's notes indicate that J.S. was right on schedule and commented that he was "on a low level" of the Xanax and could "go a day without it and not freak out." Respondent asked J.S., "Does that help get you through the," and J.S. interrupted, "Yeah, it sure does." That was the extent of Respondent's questions regarding

whether J.S.'s symptoms were adequately controlled. Respondent asked J.S. if he took a whole tablet or broke the tablet, again referring to the Xanax, and J.S. said he broke them up. Respondent commented again that J.S. was "right on schedule." Respondent then counseled J.S. about the potential for dependence upon Xanax without actually asking J.S. if he was having any trouble controlling his use of the drug. Respondent did not question J.S. at all about the Prozac. In Respondent's visit with J.S. on December 27, 2013, he suggested the Prozac would be helpful in facilitating J.S.'s weaning off Xanax, but there was no discussion as to weaning the Xanax at the January 27, 2014 visit. Respondent did not perform a physical examination during this visit. Documentation for this visit is limited to listing J.S.'s weight and indicating refills for Xanax and Prozac.

377. Respondent noted that J.S. had an elevated blood pressure at the first visit, which would be unusual for a 30-year old man, but Respondent failed to recheck his blood pressure at the subsequent two visits. There is also nothing to indicate Respondent considered diagnostic testing to assess why J.S. might have elevated blood pressure and anxiety, such as urine drug screening and laboratory testing.

**PATIENT J.W.**[4]

378. Respondent first saw J.W. on December 13, 2013 and on three follow-up occasions on December 27, 2013, January 8, 2014 and January 27, 2014. These visits were recorded on video and audio.

379. J.W. presented to Respondent complaining of left ankle pain and told Respondent that Vicodin and Percocet had been helpful to her in the past for managing flare-ups of this pain. Respondent asked her how she had hurt her ankle. She again told him she had previously received medications through an urgent care and had found Percocet and Vicodin helpful in allaying the pain. Respondent took a limited history and did not ask her about any prior substance abuse problems, though she did complete a medical history checklist (which is undated) on which she indicated she had no history of alcohol or drug problems.

[4] This is a simulated patient who saw Respondent as part of an undercover operation during the investigation of Respondent.

380. Respondent's physical examination, as the undercover video shows, consisted of asking her to stand and auscultating her heart. He did not examine her ankle by palpating the ankle, testing strength and stability or any other examination. In his note from the initial visit Respondent indicated her left ankle was tender but not swollen. His note also records other information from a "physical exam" that are not demonstrated in the undercover video, in other words, that did not actually occur.

381. Respondent then diagnosed her with a left ankle sprain and prescribed her Vicodin ES #30 and ibuprofen 400 mg #30 each with no refills. Respondent did not talk with her about possible risks of Vicodin, including drowsiness and potential for impairment of function, such as driving nor did he discuss other treatment options with her.

382. Respondent recommended an x-ray of J.W.'s ankle and explained the rationale for the x-ray. There is no indication Respondent checked or requested a urine drug screen or a CURES report.

383. Respondent examined J.W. on the three occasions noted above. On December 27, 2013, J.W. reported she had not had the x-ray of her ankle, because she did not have the funds to do it. J.W. told Respondent that she planned to have the x-ray done soon. The undercover records show that Respondent and J.W. reviewed the manner in which J.W. was taking the prescribed medications. Respondent briefly examined her ankle on this visit. Respondent agreed to write J.W. a prescription for a limited quantity of medication but said he could write her no more unless there was a problem on the x-ray. Respondent then talked with her about treatment options, including bracing and casting. Although Respondent recommended that J.W. wean herself off Vicodin, he then prescribed her Vicodin ES #20 and ibuprofen 400 mg #60 each with no refills. In his notes for the December 27, 2013 visit Respondent indicated that he told J.W. that he would no longer prescribe J.W. controlled substances after that visit.

384. Respondent next saw J.W. on January 8, 2014, when she indicated she was out of her medication. Respondent replied that "I can give you anything except narcotic pain medication." She asked him for prescriptions for ibuprofen, Xanax, and Soma. She volunteered that she had previously taken the 1 mg and the 2 mg formulations of Xanax and found the 2 mg formulation to

work better, but there was no discussion as to why she had taken Xanax previously. Respondent did not question her regarding her previous use of Xanax. Neither did he question her concerning whether she had anxiety, though in his progress note from this date he noted "anxiety" under the assessment section. He prescribed her ibuprofen 400 mg #90 and Xanax 1 mg #30. He failed to establish a medical indication for the prescription of Xanax.

385. Respondent opened the visit on January 27, 2014, by asking J.W. if she wished "the usual Xanax and Motrin." Respondent then asked her how she took the medication and if she needed as many Motrin tablets. J.W. then asked Respondent for Adderall, telling him that she had taken her roommate's Adderall and found it helped her to focus better. Respondent responded by telling her "Yes you probably do need it. .. , but I am not qualified to write for Adderall." Respondent then talked with her about attention deficit disorder and risks for dependence on the medication. They talked further about the potential benefits of stimulants. Just before ending the visit, he commented to her, "You're so young, you probably want to try to get off the Xanax, because those will become, those will create a dependence." He suggested she begin skipping days without taking the medication. He wrote her prescriptions for Xanax 1 mg #30 and ibuprofen 400 mg #30. There was no physical examination apart from a record of her weight. In the progress note, there is nothing documented under the objective section or the assessment section. There is no evident treatment plan.

PATIENT G.W.

386. Respondent's initial visit with G.W. took place on September 30, 2002, when she presented with complaints of chronic headaches. He reviewed her prior treatments, which included Inderal, Advil, Imitrex and Fioricet. He noted that G.W. had seen another physician previously and mentioned the doctor's name.

387. When Respondent initially started treating G.W. on September 30, 2002, she weighed 100 pounds. Her weight gradually drifted downwards over the years he treated her, and by March 7, 2014, G.W. weighed only 77 pounds. There is no evidence in the notes for the 11 years of treatment that Respondent noticed or made any effort to investigate the cause for her weight loss until July 26, 2013, when he noted the weight loss and recommended laboratory testing. At the

ensuing visit on August 19, 2013, Respondent ordered a chest x-ray. Most of his notes are devoid of even the most basic physical examination findings, including weight.

388. A note in Respondent's file that appears to be dated September 25, 2006 (the date is very faint), indicates Respondent spoke with G.W. about a notice he had "received from CURES concerning potential over usage/dependence." (There is a CURES report in the file dated September 20, 2006.) Nonetheless, Respondent prescribed her 60 Fioricet tablets that day. There is no documentation in the file addressing G.W.'s possible drug dependence and its effect on a treatment plan. There are no records of any urine drug testing in the file. G.W. did sign a consent for chronic opioid therapy and a treatment agreement for controlled substances in the treatment of pain, but these were not signed until December 10, 2012. The records show that no consultation to a headache specialist was suggested, which was warranted in this case considering her history and high utilization of Fioricet.

389. Fioricet is an analgesic that combines a low dose of an opioid (30 mg of codeine), a barbiturate (50 mg of butalbital), acetaminophen, and caffeine. It is used for the acute treatment of headache with the recommendation not to exceed a total daily dose of six capsules. It is not intended to be taken daily or even most days of the month because of its habit-forming potential and its potential to make a person's headache condition worse.

390. Respondent's note of March 21, 2005, indicates that he talked with G.W. about rebound headache and was "trying to gradually cut back" her medications, but he failed to take adequate action in this respect over the ensuing years of treatment. This note indicates Respondent's awareness of Fioricet's potential to worsen headache symptoms.

391. Respondent's November 13, 2008 notes indicate that G.W. claimed that her travel bag had been stolen, so Respondent refilled her prescription for Fioricet #60 tablets even though he had given her a prescription for that quantity of the drug just six days before on November 7, 2006. This behavior pattern is reflected throughout the 11 years of records when claims of lost or stolen medications were asserted and a new prescription was immediately provided by Respondent.

392. Respondent's April 10, 2013 note (over a decade after he initiated treatment of G.W.) indicated (for no apparent reason) that G.W. had tried acupuncture and found it helpful. At that visit he prescribed her Elavil, which is a drug potentially helpful in the treatment of migraine. His notes indicate that he "emphasized that we would like to l Fioricet."

393. Respondent's notes for the following visit on May 5, 2013 indicate that the Elavil had been of "no help," although there is no evidence that G.W. had an adequate trial of that drug. It was at the August 19, 2013 visit that he recommended she start Chantix. However, G.W. is a cigarette smoker, which increases her risk for cancer as a potential cause for her weight loss. Her loss of weight seems not to have impacted his prescribing her Fioricet. The records do not reflect adequate attention to monitoring her adherence to treatment with Fioricet. The quantity of drug he prescribed her suggests she was taking it daily, and the drug is not intended to be used in this fashion.

394. Three CURES reports were obtained during the investigation of Respondent. The reports reflect data from August 13, 2009 through August 13, 2012, December 19, 2011 through December 19, 2012 and December 5, 2012 through December 15, 2013.

395. The CURES reports show that G.W. filled 54 prescriptions for Fioricet from Respondent from August 8, 2011 through October 7, 2013. The quantity of tablets per prescription ranged from 45 to 120, and he prescribed her an average of 6.7 tablets daily for a total of 3,600 tablets during that time.

396. Respondent's overall records for G.W. show that he failed to offer her alternative options for managing her migraine, including commonly used medications the benefit for which has been demonstrated in randomized controlled trials.

397. Respondent's progress notes are deficient. They have little or no history and little or no physical examination findings. G.W.'s pain complaints are not adequately described in the medical record. There is no adequate physical examination and the treatment objectives are unclear.

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## FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Gross Negligence)

398. By reason of the matters set forth above in paragraphs 16 through 397, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2234, subdivision (b), for gross negligence in the care and treatment of patients C.A., M.A., V.B., S.B., T.B., V.C., N.D., E.H., K.L., K.M. and G.W.

399. Respondent failed to provide proper oversight in order to monitor the use of controlled substances by C.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., K.L. and G.W., which constitutes gross negligence and is a violation of section 2234, subdivision (b).

400. Respondent failed to maintain a medical record for R.A. and K.M. and therefore failed to provide proper oversight in order to monitor the use of controlled substances by R.A. and K.M., which constitutes gross negligence and is a violation of section 2234, subdivision (b).

401. Respondent failed to maintain a medical record for R.A. and K.M. to whom he was prescribing controlled substances, which constitutes gross negligence and is a violation of section 2234, subdivision (b).

402. Respondent failed to perform any prior examination for the prescription of controlled substances to R.A. and K.M., which constitutes gross negligence and is a violation of section 2234, subdivision (b).

## SECOND CAUSE FOR DISCIPLINE
(Unprofessional conduct - Repeated Negligent Acts)

403. By reason of the matters set forth above in paragraphs 16 through 402, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2234, subdivision (c), in that Respondent for repeated negligent acts in the care and treatment of L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., M.F., E.H., J.I., C.L., K.L., C.P., J.S. and J.W. The circumstances are as follows:

404. Respondent did not perform an appropriate prior examination before prescribing high dose opioid therapy to L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S. and J.W. Respondent's failure to properly examine any of

the foregoing patients while prescribing numerous medications constitutes repeated negligent acts and a violation of section 2234, subdivision (c).

405. Respondent failed to provide proper oversight in order to monitor the use of controlled substances by L.A., D.A., K.A., V.B., S.B., T.B., V.C., B.C., N.D., M.F., E.H., J.I. and C.P., which, in conjunction with Respondent's other negligent acts, constitutes a violation of section 2234, subdivision (c).

406. Respondent's record-keeping relative to his prescription of controlled substances to D.A. for his complaints of pain and anxiety constitutes negligence, which, in conjunction with Respondent's other negligent acts, constitutes a violation of section 2234, subdivision (c).

407. Respondent failed to perform an appropriate prior examination for the prescription of hydrocodone to C.A., and T.B., which, in conjunction with Respondent's other negligent acts, constitutes a violation of section 2234, subdivision (c).

408. Respondent's records for C.A. have little or no history and little or no physical examination findings. C.A.'s pain complaints are not adequately described in the medical record and the treatment objectives are unclear, which, in conjunction with Respondent's other negligent acts, constitutes a violation of section 2234, subdivision (c).

409. Respondent failed to perform an appropriate prior examination for the prescription of non-opioid controlled substances to V.B. and T.B., which, in conjunction with Respondent's other negligent acts, constitutes a violation of section 2234, subdivision (c).

410. Respondent failed to order diagnostic testing for V.C., despite V.C. having persisting, severe pain four months after an accident which, in conjunction with Respondent's other negligent acts, constitutes a violation of section 2234, subdivision (c).

## THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

411. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate medical records for patients L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., M.F., E.H., J.I., C.L., K.M., C.P., J.S., J.W. and G.W. The circumstances are as follows:

412. Paragraphs 16 through 410 are incorporated herein by reference as if fully set forth herein.

413. The standard of care for medical record documentation is that such documentation be interpretable by other medical providers who may be called routinely or unexpectedly to use the information therein to further the care of the patient. This requires that the information be legible, organized, and complete enough not to require a guess as to its content, and that any abbreviations used are commonly recognized by other medical care providers. A record that can only be deciphered by the author puts the patient at unnecessary risk of delay of care to track down the author, or worse, may withhold important information if the author is not immediately available.

414. Respondent's records relative to his prescription of controlled substances to D.A. for his complaints of pain and anxiety fail to meet the requirements of the relevant standard of care.

415. Respondent's records relative to his prescription of controlled substances to S.B. for her complaints of pain and anxiety fail to meet the requirements of the relevant standard of care.

416. Respondent falsified the records for the medical examination of J.W., indicating that he examined J.W., when that did not happen as shown by a videotape of that meeting, which is a violation of section 2266 of the Code.

417. Respondent falsified the records for the medical examination of J.W., indicating in his notes that that J.W. suffered from anxiety when he did not ask J.W. about that issue.

418. Respondent's records are incomplete or non-existent and, thus, Respondent failed to maintain adequate and accurate medical records for patients L.A., D.A., C.A., K.A., R.A., M.A., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.M., C.P., J.S., J.W. and G.W., which is a violation of section 2266 of the Code.

## FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Prescribing Controlled Substances without Medical Indication)

419. By reason of the matters set forth above in paragraphs 16 through 418, incorporated herein by this reference, Respondent is subject to disciplinary action under section 11154 of the

Health and Safety Code, in that he prescribed controlled substances without medical indication. The circumstances are as follows:

420. Respondent never performed a complete history and physical exam over the course of treatment for patients L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S., J.W. and G.W., yet continued to prescribe controlled substances to those patients, which prescribing practice constitutes prescribing controlled substances without medical indication and is a violation of Health and Safety Code section 11154.

421. Respondent never ordered standard tests and follow up, nor established an appropriate differential diagnoses over the course of treatment for patients L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S., J.W. and G.W., yet continued to prescribe controlled substances to those patients, which prescribing practice constitutes prescribing controlled substances without medical indication and is a violation of Health and Safety Code section 11154.

FIFTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Violating Statute Regulating Controlled Substances)

422. By reason of the matters set forth above in paragraphs 16 through 421, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2238 of the Code, in that he violated Health and Safety Code section 11154. The circumstances are as follows:

423. Respondent prescribed controlled substances without medical indication to L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S., J.W. and G.W., which constitutes a violation of Health and Safety Code section 11154 and, thus, section 2238 of the Code.

SIXTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Prescribing Dangerous Drugs without Prior Examination or Medical Indication)

424. By reason of the matters set forth above in paragraphs 16 through 423 incorporated herein by this reference, Respondent is subject to disciplinary action under section 2242, subdivision (a) of the Code, in that he prescribed dangerous drugs without an appropriate prior

examination and a medical indication to L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S., J.W. and G.W. The circumstances are as follows:

425. Respondent prescribed dangerous drugs without performing an appropriate prior examination to L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S., J.W. and G.W. Respondent's failure to properly examine any of the foregoing patients while prescribing dangerous drugs to those patients constitutes a violation of section 2242, subdivision (a).

426. Respondent prescribed dangerous drugs to L.A., D.A., C.A., K.A., R.A., M.A., V.B., S.B., T.B., V.C., B.C., N.D., E.H., J.I., C.L., K.L., K.M., C.P., J.S., J.W. and G.W. without medical indication, which actions constitute a violation of section 2242, subdivision (a).

## 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 38595, issued to Kent Lehman, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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

DATED: December 11, 2015

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

*Complainant*

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