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

In the Matter of the First Amended Accusation Against: Michael Lawrence MacMurray, M.D. Physician's and Surgeon's Certificate No. A 83313 Respondent.	Case No.: 800-2019-053767

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 September 30, 2022.

IT IS SO ORDERED: August 31, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
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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 First Amended Accusation Against: **MICHAEL LAWRENCE MACMURRAY, M.D.** **914 Capistrano Drive** **Oceanside, CA 92058-1108** **Physician's and Surgeon's Certificate No. A 83313** Respondent.	Case No. 800-2019-053767 OAH No. 2021060656 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Michael Lawrence MacMurray, M.D. (Respondent) is represented in this proceeding by attorney Gabriel M. Benrubi, Esq., whose address is: 501 West Broadway, Suite 1220 San Diego, CA 921012.1.

3. On or about May 30, 2003, the Board issued Physician's and Surgeon's Certificate No. A 83313 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-053767, and will expire on August 31, 2022, unless renewed.

JURISDICTION

4. On May 19, 2021, Accusation No. 800-2019-053767 was filed before the Board. The Accusation and all other statutorily required documents were properly served on Respondent on or about May 19, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. On February 7, 2022, First Amended Accusation No. 800-2019-053767 was filed before the Board. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on or about February 7, 2022. A copy of First Amended Accusation No. 800-2019-053767 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in First Amended Accusation No. 800-2019-053767. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended 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.

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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 contained in First Amended Accusation No. 800-2019-053767, a copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 83313 to disciplinary action.

9. Respondent agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2019-053767 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.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. A 83313 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

11. 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.

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12. Respondent agrees that if he ever petitions for early termination or modification of probation, 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 First Amended Accusation No. 800-2019-053767 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.

ADDITIONAL PROVISIONS

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

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 83313 issued to Respondent Michael Lawrence MacMurray, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. 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.

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

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

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

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

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

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

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. 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 of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, 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, evaluation or treatment for any

medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment 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 competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment 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.]

5. 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(s), 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, billing appropriately or both. 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 approved in advance by the Board or its designee that includes, at minimum, 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.

6. 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.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. 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.

9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusation, and legal reviews, in the amount of $9,786.56. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board.

The filing of bankruptcy by respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including, but not limited to, expert review costs.

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10. 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.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

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, subdivision (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.

12. 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.

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

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

14. 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.

15. 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.

16. 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.

17. 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.

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18. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-053767 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 license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gabriel M. Benrubi, Esq. I fully 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: 04/14/2022

MICHAEL LAWRENCE MACMURRAY, M.D.
Respondent

I have read and fully discussed with Respondent Michael Lawrence MacMurray, 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: 04/20/2022

GABRIEL M. BENRUBI, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: April 20, 2022

Respectfully submitted,

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

JASON J. AHN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

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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: **MICHAEL LAWRENCE MACMURRAY, M.D.** **914 Capistrano Drive** **Oceanside, CA 92058-1108** **Physician's and Surgeon's Certificate No. A 83313,** Respondent.	Case No. 800-2019-053767 OAH No. 2021060656 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about May 30, 2003, the Medical Board issued Physician's and Surgeon's Certificate No. A 83313 to Michael Lawrence MacMurray, 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 August 31, 2020, unless renewed.

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JURISDICTION

3. This First Amended Accusation which supersedes Accusation No. 800-2019-053767, filed on May 19, 2021, in the above-entitled matter, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

> (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.

5. 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.

(d) Incompetence.

"..."

6. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

7. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

COST RECOVERY

8. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may

reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

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

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any 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 costs.

(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.

(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.

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 83313 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A,[1] B, and C, as more particularly alleged hereinafter:

Patient A

10. In or around November 2006,[2] Patient A first presented to Respondent. On or about

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[1] References to "Patient A, B, and C" are used to protect patient privacy.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

April 7, 2016, Patient A first returned to Respondent. At the time of this visit, Patient A was a sixty (60) year-old male who had a history of high blood pressure, chronic back pain, allergies, high cholesterol, chronic obstructive pulmonary disease (COPD)[3], and regular alcohol and tobacco use. Respondent prescribed to Patient A oxycodone[4] 30 mg, Norvasc[5] 10 mg, Naprosyn[6] 500 mg, Lisinopril[7] 20 mg, and Fluocinonide[8] 0.5% topical cream.

11. On or about July 18, 2017, Patient A returned to Respondent. Respondent prescribed to Patient A Atorvastatin 20 mg, Lisinopril 20 mg, Norvasc 10 mg, and oxycodone 30 mg.

12. On or about October 4, 2017, Patient A returned to Respondent. Respondent prescribed oxycodone 30 mg.

13. On or about January 18, 2018, Patient A returned to Respondent. Respondent prescribed to Patient A oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, Fluocinonide 0.5% topical cream, and Atorvastatin 20 mg.

14. On or about March 28, 2018, Patient A returned to Respondent. Respondent prescribed to Patient A oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, and Fluocinonide 0.5% topical cream. Respondent administered a urine toxicology screening to Patient A and

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[3] Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases that block airflow and make it difficult to breathe.

[4] Oxycodone HCL (OxyContin®) is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

[5] Norvasc (Amlodipine) is a calcium channel blocker, which can be used to treat high blood pressure and chest pain.

[6] Naprosyn (Naproxen) is a nonsteroidal anti-inflammatory drug, which can be used to treat fever and pain.

[7] Lisinopril is a medication used to treat high blood pressure, heart failure, and after heart attacks.

[8] Fluocinonide is used as an anti-inflammatory agent for the treatment of skin disorders.

Patient A tested positive for opiates.

15. On or about July 6, 2018, Patient A returned to Respondent. Respondent prescribed to Patient A Oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, Fluocinonide 0.5% topical cream, and Atorvastatin 20 mg.

16. On or about October 1, 2018, Patient A returned to Respondent. Respondent prescribed to Patient A Oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, Fluocinonide 0.5% topical cream, and Atorvastatin 20 mg. Respondent administered a urine toxicology screening to Patient A and Patient A tested negative for all substances, including opiates, even though Respondent was prescribing monthly refills of Oxycodone at this time. However, this inconsistency was not addressed until March 29, 2019, when Respondent noted in the medical records, among other things "stable on current regimen and will be checking his tox today, if negative for opioids will have to d/c refills."

17. On or about December 27, 2018, Patient A returned to Respondent. Respondent prescribed to Patient A Oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, Fluocinonide 0.5% topical cream, and Atorvastatin 20 mg.

18. On or about March 29, 2019, Patient A returned to Respondent. Respondent prescribed to Patient A Oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, Fluocinonide 0.5% topical cream, and Atorvastatin 20 mg. Respondent administered urine toxicology screening to Patient A and Patient A tested negative on all substances, including opiates. However, Respondent did not address this discrepancy until the next visit on July 1, 2019, wherein Respondent noted in the medical records, among other things, "last time tested negative for oxy."

19. On or about July 1, 2019, Patient A returned to Respondent. Respondent prescribed to Patient A Oxycodone 30 mg, Norvasc 10 mg, Lisinopril 20 mg, Fluocinonide 0.5% topical cream, and Atorvastatin 20 mg. Respondent administered urine toxicology screening to Patient A, who tested positive for alcohol and Oxycodone. However, Patient A's alcohol use was not addressed other than the statement at the following visit on October 9, 2019, "do not drink alcohol or drive while taking this medication."

20. On or about October 9, 2019, Patient A returned to Respondent. Respondent

prescribed to Patient A Oxycodone 30 mg, and Naprosyn 500 mg.

Prescribing High-Dose Opiates

21. During the course of his care and treatment of Patient A, approximately from April 7, 2016 through October 9, 2019, Respondent prescribed to Patient A 240 mg of Oxycodone on a monthly basis, equating to 360 morphine milligram equivalents (MME)[9] per day. According to the medical records, it was unclear what conditions the opiates were being prescribed to treat. None of Patient A's symptoms, physical examination findings or remainder of the medical records suggest any significant medical diagnosis to warrant such high doses. Patient A was drinking alcohol regularly, which increases the risks of using opiates. Respondent failed to adequately consider and/or failed to document having adequately considered alternative treatment modalities such as physical therapy, steroid injections, orthopedic evaluation, or TENS units.[10] Respondent failed to acknowledge and/or failed to document having acknowledged that Patient A's Oxycodone dosage was excessive or dangerous. Respondent failed to make adequate efforts and/or failed to document having made adequate efforts to reduce the oxycodone dosage or provide sufficient medical justification for the high dosages. Respondent failed to refer and/or failed to document having referred Patient A to pain management specialist(s) or other specialists to assess there were safer alternatives to help manage Patient A's pain.

Urine Drug Testing

22. During the course of his care and treatment of Patient A, approximately from April 7, 2016 through October 9, 2019, Respondent administered four (4) urine toxicology screenings to Patient A. On October 1, 2018 and March 29, 2019, Patient A tested negative for opioids, even

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[9] Morphine equivalency dose MED is a value assigned to opioids to represent their relative potencies. MED is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the prescribed opioid. Daily MED is the sum total of all opioids, with conversation factors applied, that are being taken within a 24-hour period, which is used to determine if a patient is at risk of addiction, respiratory depression, or other delirious effects associated with opioids. The process of converting opioid doses to a morphine equivalency dose can be accomplished by using a MED calculator or a morphine equivalency table, also known as opioid conversation chart.

[10] A transcutaneous electrical nerve stimulation (TENS) unit is a battery operated device used to treat pain.

though Respondent was prescribing Oxycodone to Patient A.

23. Respondent failed to more closely monitor and/or failed to document having more closely monitored Patient A by having more frequent appointments and/or confirmatory testing and/or decreasing and/or stopping Oxycodone prescription as the negative test results suggest that Patient A may be selling or diverting Oxycodone, especially in light of the fact that Patient A did not have insurance and had limited financial resources.

Treatment of Chronic Back, Neck, and Shoulder Pain

24. During the course of his care and treatment of Patient A, approximately from April 7, 2016 through October 9, 2019, Respondent failed to adequately make and/or failed to document having adequately made attempts to determine the cause of Patient A's pain; Respondent failed to adequately describe Patient A's pain in the medical records; Respondent failed to order and/or failed to document having ordered imaging studies; Respondent failed to make and/or failed to document having made referrals to specialists such as physical therapist(s), orthopedic surgeon(s), or pain management specialist(s); Respondent failed to adequately utilize and/or failed to document having adequately utilized alternative treatment modalities, including, but not limited to, topical patches, Lyrica,[11] or steroid injections.

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

(a) Respondent prescribed high dose opiates without adequate justification.

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[11] Lyrica (Pregabalin) is a nerve pain medication, which can be used to treat nerve and muscle pain.

Patient B

26. On or about August 26, 2014, Patient B first presented to Respondent. Patient B was a fifty-three (53) year-old female who had a history of hypertension,[12] epilepsy,[13] knee pain, anemia, depression, obesity, deep vein thrombosis,[14] and tobacco use.

27. On or about January 14, 2016, Patient B returned to Respondent for medication refills and right knee pain. In the medical records for this visit, there was no other history of present illness noted. The records also noted, among other things, that Patient B was in the Emergency Room (ER) two days prior and received Norco,[15] "because she [Patient B] is here within 72 hours will just get a warning but if this happens again, pt [Patient B] is aware her pain contract will be broken."

28. On or about February 22, 2016, Patient B returned to Respondent for a pre-operation physical examination. According to the medical records, it is unclear what surgery Patient B was to undergo. Respondent recommended Patient B to stop smoking. The review of systems and physical examination were similar to the previous visit.

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[12] Hypertension refers to high blood pressure.

[13] Epilepsy refers to a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions associated with abnormal electrical activity in the brain.

[14] Deep vein thrombosis refers to a blood clot in a deep vein, usually in the legs.

[15] Hydrocodone APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

29. On or about April 4, 2016, Patient B returned to Respondent for "pain." The review of systems was positive for fatigue, irritability, weight loss, back pain, bone/joint symptoms and that Patient B was post-menopausal. Vital signs were normal and the physical examination noted tenderness in lumbar spine, right hip, and right knee, swelling in her hands and that her right knee was in a splint/soft cast.

30. On or about April 13, 2016, Patient B returned to Respondent for pain. Review of systems and physical examination sections of the medical records were repeated from the prior visit. Respondent diagnosed Patient B with "Arthropathy[16] of knee."

31. On or about May 16, 2016, Patient B returned to Respondent for "pain." The medical records for this visit state, among other things, "we reviewed her [Patient B] CURES report[17] which shows and excessive amt [amount] of Norco use past few weeks. We discussed dangers of this and she agrees to be cautious." There is no description of Patient B's pain, any effects on her function, or explanation of Patient B's Norco use. The History of Present Illness section notes only notes "pain." Other than vital signs, the review of systems and physical examination sections were repeated verbatim from the prior visit. Respondent again diagnosed arthropathy of knee and "discussed Norco use and warned about addiction, tolerance, and withdrawal."

32. On or about June 20, 2016, Patient B returned to Respondent for a pre-operation physical examination. Respondent refilled Patient B's Norco prescription 10 mg – 325 mg tablet, one tablet every 3-4 hours as needed for pain.

33. On or about July 13, 2016, Patient B returned to Respondent. Notes related to the physical examination noted knee swelling and severe pain in Patient B's knee with motion. According to the Assessment/Plan section of the medical records, Respondent decreased Norco to

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[16] Arthropathy is a terms for any disease of the joints.

[17] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database of schedule II, III, and IV controlled substance prescriptions dispensed in California, serving the public health, regulatory oversight agencies, and law-enforcement.

100 per month and started prescription of MS Contin[18] to 60 mg in the morning, 30 mg at night, in addition to Norco.

34. On or about October 25, 2016, Patient B returned to Respondent. Respondent prescribed Ambien[19] for Patient B's insomnia. In addition, Respondent prescribed and/or refilled Omeprazole,[20] Montelukast,[21] Albuterol,[22] Q-var[23], and Colace.[24]

35. On or December 7, 2016, Patient B returned to Respondent for pain and lung cancer. Patient B complained that the current pain plan was "not adequate," the MS Contin did not provide enough relief, and she wanted more Norco. Medical records for this visit do not include information regarding where Patient B's pain is located, whether it radiated, what, if anything else, Patient B has tried for pain relief, and how it affected her function. Review of systems was positive for pain, dyspnea,[25] nausea, vomiting, and anxiety. Physical examination was normal.

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[18] MS Contin® (morphine sulfate), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for MS Contin® which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of MS Contin® with benzodiazepines or other central nervous system (CNS) depressants.

[19] Zolpidem Tartrate (Ambien®), a centrally acting hypnotic-sedative, 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. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

[20] Omeprazole is a medication, which can be used to treat heartburn, a damages esophagus, stomach ulcers, and gastroesophageal reflux disease (GERD).

[21] Montelukast is an anti-inflammatory medication, which can be used to treat allergies and prevent asthma attacks.

[22] Albuterol is a medication, which can be used to treat or prevent bronchospasm. Bronchospasm occurs when airways (bronchial tubes) go into spasm and contract).

[23] Beclometasone (solder under brand name Qvar, among others) is a steroid medication. The inhaled form is used in the long-term management of asthma.

[24] Docusate (sold under brand name Colace, among others) is a stool softener.

[25] Dyspnea refers to difficult or labored breathing.

According to the Assessment / Patient Plan section of the medical records, Respondent, among other things, "refilled pain meds," "increased Diazepam[26] today," and "discussed dangers of narcotics."

36. On or about January 24, 2017, Patient B returned to Respondent for refills of her medications. According to the medical records for this visit, it is noted, among other things, that Patient B's pain is worsening, although where it is worsening is not clearly stated. According to the Assessment / Patient Plan section of the medical records, Respondent, among other things, "increased MS Contin night time dosage," "[advised Patient B] do not drink alcohol or drive while taking this medication."

37. On or about March 2, 2017, Patient B telephonically requested an early refill of her MS Contin. Respondent declined.

38. On or about March 20, 2017, Patient B returned to Respondent. Patient B reported that she had been in the emergency room. It was noted that Patient B's oncologist had refilled her Lorazepam.[27] At this time, Patient B was taking Diazepam 10 mg for anxiety, MS Contin 60 mg every morning and 90 mg every evening, and Norco approximately 100 per month for pain, which is equivalent to approximately 180 MME / day. Under the Plan section of the medical records, it is noted, among other things, "reviewed controlled subs contract terms."

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[26] Valium® (diazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used for the management of anxiety disorders or for short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[27] Ativan® (lorazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of Ativan® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Ativan®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

39. On or about May 1, 2017, Patient B returned to Respondent with severe knee pain. According to the medical records for this visit, it is noted, among other things, that Patient B was using valium for anxiety and muscle spasm, although the records not clearly state where the muscle spasm is located. Patient B requested an increase of her opioid narcotic dosages. The physical examination noted that Patient B was using crutches and had "tenderness" of the right knee. Respondent added prescription of cyclobenzaprine[28] for muscle spasm and advised Patient B to use Diazepam sparingly and to avoid alcohol and driving while taking it. However, within the same medical records for this visit, it also states, "we agree to stop the Diazepam."

40. On or about July 3, 2017, Patient B returned to Respondent, having suffered a fractured left hand since the last visit to Respondent. According to the medical records for this visit, Respondent increased Norco from 100 to 120 per month to help with Patient B's hand pain.

41. On or about September 6, 2017, Patient B returned to Respondent. According to the medical records, Patient B was filling Diazepam early "due to increased stress."

42. On or about October 6, 2017 and October 10, 2017, Patient B returned to Respondent for pre-operative evaluation for knee surgery.

43. On or about November 7, 2017, Patient B returned to Respondent for medication refills. According to the medical records for this visit, Patient B reported that the knee replacement surgery was on hold due to a possible thyroid cancer. The medical records also state, among other things, that prescription for Diazepam was being discontinued "due to new limitations in my Rx regiment."

44. On or about January 23, 2018, Patient B returned to Respondent. According to the medical records for this visit, Patient B continued to smoke tobacco, was in remission from her lung cancer, had undergone a thyroidectomy[29] and had not yet undergone knee surgery. Also noted in the medical records, among other things, were "Refilled analgesics. Take as

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[28] Cyclobenzaprine is a muscle relaxant, which can be used to treat pain and stiffness caused by muscle spasms.

[29] Thyroidectomy is the surgical removal of all or part of your thyroid gland.

prescribed... I also reminded her to use lowest dose, we should really try to avoid the Norco and wean off the extra 30 mg MS, ASAP."

45. On or about March 22, 2018, Patient B returned to Respondent for "pain management" and "medication refills." According to the medical records for this visit, Patient B reported worsening back pain and left arm numbness/nerve pain. Patient B also reported a prior spine fracture and a recently performed CT scan performed and followed by an oncologist. Respondent refilled Patient B's medications. Patient B was now taking 200 Norco per month, MS Contin 60 mg in the morning and 90 mg in the evening, for an approximately 210 MME/day.

46. On or about May 18, 2018, Patient B returned to Respondent for medication refills. According to the medical records for this visit, Patient B reported "worsening stomach issues and wanted to increase MS Contin to help decrease Patient B's Norco intake/dependence." Respondent increased MS Contin to 90 mg twice daily. Respondent also prescribed Narcan[30] in case of opioid overdose.

47. On or about November 28, 2018, Patient B returned to Respondent for medication refills. According to the medical records for this visit, Patient B's symptoms were mild and chronic. Respondent increased MS Contin to 100 mg twice daily, in addition to the Norco, and advised Patient B to "limit narcotic intake when tolerable."

48. On or about January 7, 2019, Patient B returned to Respondent after she had a seizure and was being treated for a urinary tract infection at a hospital. Respondent ordered a urine culture test, recommended a low sodium diet for Patient B's blood pressure, and advised Patient B to finish the antibiotics medications from the hospitalization. Respondent diagnosed "other chronic pain" and "opioid dependence, uncomplicated" and noted that "we had a long discussion about her encephalopathic[31] symptoms of recent hospitalization, really emphasized her need to keep Norco intake to a minimum. Given her many diagnoses and combination of narcs for pain and seizures and insomnia meds she could very easily overdose, especially when ill ... will need

[30] Narcan (Naloxone) is a narcotic, which can be used to treat narcotic overdose in an emergency situation.

[31] Encephalopathy refers to any brain disease that alters brain function or structure.

to wait until January 17 for the Norco refill. Patient promises to be more careful."

49. On or about April 10, 2019, Patient B returned to Respondent for a follow-up visit from the emergency room for altered mental status. Respondent referred Patient B to a urologist for blood in the urine, referred Patient B to a pain management specialist, ordered an MRI of the brain, a CT Scan of the abdomen, fecal testing to rule out colon cancer, and reviewed a CURES report. A urine toxicology test administered to Patient B showed negative for illicit substances, benzodiazepines, hydrocodone, and positive for opiates and morphine even though Patient B had filled #100 Norco on March 17, 2019 and on April 16, 2019.

50. On or about July 22, 2019, Patient B returned to Respondent for management of her chronic pain. Patient B was now receiving pain medications from a pain management specialist, which was stopped in December 2019, when Patient B was "kicked out for the presence of barbiturates in her urine."

51. On or about December 10, 2019, Patient B underwent a urine toxicology screening, which was negative for illicit drugs, hydrocodone, benzodiazepines, and alcohol and positive for opiates, including morphine.

Prescribing Escalating Doses of Opioids for Knee Pain

52. During the course of his care and treatment of Patient B, approximately from August 26, 2014 through December 10, 2019, Respondent failed to adequately implement and/or failed to document having adequately implemented alternative treatment modalities, including, but not limited to, steroid or hyaluronic acid injections[32], physical therapy, acetaminophen,[33] or topical treatments such as Flector patch,[34] lidocaine[35] or bracing. In early 2016, Patient B was on Norco 10 mg every 3-4 hours for pain, equating to approximately 60 MME / day. By March 2019, Respondent prescribed over 240 MME / day, without adequate attempts at intervention for the

[32] Hyaluronic acid, when injected, can be used to treat severe knee pain.

[33] Acetaminophen (common brand Tylenol) can be used to treat minor aches and pains, and reduces fever.

[34] Flector Patch (diclofenac epolamine topical patch) is a pain medication, which helps relieve pain and inflammation (swelling) in a small area of your body.

[35] Lidocaine can be used to relieve pain and numb the skin.

pain and without adequate justification for the increase, other than Patient B's subjective reports of increased pain. In addition, Respondent concomitantly prescribed opioids along with benzodiazepines as well as zolpidem, both of which increase the risk of overdose, when combined with opioids. Respondent continued to prescribe opiates at increasing doses, even after Patient B exhibited red flags, including, but not limited to, requests for increasing dosages, early refills, receiving medications from other providers, and continued tobacco use even after being diagnosed with lung cancer.

Inadequate Documentation

53. During the course of his care and treatment of Patient B, approximately from August 26, 2014 through December 10, 2019, Respondent failed to document a description of Pain B's pain and how it affected her function. The review of systems portion of the medical records were extensive, but often repeated verbatim from visit to visit. The physical examination section of the medical records were also repeated verbatim from visit to visit. Prescriptions were not adequately documented at each patient visit and it is difficult to determine exactly what medications Patient B was prescribed and what medications were being taken from visit to visit.

Failure to Consider Opioid Use Disorder

54. During the course of his care and treatment of Patient B, approximately from August 26, 2014 through December 10, 2019, Respondent failed to screen and/or failed to document having screened Patient B for opioid use disorder. Respondent failed to recognize or consider and/or failed to document having recognized and/or considered this diagnosis. However, during the treatment period from approximately August 26, 2014 through December 10, 2019, Patient B exhibited symptoms of opioid dependence, including, but not limited to, taking opioids for many years at increasing dosages, inability to decrease the dosage even after other providers expressed concerns about the dosages, and exhibiting mental status changes, which could be attributed to her opioid use. In addition, Patient B exhibited red flags for opioid use disorder, including, but not limited to, requests for increasing dosages, early refills, receiving medications from other providers, and continued tobacco use even after being diagnosed with lung cancer.

55. Respondent committed gross negligence in his care and treatment of Patient B, which

included, but was not limited to, the following:

(a) Respondent prescribed escalating doses of opiates for Patient B's knee pain without adequate justification.

Patient C

56. On or about January 11, 2016, Patient C presented to Respondent. At that time, Patient C was a fifty-six (56) year-old male with a history of anxiety, bipolar disorder, and low back pain. Patient C had been on Methadone[36] for over 35 years for chronic back pain after having suffered an automobile accident in 1977. The Review of Systems section of the medical records for this visit noted "back pain, bone/joint symptoms and myalgia[37]." Examination was normal other than tenderness of the thoracic and lumbar spine, left hip, and bilateral knees. Respondent diagnosed "low back pain" and "refilled meds." The medication list included clonazepam 0.5 mg three per day and Methadone 10 mg 7 tablets twice daily.

57. On or about March 15, 2016, Patient C returned to Respondent. In the medical records for this visit, it is noted, among other things, that Patient C is moving to the Midwest.

58. On or about July 26, 2016, Patient C presented to Respondent for back pain. The History section of the medical records for this visit notes that Patient C "is back from Oklahoma and needs refill of his Methadone and clonazepam." However, there is no description of Patient C's pain, notations regarding the location and radiation of the pain or associated symptoms, if any. The Review of Systems section of the medical records noted "back pain, bone/joint symptoms and myalgia." Patient C's blood pressure was elevated at 144/95, pulse 91, and the physical examination was normal other than thoracic and lumbar spine tenderness. There is no discussion of the range of motion of the spine, any deformities, nor any neurological examination. The affect is noted as normal. Respondent diagnosed Patient C with "low back pain" and "other specific anxiety disorders" and refilled Methadone 10 mg seven tablets every 12 hours, as needed,

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[36] Methadone is 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.

[37] Myalgia refers to soreness and achiness in the muscles than can range from mild to severe.

and clonazepam 0.5 mg one every 8 hours as needed for anxiety. The quantities and refills were not noted in the medical records. The medication list noted fluoxetine[38] 40 mg, lisinopril-hydrochlorothiazide[39] 20/25, meloxicam[40] 15 mg, and Topamax[41] 25 mg prescribed by a psychiatrist. However, it is unclear if Patient C is actually taking these medications and if they were prescribed during this visit.

59. On or about August 3, 2016, Patient C returned to Respondent for "pain." The medical records for this visit note, among other things, "there was a mix up with his [Patient C's] insurance and rx, had to pay cash for last fill of Methadone, then shortly thereafter his [Patient C's] backpack was stolen." The physical examination was significant for elevated blood pressure of 150/87, neck stiffness, cervical spine muscle spasm, lumbar spine tenderness. It was also noted that "pt [Patient C] was having some withdrawal symptoms and his neck went into spasm and is tender." The assessments section noted other muscle spasm, low back pain, other specified anxiety disorders, essential hypertension, and colon cancer screening. Respondent refilled Methadone "X3," prescribed "a few Flexeril[42]" advised Patient C to continue his fluoxetine for anxiety and noted that Patient C had been out of his lisinopril for his blood pressure and advised Patient C to resume this and follow in 3 months to check blood pressure. The documentation for this visit does not contain notation on the quantity of medications prescribed. The medication list section notes, among other things, "pt [Patient B] had his #350 Methadone he picked up on 7/26/16 stolen. Patient [C] did show an investigation # and proof of the crime. Early refill ok due to theft."

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[38] Fluoxetine is a Selective Serotonin Reuptake Inhibitor (SSRI), which can be used to treat depression, obsessive-compulsive disorder

[39] Lisinopril-hydrochlorothiazide is a drug which can be used to treat high blood pressure.

[40] Meloxicam is a nonsteroidal anti-inflammatory drug which can be used to treat osteoarthritis and rheumatoid arthritis.

[41] Topiramate (Topamx) is an anticonvulsant and nerve pain medication, which can be used to treat and prevent seizures.

[42] Flexeril (Cyclobenzaprine) is a muscle relaxant.

60. On or about August 15, 2016, Patient C returned to Respondent for "pain." Patient C had been hospitalized for a low back abscess[43] and was on antibiotics. Medical records for this visit noted, among other things, "[Patient C] has pain under control." The history of present illness only notes "pain." There is no mention of the location of pain or any other associated symptoms. Review of systems section noted fatigue, irritability, insomnia, back pain, and tender subcutaneous[44] lumps that have been improving. Physical examination noted elevated blood pressure of 140/80, tenderness of the thoracic and lumbar spine, and no evaluation of the skin or any abscess. Respondent diagnosed Patient C with low back pain. No prescriptions were noted. The plan section noted that Respondent advised Patient C to finish the antibiotic and follow up in two months.

61. On or about August 19, 2016, Patient C returned to Respondent for "follow up." The medical records for this visit noted, among other things, that Patient B was taking "ATB" at times with decreased breath sound. No other history was noted. Review of systems section noted dyspnea[45], anxiety, and back pain. Vital signs noted a decreased pulse oximetry reading of 92%. The physical examination noted that Patient C was in a body brace, had decreased breath sounds on his lung examination, and normal cervical spine and shoulder examinations. Respondent diagnosed Patient C with high blood pressure and "other chronic pain" with left dorsal paraspinal musculature fluid distribution. According to the medical records, Respondent recommended Patient C to do deep breathing exercises, continue his medications, and return as needed.

62. On or about October 6, 2016, Patient C returned to Respondent for refills of his medications and itchiness. However, there was no skin examination noted. Respondent diagnosed Patient C with dermatitis.[46] Respondent prescribed triamcinolone[47] steroid cream and

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[43] Abscess refers to a confined pocket of pus that collects in tissues, organs, or spaces inside the body.

[44] Subcutaneous means situated or applied under the skin.

[45] Dyspnea refers to difficult or labored breathing.

[46] Dermatitis is a general term that describes a skin irritation.

[47] Triamcinolone is a glucocorticoid used to treat certain skin diseases, allergies, and (continued...)

refilled Patient C's other medications. During this time, Respondent was prescribing Patient C with clonazepam 0.5 mg #90 per month and Methadone 10 mg #420 per month, which equates to 1,680 MME per day.

63. On or about December 15, 2016, Patient C presented to Respondent for ear irritation. According to the medical records for this visit, Patient C had vertigo, which was worse with lying down and had recent cold symptoms. Patient C denied alcohol use and reported that he was seeing a psychiatrist who stopped his fluoxetine prescription and changed it to a different medication. Physical examination noted blood pressure of 95/67, retracted eardrums, "minor nystagmus[48]" and normal psychiatric examination.

64. On or about December 21, 2016, Patient C returned to Respondent. According to the medical records for this visit, Respondent noted, among other things, pain in Patient C's back and shoulders and that it was well controlled with Methadone. Respondent also noted that Patient C had a history of anxiety and was on a mood stabilizer and clonazepam.

65. On or about February 27, 2017, Patient C presented to Respondent who noted in the medical records, among other things, that Patient C "was no longer homeless." According to the medical records for this visit, Respondent advised Patient C to continue meloxicam and Methadone for pain, "instructed patient [C] to limit clonazepam usage" and to follow up in three months for a physical examination.

66. On or about April 22, 2017, Patient C returned to Respondent. According to the medical records for this visit, Patient C reported upper body pain worse when he wakes up and pain with breathing. According to Patient C, he had been losing weight due to being depressed and homeless. Physical examination was normal except abdominal tenderness and tenderness at the intercostal spaces[49] and costochondral junctions.[50]

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rheumatic disorder among others.

[48] Nystagmus refers to an involuntary eye movement, which may cause the eye to rapidly move from side to side, up and down, or in a circle, and may slightly blur vision.

[49] Intercostal space is the space between two ribs.

[50] Costochondral junction (joint) are immobile articulations between the ribs and costal cartilages.

67. On or about May 4, 2017, Patient C presented to Respondent. According to the medical records for this visit, Respondent advised Patient C not to drive a vehicle or drink alcohol while taking his medications. Respondent ordered laboratory studies and refilled Patient C's medications. Respondent noted, among other things, that clonazepam was taken as needed for anxiety and changed his lisinopril-hydrochlorothiazide to lisinopril alone because Patient C's blood pressure was now low.

68. On or about June 7, 2017, Patient C returned to Respondent after a visit to the emergency room for severe pain in his arm and upper abdomen and was diagnosed with osteoarthritis of the right shoulder and constipation. The emergency room physician advised Patient C to continue meloxicam and Methadone and added Milk of Magnesia[51] for constipation. Patient C had a CT scan while in the emergency room. Respondent's plan and regimen remained unchanged.

69. On or about July 28, 2017, Patient C returned to Respondent after another visit to the emergency room for arm pain which "may be stemming from neck." According to the medical records, Patient C purportedly denied tobacco and alcohol use. Medical records relating to the physical examination noted tenderness of the cervical spine, lumbar spine, left and right shoulders, grip strength of 5/5, and bicep 4/5. Respondent ordered an x-ray examination of the neck, physical therapy, and requested an MRI. Respondent also ordered fecal testing for colon cancer screening.

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70. On or about September 6, 2017, Patient C returned to Respondent. In the medical records, Respondent noted, among other things, retrolisthesis[52] and cervical spondylosis[53] on the

[51] Milk of Magnesia (Magnesium hydroxide) can be used for constipation, upset stomach, and heartburn.

[52] Retrolisthesis is an uncommon joint dysfunction that occurs when a single vertebra in the back slips backward along or underneath a disc.

[53] Spondylosis is a general term for age-related wear and tear of the spinal disks.

neck x-ray examination. Respondent advised Patient C to follow up with physical therapy, continue meloxicam and Methadone for pain, and to avoid drinking alcohol or driving while taking the medications. Respondent also noted that if Patient C's pain persisted, Respondent would consider MRI and orthopedic consultation.

71. On or about October 23, 2017, Patient C presented to Respondent. According to the medical records, Patient C reported a seizure. Respondent started prescribing gabapentin[54] to Patient C and referred Patient C to a neurologist.

72. On or about December 6, 2017, according to the medical records, a fax was received noting that Patient C had failed to follow up with physical therapy.

73. On or about December 26, 2017, Patient C returned to Respondent. According to the medical records, it is noted, among other things, "patient [C] has clonazepam leftover but will not be able to refill due to opioid meds and he will need to be referred to psych today." Respondent referred Patient C to psychiatry, ordered a urine toxicology screening, and noted, "informed patient [C] of clinic rules regarding controlled subs[tances]. No more clonazepam refills."

74. On or about February 2, 2018, Patient C presented to Respondent. Respondent continued to prescribe Methadone for Patient C's chronic arthritis of his neck and right shoulder.

75. On or about May 2, 2018, Patient C returned to Respondent. According to the medical records, Patient C reported increasing mania. The medical records also indicate, among other things, "per the CURES report, he [Patient C] is taking 140 mg of Methadone per day" and had never received Narcan.[55] Respondent prescribed and explained Narcan use and continued prescribing Neurontin and Methadone 70 mg twice daily for pain.

76. On or about May 22, 2018, Patient C returned to Respondent. According to the medical records, Patient C reported that his home was robbed and that his medications were

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[54] Gabapentin is an anticonvulsant and nerve pain medication, which can be used to treat seizures and pain caused by shingles. Neurontin is the brand name for gabapentin.

[55] Narcan (Naloxone) is a narcotic, which can be used to treat narcotic overdose in an emergency situation.

stolen. According to the CURES report, on May 22, 2018 and again on June 18, 2022, Patient C filled Methadone 10 mg #420 prescribed by Respondent on May 2, 2018.

77. On or about September 17, 2018, Patient C returned to Respondent. According to the medical records, Patient C reported that his back pain was worsening and he was applying for permanent disability.

78. On or about November 9, 2018, Patient C presented to Respondent. Respondent ordered a urine toxicology screening.

79. On or about December 21, 2018, Patient C returned to Respondent. According to the medical records, Patient C had been to the emergency room for abdominal pain, nausea, and constipation. It is also noted in the medical records, among other things that "[Respondent] believes he [Patient C] is not absorbing his Methadone and is experiencing withdrawals." Patient C had a CT scan exhibiting fecal impaction[56] and severe constipation. According to the medical records, Patient C reported chronic infrequent stools. Respondent prescribed Colace,[57] Miralax,[58] and gave samples of Movantik[59] for constipation. Respondent also prescribed Compazine for nausea.

80. On or about February 26, 2019, Patient C presented to Respondent, reporting nausea, malaise, headache, vomiting, and weight loss. Respondent was now taking Latuda[60] prescribed by his psychiatrist and continued to take Methadone 70 mg twice daily as prescribed by Respondent. Respondent stopped the prescription for Latuda, prescribed ondansetron[61] for

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[56] Fecal impaction refers to hardened stool that is stuck in the rectum or lower colon due to chronic constipation.

[57] Colace is a stool softener medication.

[58] Miralax is a medication used for relief from constipation.

[59] Movantik is a prescription medication used to treat constipation that is caused by prescription pain medicines.

[60] Latuda refers to an antipsychotic drug, which can be used to treat schizophrenia.

[61] Ondansetron is a medication, which can be used to prevent nausea and vomiting.

nausea, pantoprazole for "gastritis," stopped the meloxicam and encouraged the patient to wait as long as possible between Methadone dosages. Respondent referred Patient C to gastroenterology.

81. On or about April 29, 2019, Patient C returned to Respondent. According to the medical records, Patient C reported that the gastroenterologist recommended removal of Patient C's gallbladder. Respondent continued prescription of Methadone, among other medications.

82. On or about May 17, 2019, Patient C presented to Respondent for a follow-up visit following his visit to the emergency room. According to the medical records, Patient C was found to have common bile duct stones and he underwent removal of the gallbladder. According to the medical records, Patient C received Percocet (oxycodone-acetaminophen) for the pain, but had side effects from the acetaminophen (Tylenol). Respondent changed the prescription for Percocet to oxycodone 15 mg for pain related to the surgery, in addition to the chronic Methadone.

83. On or about July 12, 2019, Patient C returned to Respondent. According to the medical records, Patient C reported nausea, constipation, melena (black stools), and loss of appetite. According to the medical records, Patient C was losing weight and missed his last appointment with the psychiatrist because his car was stolen. His depression screening (PHQ9) noted severe depression. Respondent continued Patient C's medications and ordered a stool test and urinalysis. According to the medical records, Respondent also encouraged Patient C to follow up with his behavioral health providers.

84. On or about September 23, 2019, Patient C presented to Respondent. According to the medical records, Patient C had been diagnosed with Barrett's esophagus[62] and was not taking

[62] Barrett's esophagus refers to damage to the lower portion of the tube that connects the mouth and stomach (esophagus).

omeprazole[63] and pantoprazole,[64] as well as promethazine[65] and Zofran[66] for nausea. According to the medical records, Patient C was having continued abdominal pain, anxiety, and insomnia. According to the medical records, Patient C was not taking Abilify, clonazepam, and Prozac for his bipolar illness. Respondent refilled Methadone and Patient C's other medications, and advised him to follow up in three months.

85. On or about November 26, 2019, Patient C returned to Respondent. According to the medical records, Patient C had continued abdominal pain and vomiting, had gained 15 pounds since the previous visit, and was wearing a back brace. According to the medical records, Patient C had blood in his urine, but Patient C was not examined. According to the medical records, Patient C had an EKG[67] because of his hypertension. According to the medical records, Respondent reviewed CURES report and advised a "step-wise" approach to treating pain, advising Patient C to take Naprosyn 500 mg twice daily as needed, Tylenol 500 mg two tablets every 8 hours as needed, Methadone for severe pain. Respondent ordered a urine culture, urine drug screen, but did not address Patient C's abdominal pain or vomiting.

Prescribing High Dose Methadone

86. Respondent prescribed to Patient C Methadone 10 mg # 420 per month from October 2016 through December 2019, equating to a daily MME of over 1,100. Respondent also prescribed clonazepam 0.5 mg # 90 per month from October 2016 through February 2018, when another physician began to prescribe clonazepam to Patient C. It was unclear what was causing Patient C's pain other than an x-ray examination results suggesting spondylosis of the cervical

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[63] Omeprazole (Prilosec) is a prescription and over-the-counter (OTC) drug used as a treatment for frequent heartburn.

[64] Pantoprazole is a medication used to treat certain stomach and esophagus problems (such as acid reflux).

[65] Promethazine is a medication which can be used to treat allergies and motion sickness. It can also be used as a sedative before and after surgery and medical procedures.

[66] Zofran (Ondansetron) refers to a medication, which can be used to prevent nausea and vomiting.

[67] Electrocardiography (EKG) records the electrical signal from your heart to check different heart conditions.

spine. There was insufficient medical justification for the extremely high doses of Methadone prescribed. Respondent failed to make adequate efforts and/or failed to document having made adequate efforts to determine the cause of Patient C's pain. In addition, Respondent noted that Patient C had a history of IV drug use, which means Patient C was at risk for misuse and/or abuse. Respondent failed to adequately revisit alternative therapies and/or failed to document having adequately revisited alternative therapies. Respondent failed to discuss and/or failed to document having discussed with Patient C specific cardiac risks unique to Methadone. Respondent failed to adequately attempt and/or failed to document having adequately attempted to decrease the dosage of Methadone and/or monitor Patient C's EKG.

Inadequate Documentation

87. During the course of his care and treatment of Patient C, approximately from January 11, 2016 through November 26, 2019, Respondent failed to adequately document a description of Patient C's pain or how it affected Patient C's function. The review of systems portion of the medical records were extensive, but often repeated verbatim from visit to visit. The physical examination section of the medical records were also repeated verbatim from visit to visit and on occasion, omitted pertinent systems such as diagnosing dermatitis, a skin rash, without an evaluation of the skin. Prescriptions were not adequately documented at each patient visit and it is difficult to determine exactly what medications Patient C was prescribed and what medications were being taken from visit to visit.

88. Respondent committed gross negligence in his care and treatment of Patient C, which included, but was not limited to, the following:

(a) Respondent inappropriately prescribed high doses of Methadone.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

89. Respondent has subjected his Physician's and Surgeon's Certificate No. A 83313 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, Patient B, and Patient C, as more particularly alleged herein:

90. Respondent committed repeated negligent acts in his care and treatment of Patient A Patient B, and Patient C, including, but not limited to:

Patient A

91. Paragraphs 10 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

92. Respondent prescribed high dose opiates to Patient A without adequate justification; and

93. Respondent failed to appropriately and/or adequately treat Patient A's chronic back, neck, and shoulder pain;

Patient B

94. Paragraphs 26 through 55, above, are hereby incorporated by reference and realleged as if fully set forth herein.

95. Respondent prescribed escalating doses of opiates for Patient B's knee pain without adequate justification; and

96. Respondent failed to maintain adequate and/or accurate records of Respondent's care and treatment of Patient B;

Patient C

97. Paragraphs 56 through 88, above, are hereby incorporated by reference and realleged as if fully set forth herein.

98. Respondent inappropriately prescribed high doses of Methadone to Patient C; and

99. Respondent failed to maintain adequate and/or accurate records of Respondent's care and treatment of Patient C.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

100. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 83313 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent in his care and treatment of Patients A, and B, as more particularly alleged hereinafter:

Patient A

101. Paragraphs 10 through 25 above, are incorporated by reference and realleged as if fully set forth herein.

102. Respondent was incompetent, in his care and treatment of Patient A, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge in Respondent's understanding of the purpose and/or interpretation of urine drug testing in patients who are prescribed high-dose opiates.

Patient B

103. Paragraphs 26 through 55 above, are incorporated by reference and realleged as if fully set forth herein.

104. Respondent was incompetent, in his care and treatment of Patient B, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge by failing to screen Patient B for opioid use disorder and/or failing to recognize or consider this diagnosis even though Patient B exhibited symptoms of opioid dependence and red flags for opioid use disorder.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

105. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 83313 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient B and Patient C, as more particularly alleged in paragraphs 25 through 87, above, which are hereby incorporated by reference and realleged as if fuolly set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

106. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 83313 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is

unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 105, above, which are hereby 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. A 83313, issued to Respondent Michael Lawrence MacMurray, M.D.;

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

3. Ordering Respondent Michael Lawrence MacMurray, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: FEB 0 7 2022

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

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