

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

**In the Matter of the First Amended  
Accusation Against:**

**David Brooks, M.D.**

**Physician's and Surgeon's  
Certificate No. G 11503**

**Respondent.**

**Case No. 800-2019-053391**

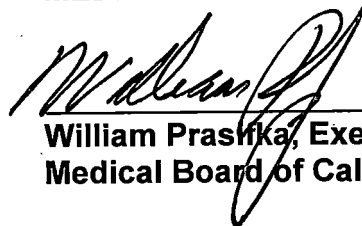
**DECISION**

**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  
September 1, 2022.**

**IT IS SO ORDERED August 25, 2022.**

**MEDICAL BOARD OF CALIFORNIA**



**William Prasnik, Executive Director  
Medical Board of California**

1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 KAROLYN M. WESTFALL  
Deputy Attorney General  
4 State Bar No. 234540  
600 West Broadway, Suite 1800  
5 San Diego, CA 92101  
P.O. Box 85266  
6 San Diego, CA 92186-5266  
Telephone: (619) 738-9465  
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

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

In the Matter of the First Amended Accusation  
Against:  
**DAVID BROOKS, M.D.**  
176 S. Palm Street  
Blythe, CA 92225  
**Physician's and Surgeon's Certificate  
No. G 11503,**  
Respondent.

Case No. 800-2019-053391  
OAH No. 2021110596  
**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 Karolyn M. Westfall, Deputy Attorney General.

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1 **CULPABILITY**

2 8. Respondent does not contest that, at an administrative hearing, Complainant could  
3 establish a *prima facie* case with respect to the charges and allegations contained in First  
4 Amended Accusation No. 800-2019-053391, a true and correct copy of which is attached hereto  
5 as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No.  
6 G 11503 to disciplinary action. Respondent hereby surrenders his Physician's and Surgeon's  
7 Certificate No. G 11503 for the Board's formal acceptance with an agreed upon effective date of  
8 September 1, 2022.

9 9. Respondent agrees that his Physician's and Surgeon's Certificate No. G 11503 is  
10 subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth  
11 in the Disciplinary Order below.

12 10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's  
13 and Surgeon's Certificate No. G 11503, all of the charges and allegations contained in First  
14 Amended Accusation No. 800-2019-053391 shall be deemed true, correct, and fully admitted by  
15 Respondent for purposes of any such proceeding or any other licensing proceeding involving  
16 Respondent in the State of California or elsewhere.

17 11. Respondent understands that by signing this stipulation he enables the Executive  
18 Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his  
19 Physician's and Surgeon's Certificate No. G 11503 without further process.

20 **CONTINGENCY**

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

24 13. This stipulation shall be subject to the approval of the Executive Director on behalf of  
25 the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order  
26 shall be submitted to the Executive Director for his consideration in the above-entitled matter and,  
27 further, that the Executive Director shall have a reasonable period of time in which to consider  
28 and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By

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

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

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

9 **ORDER**

10 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 11503, issued  
11 to Respondent David Brooks, M.D., is surrendered effective September 1, 2022, and accepted by  
12 the Board.

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

17 2. Respondent shall lose all rights and privileges as a physician and surgeon in  
18 California as of the effective date of the Board's Decision and Order, which shall be September 1,  
19 2022.

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

22 4. If Respondent ever files an application for licensure or a petition for reinstatement in  
23 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must  
24 comply with all the laws, regulations and procedures for reinstatement of a revoked or  
25 surrendered license in effect at the time the petition is filed, and all of the charges and allegations  
26 contained in First Amended Accusation No. 800-2019-053391 shall be deemed to be true, correct  
27 and admitted by Respondent when the Board determines whether to grant or deny the petition.

28 ///


1 5. Respondent shall pay the agency its costs of investigation and enforcement in the  
2 amount of \$3,491.25 prior to issuance of a new or reinstated license.

3 6. If Respondent should ever apply or reapply for a new license or certification, or  
4 petition for reinstatement of a license, by any other health care licensing agency in the State of  
5 California, all of the charges and allegations contained in First Amended Accusation, No. 800-  
6 2019-053391 shall be deemed to be true, correct, and admitted by Respondent for the purpose of  
7 any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

8 ACCEPTANCE


9 I have carefully read the above Stipulated Surrender of License and Disciplinary Order and  
10 have fully discussed it with my attorneys Peter R. Osinoff, Esq., and/or Carolyn Lindholm, Esq. I  
11 understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate.  
12 I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly,  
13 and intelligently, and agree to be bound by the Decision and Order of the Medical Board of  
14 California.

15  
16 DATED: 05-19-2022

  
17 DAVID BROOKS, M.D.  
Respondent

18 I have read and fully discussed with Respondent David Brooks, M.D., the terms and  
19 conditions and other matters contained in this Stipulated Surrender of License and Disciplinary  
20 Order. I approve its form and content.

21  
22 DATED: 5/19/22

  
23 PETER R. OSINOFF, ESQ.  
CAROLYN LINDHOLM, ESQ.  
Attorneys for Respondent

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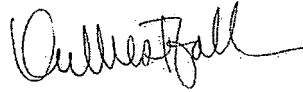
**ENDORSEMENT**

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: 5/19/22

Respectfully submitted,

ROB BONTA  
Attorney General of California  
ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General



KAROLYN M. WESTFALL  
Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**First Amended Accusation No. 800-2019-053391**



1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 KAROLYN M. WESTFALL  
Deputy Attorney General  
4 State Bar No. 234540  
600 West Broadway, Suite 1800  
5 San Diego, CA 92101  
P.O. Box 85266  
6 San Diego, CA 92186-5266  
Telephone: (619) 738-9465  
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

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

In the Matter of the First Amended Accusation  
Against:

Case No. 800-2019-053391

**FIRST AMENDED ACCUSATION**

**DAVID BROOKS, M.D.  
176 S. Palm Street  
Blythe, CA 92225**

**Physician's and Surgeon's Certificate  
No. G 11503,**

Respondent.

**PARTIES**

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

2. On or about December 13, 1965, the Board issued Physician's and Surgeon's Certificate No. G 11503 to David Brooks, 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 October 31, 2023 unless renewed.

///

**JURISDICTION**

1  
2           3.    This First Amended Accusation, which supersedes the Accusation filed on October  
3 12, 2021, is brought before the Board, under the authority of the following laws. All section  
4 references are to the Business and Professions Code (Code) unless otherwise indicated.

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

6                   (a) A licensee whose matter has been heard by an administrative law judge of  
7 the Medical Quality Hearing Panel as designated in Section 11371 of the Government  
8 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:

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

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

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

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

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

17                           ...

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

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

21                           ...

22                           (b) Gross negligence.

23                           (c) Repeated negligent acts. To be repeated, there must be two or more  
24 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.

25                           ...

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1 (g)(1) Except as provided in paragraph (2), the board shall not renew or  
reinststate the license of any licensee who has failed to pay all of the costs ordered  
under this section.

2  
3 (2) Notwithstanding paragraph (1), the board may, in its discretion,  
conditionally renew or reinststate for a maximum of one year the license of any  
4 licensee who demonstrates financial hardship and who enters into a formal agreement  
with the board to reimburse the board within that one-year period for the unpaid  
5 costs.

6 (h) All costs recovered under this section shall be considered a reimbursement  
for costs incurred and shall be deposited in the fund of the board recovering the costs  
to be available upon appropriation by the Legislature.

7  
8 (i) Nothing in this section shall preclude a board from including the recovery of  
the costs of investigation and enforcement of a case in any stipulated settlement.

9 (j) This section does not apply to any board if a specific statutory provision in  
10 that board's licensing act provides for recovery of costs in an administrative  
disciplinary proceeding.

11 **FIRST CAUSE FOR DISCIPLINE**

12 **(Gross Negligence)**

13 9. Respondent has subjected his Physician's and Surgeon's Certificate No. G 11503 to  
14 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of  
15 the Code, in that he was grossly negligent in his care and treatment of Patients A and B,<sup>1</sup> as more  
16 particularly alleged hereinafter:

17 10. Since in or around 1992, Respondent has maintained a solo general medicine practice  
18 out of his home in Blythe, California.

19 11. On or about November 15, 2019, Board investigators performed an unannounced site  
20 inspection at Respondent's clinic. During this inspection, investigators witnessed expired  
21 medications stored immediately beside food inside the kitchen refrigerator, hundreds of bottles of  
22 expired medications belonging to deceased patients located in bags and on shelves in a storage  
23 room, medication and medical equipment maintained in unsanitary conditions, and patient  
24 medical records stored in milk crates on shelves in a room between the reception area and the  
25 kitchen. At that time, Respondent admitted to investigators that he sometimes provides the

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27 \_\_\_\_\_  
28 <sup>1</sup> To protect the privacy of the patients involved, the patients' names have not been  
included in this pleading. Respondent is aware of the identity of the patients referred to herein.

1 expired medications to patients who cannot afford medical treatment, but informed the  
2 investigators that he would dispose of the medications properly.

3 12. On or about December 16, 2019, Board investigators returned to Respondent's clinic  
4 for another unannounced site visit and noted Respondent had still not disposed of the hundreds of  
5 bottles of expired medications. Respondent authorized the investigators to dispose of the  
6 medications for him, which filled approximately sixteen large garbage bags.

7 **PATIENT A**

8 13. On or about April 5, 2019, Respondent began providing primary care treatment to  
9 Patient A, a then fifty-two year old female patient. At this initial visit, and every visit thereafter,  
10 Respondent obtained the patient's vital signs and took short illegible notes that did not include a  
11 physical examination or review of systems. At the conclusion of this visit, Respondent did not  
12 specify a diagnosis for Patient A,<sup>2</sup> but prescribed her multiple medications including 90 tablets of  
13 methadone<sup>3</sup> 10mg, and 30 tablets of lorazepam<sup>4</sup> 2mg.<sup>5</sup>

14 14. Between on or about April 5, 2019, and on or about February 28, 2020, Patient A  
15 presented to Respondent for approximately twelve (12) clinical visits. Throughout that time,  
16 Respondent did not obtain a detailed history from the patient, did not perform a focused physical  
17 examination, did not elicit information from the patient regarding the cause, location, duration, or  
18 nature of her pain, did not obtain any prior imaging or other treatment records, did not  
19 recommend non-pharmacologic treatment modalities, did not offer or recommend safer  
20 alternatives to opioids and benzodiazepines, did not did document a discussion with the patient

21 \_\_\_\_\_  
22 <sup>2</sup> At the subject interview on February 23, 2021, Respondent stated he was treating the a  
patient for pain.

23 <sup>3</sup> Methadone is an opioid medication used for the treatment of pain or drug addiction. It is  
24 a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision  
(c), and a dangerous drug pursuant to Business and Professions Code section 4022.

25 <sup>4</sup> Lorazepam (brand name Ativan) is a benzodiazepine medication used to treat anxiety. It  
26 is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,  
subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

27 <sup>5</sup> The number and dosing of the prescribed medications was not identified in the patient's  
28 chart at each visit. This information was obtained from CURES and original prescriptions.

1 regarding the risks and benefits of the use of opioids and benzodiazepines, did not obtain a  
2 baseline EKG, did not refer the patient to any specialists, did not assess the patient for drug  
3 addiction or aberrancy, did not perform a psychological evaluation, did not complete an anxiety  
4 screening questionnaire, and did not review CURES.<sup>6</sup>

5 15. On or about May 3, 2019, Patient A presented to Respondent for a follow-up visit.  
6 During this visit, Respondent obtained the patient's vital signs and prescribed the patient multiple  
7 medications including 90 tablets of methadone 10mg, 30 tablets of lorazepam 2mg, and 120  
8 tablets of tramadol<sup>7</sup> 50mg.

9 16. Between on or about May 3, 2019, and on or about October 25, 2019, Patient A  
10 presented to Respondent for approximately seven (7) clinical visits. Throughout that time,  
11 Respondent maintained the patient on her medication regimen of methadone, lorazepam, and  
12 tramadol.

13 17. On or about May 17, 2019, Patient A provided a urinalysis at Palo Verde Hospital  
14 that revealed negative results for benzodiazepines and opiates, and positive results for  
15 cannabinoids. Respondent did not discuss these results with the patient at her subsequent visit, or  
16 any visit thereafter.

17 18. On or about November 29, 2019, Patient A presented to Respondent for a follow-up  
18 visit with complaints of a resistant urinary tract infection. During this visit, Respondent obtained  
19 the patient's vital signs and prescribed her multiple medications including 90 tablets of  
20 methadone 10mg, 120 tablets of tramadol 50mg, and 30 tablets of clonazepam<sup>8</sup> 2mg.

21 ///

22 <sup>6</sup> The Controlled Substances Utilization Review and Evaluation System (CURES), is a  
23 database maintained by the Department of Justice of Schedule II, III and IV controlled substance  
24 prescriptions dispensed in California serving the public health, regulatory oversight agencies, and  
law enforcement.

25 <sup>7</sup> Tramadol (brand name Ultram) is an opioid analgesic medication. It is a Schedule IV  
26 controlled substance pursuant to Health and Safety Code section 11057, and a dangerous drug  
pursuant to Business and Professions Code section 4022.

27 <sup>8</sup> Clonazepam (brand name Klonopin) is a benzodiazepine medication used to treat  
28 anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section  
11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section  
4022.

1           19. Between on or about November 29, 2019, and on or about February 28, 2020, Patient  
2 A presented to Respondent for approximately five (5) clinical visits. Throughout that time,  
3 Respondent maintained the patient on her medication regimen of methadone, clonazepam, and  
4 tramadol.

5           20. Between on or about May 3, 2019, and on or about February 28, 2020, Respondent  
6 maintained Patient A on a high narcotic dosage without performing or documenting a functional  
7 assessment of the patient with a focus on analgesia, activities of daily living, adverse effects of  
8 opiates, aberrant behaviors, or the patient's affect. Respondent did not have the patient sign a  
9 pain management agreement, did not document a review of CURES, did not order any urine  
10 screens to assess for aberrancy, and did not perform any pill counts. Respondent did not identify  
11 any treatment goals, did not attempt to taper the patient's medications, and did not prescribe  
12 naloxone.

13           21. Respondent committed gross negligence in his care and treatment of Patient A, which  
14 included, but was not limited to, the following:

- 15           A. Failing to appropriately evaluate and manage the patient's chronic pain;  
16           B. Failing to risk stratify the patient prior to initiating opiate therapy, and then  
17           failing to properly monitor the patient's use of opiate pain medications, while  
18           continuing to prescribe chronic opiate therapy; and  
19           C. Failing to maintain and securely store adequate and accurate records.

20           **PATIENT B**

21           22. On or about March 21, 2017, Respondent began providing primary care treatment to  
22 Patient B, a then fifty-five year old female patient with a history of human immunodeficiency  
23 virus and diabetes. At this initial visit, and every visit thereafter, Respondent obtained the  
24 patient's vital signs, and took short illegible notes that did not include a physical examination or  
25 review of systems. At this visit Respondent did not specify a diagnosis for Patient B or a plan for  
26 treatment, other than to state, "refills," without mention of a type or dose of any specific

27           ///

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1 medication.<sup>9</sup> Although it is not documented in the chart, at the conclusion of this visit,  
2 Respondent prescribed the patient 60 tablets of Norco<sup>10</sup> 10/325 mg.<sup>11</sup>

3 23. On or about April 20, 2017, Patient B presented to Respondent for a follow-up visit  
4 During this visit, Respondent obtained the patient's vital signs and glucose value, but did not  
5 document any subjective complaints, a physical evaluation, or a diagnosis. At the conclusion of  
6 this visit, Respondent prescribed the patient 90 tablets of Norco 10/325 mg and 30 tablets of  
7 diazepam<sup>12</sup> 10mg.

8 24. Between on or about April 20, 2017, and on or about September 30, 2019, Patient B  
9 presented to Respondent for approximately sixteen (16) clinical visits. Throughout that time,  
10 Respondent did not obtain a detailed history from Patient B, did not perform a focused physical  
11 examination, did not elicit information from the patient regarding the cause, location, duration, or  
12 nature of her pain, did not elicit information about the nature or frequency of her insomnia, did  
13 not obtain any prior imaging or other treatment records, did not recommend non-pharmacologic  
14 treatment modalities, did not offer or recommend safer alternatives to opioids and  
15 benzodiazepines, did not document a discussion with the patient regarding the risks and benefits  
16 of the use of opioids and benzodiazepines, did not refer the patient to any specialists, did not  
17 assess the patient for drug addiction or aberrancy, did not perform a psychological evaluation, did  
18 not complete an anxiety screening questionnaire, did not review CURES, did not provide dietary  
19 counselling or education, did not obtain regular Hgb A1C checks, did not obtain cholesterol blood

20 \_\_\_\_\_  
21 <sup>9</sup> At the subject interview on February 23, 2021, Respondent stated he was treating the  
patient for back pain and insomnia.

22 <sup>10</sup> Norco (brand name for hydrocodone and acetaminophen) is an opioid combination  
23 medication used for the treatment of pain. It is a Schedule III controlled substance pursuant to  
24 Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

25 <sup>11</sup> The number and dosing of the prescribed medications was not identified in the patient's  
26 chart at each visit. This information was obtained from CURES and original prescriptions.

27 <sup>12</sup> Diazepam (brand name Valium) is a benzodiazepine medication used to treat anxiety. It  
28 is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision  
subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.



1 testing, did not prescribe cholesterol medication, and did not perform an eye screening or foot  
2 sensory examination.

3 25. On or about January 24, 2018, Patient B presented to Respondent for a follow-up  
4 visit. During this visit, Respondent obtained the patient's vital signs and glucose value, but did  
5 not document any subjective complaints, a physical evaluation, or a diagnosis. At the conclusion  
6 of this visit, Respondent prescribed the patient 30 tablets of diazepam 10mg and 90 tablets of  
7 oxycodone<sup>13</sup> 30mg.

8 26. Between on or about January 24, 2018, and on or about April 29, 2019, Patient B  
9 presented to Respondent for approximately twelve (12) clinical visits. Throughout that time;<sup>115</sup>  
10 Respondent maintained the patient on her medication regimen of oxycodone and diazepam.

11 27. On or about June 26, 2019, Patient B presented to Respondent for a follow-up visit.  
12 During this visit, Respondent obtained the patient's vital signs and glucose value, but did not  
13 document any subjective complaints, a physical evaluation, or a diagnosis. At the conclusion of  
14 this visit, Respondent prescribed the patient 90 tabs of oxycodone 30mg and an unknown amount  
15 of gabapentin.<sup>14</sup>

16 28. On or about June 30, 2019, Respondent received a notification from Silver Script  
17 alerting him that Patient B was receiving a potentially dangerous combination of gabapentin and  
18 oxycodone.

19 29. Between on or about June 26, 2019, and on or about September 30, 2019, Patient B  
20 presented to Respondent for approximately four (4) clinical visits. Throughout that time,  
21 Respondent maintained the patient on her medication regimen of oxycodone and gabapentin.

22 30. Between on or about January 24, 2018, and on or about September 30, 2019,  
23 Respondent maintained Patient B on a high narcotic dosage without performing or documenting a  
24 functional assessment of the patient with a focus on analgesia, activities of daily living, adverse

25 \_\_\_\_\_  
26 <sup>13</sup> Oxycodone (brand name Oxycontin) is an opioid medication used for the treatment of  
27 pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055,  
subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

28 <sup>14</sup> Gabapentin is an anticonvulsant and nerve pain medication, and a dangerous drug  
pursuant to Business and Professions Code section 4022.

1 effects of opiates, aberrant behaviors, or the patient's affect. Respondent did not have the patient  
2 sign a pain management agreement, did not document a review of CURES, did not order any  
3 urine screens to assess for aberrancy, and did not perform any pill counts. Respondent did not  
4 identify any treatment goals, did not attempt to taper the patient's medications, and did not  
5 prescribe naloxone.

6 31. Respondent committed gross negligence in his care and treatment of Patient B, which  
7 included, but was not limited to, the following:

- 8 A. Failing to appropriately evaluate and manage the patient's chronic pain;
- 9 B. Failing to risk stratify the patient prior to initiating opiate therapy, and then  
10 failing to properly monitor the patient's use of opiate pain medications, while  
11 continuing to prescribe chronic opiate therapy;
- 12 C. Failing to appropriately manage the patient's diabetic care, including but not  
13 limited to, failing to provide dietary counseling or education, failing to obtain  
14 regular Hgb A1C check every 3-6 months, and failing to obtain eye screening  
15 or feet sensory exams; and
- 16 D. Failing to maintain and securely store adequate and accurate records.

17 **SECOND CAUSE FOR DISCIPLINE**

18 **(Repeated Negligent Acts)**

19 32. Respondent has further subjected his Physician's and Surgeon's Certificate No.  
20 G 11503 to disciplinary action under sections 2227 and 2234, as defined by section 2234,  
21 subdivision (c), of the Code, in that he committed repeated negligent acts in his care and  
22 treatment of Patients A and B, as more particularly alleged hereinafter:

- 23 A. Paragraphs 9 through 31(D), above, are hereby incorporated by reference and  
24 realleged as if fully set forth herein;
- 25 B. Prescribing Patient A lorazepam without indication, without an appropriate  
26 evaluation, and without considering and recommending non-benzodiazepine  
27 treatment;

28 ///

- 1 C. Prescribing Patient A an unsafe combination of opiate and benzodiazepine
- 2 medications without making attempts to taper and without prescribing
- 3 naloxone;
- 4 D. Prescribing methadone to Patient A without a documented assessment or
- 5 indication;
- 6 E. Prescribing Valium to Patient B without indication, without an appropriate
- 7 evaluation, and without considering and recommending non-benzodiazepine
- 8 treatment; and
- 9 F. Prescribing Patient B an unsafe combination of opiate and benzodiazepine
- 10 medications without making attempts to taper and without prescribing the
- 11 patient naloxone.

12 **THIRD CAUSE FOR DISCIPLINE**

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

14 33. Respondent has further subjected his Physician's and Surgeon's Certificate No.  
15 G 11503 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the  
16 Code, in that Respondent failed to maintain adequate and accurate records regarding his care and  
17 treatment of Patients A and B, as more particularly alleged in paragraphs 9 through 31(D), above,  
18 which are hereby incorporated by reference and realleged as if fully set forth herein.

19 **FOURTH CAUSE FOR DISCIPLINE**

20 **(General Unprofessional Conduct)**

21 34. Respondent has further subjected his Physician's and Surgeon's Certificate No.  
22 G 11503 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged  
23 in conduct which breaches the rules or ethical code of the medical profession, or conduct which is  
24 unbecoming to a member in good standing of the medical profession, and which demonstrates an  
25 unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 33, above,  
26 which are hereby incorporated by reference and realleged as if fully set forth herein.

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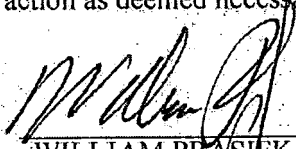
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PRAAYER

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 11503, issued to Respondent, David Brooks, M.D.;
2. Revoking, suspending or denying approval of Respondent, David Brooks, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Respondent, David Brooks, M.D., to pay the Board the costs of the investigation and enforcement of this case, and 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: MAR 03 2022

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

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