

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

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

Richard Joseph Kempert, M.D.

**Physician's and Surgeon's
Certificate No. C 37249**

Respondent.

Case No.: 800-2019-058719

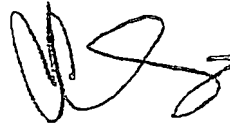
DECISION

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 October 6, 2022.

IT IS SO ORDERED: September 6, 2022.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 LEANNA E. SHIELDS
Deputy Attorney General
4 State Bar No. 239872
600 West Broadway, Suite 1800
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8 *Attorneys for Complainant*

9
10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the First Amended Accusation
14 Against:

Case No. 800-2019-058719

OAH No. 2021110587

15 **RICHARD JOSEPH KEMPert, M.D.**
16 34052 La Plaza, Suite 101
Dana Point, CA 92629

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

17 **Physician's and Surgeon's Certificate**
18 **No. C 37249.**

19 Respondent.

20
21 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
22 entitled proceedings that the following matters are true:

23 **PARTIES**

24 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
25 California (Board). He brought this action solely in his official capacity and is represented in this
26 matter by Rob Bonta, Attorney General of the State of California, by LeAnna E. Shields, Deputy
27 Attorney General.

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1 2. Respondent Richard Joseph Kempert, M.D. (Respondent) is represented in this
2 proceeding by attorney Raymond J. McMahon, Esq., with Doyle Schafer McMahon, LLP, whose
3 address is: 5440 Trabuco Road, Irvine, CA 92620.

4 3. On or about January 31, 1977, the Board issued Physician's and Surgeon's Certificate
5 No. C 37249 to Respondent. The Physician's and Surgeon's Certificate was in full force and
6 effect at all times relevant to the charges brought in Accusation No. 800-2019-058719, and will
7 expire on August 31, 2023, unless renewed.

8 **JURISDICTION**

9 4. On or about February 2, 2022, the First Amended Accusation No. 800-2019-058719
10 was filed before the Board, and is currently pending against Respondent. On or about February 2,
11 2022, the First Amended Accusation and all other statutorily required documents were properly
12 served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation.
13 A true and correct copy of the First Amended Accusation No. 800-2019-058719 is attached as
14 Exhibit A and incorporated herein by reference.

15 **ADVISEMENT AND WAIVERS**

16 5. Respondent has carefully read, fully discussed with counsel, and fully understands the
17 charges and allegations in Accusation No. 800-2019-058719. Respondent has also carefully read,
18 fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement
19 and Disciplinary Order.

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

26 7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently
27 waives and gives up each and every right set forth above.

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1 CULPABILITY

2 8. Respondent does not contest that, at an administrative hearing, Complainant could
3 establish a *prima facie* case with respect to each and every charge and allegation contained in the
4 First Amended Accusation No. 800-2019-058719 and agrees that he has thereby subjected his
5 Physician's and Surgeon's Certificate No. C 37249 to disciplinary action.

6 9. Respondent agrees that if he ever petitions for early termination or modification of
7 probation, or if an accusation and/or petition to revoke probation is filed against him before the
8 Medical Board of California, all of the charges and allegations contained in the First Amended
9 Accusation No. 800-2019-058719 shall be deemed true, correct and fully admitted by Respondent
10 for purposes of any such proceeding or any other licensing proceeding involving Respondent in
11 the State of California.

12 10. Respondent agrees that his Physician's and Surgeon's Certificate No. C 37249 is
13 subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in
14 the Disciplinary Order below.

15 CONTINGENCY

16 11. This Stipulated Settlement and Disciplinary Order shall be subject to approval of the
17 Board. The parties agree that this Stipulated Settlement and Disciplinary Order shall be
18 submitted to the Board for its consideration in the above-entitled matter and, further, that the
19 Board shall have a reasonable period of time in which to consider and act on this Stipulated
20 Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent
21 fully understands and agrees that he may not withdraw his agreement or seek to rescind this
22 stipulation prior to the time the Board considers and acts upon it.

23 12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null
24 and void and not binding upon the parties unless approved and adopted by the Board, except for
25 this paragraph, which shall remain in full force and effect. Respondent fully understands and
26 agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and
27 Disciplinary Order, the Board may receive oral and written communications from its staff and/or
28 the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify

1 the Board, any member thereof, and/or any other person from future participation in this or any
2 other matter affecting or involving Respondent. In the event that the Board does not, in its
3 discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the
4 exception of this paragraph, it shall not become effective, shall be of no evidentiary value
5 whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party
6 hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order
7 be rejected for any reason by the Board, Respondent will assert no claim that the Board, or any
8 member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this
9 Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

10 **ADDITIONAL PROVISIONS**

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

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

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

20 **DISCIPLINARY ORDER**

21 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 37249 issued
22 to Respondent RICHARD JOSEPH KEMPERT, M.D., is hereby revoked. However, the
23 revocation is stayed and Respondent is placed on probation for three (3) years on the following
24 terms and conditions:

25 1. **CONTROLLED SUBSTANCES - PARTIAL RESTRICTION.** Respondent shall not
26 order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by
27 the California Uniform Controlled Substances Act, except for those drugs listed in Schedule V of
28 the Act, until Respondent submits proof of completion of the Prescribing Practices Course.

1 Respondent shall not issue an oral or written recommendation or approval to a patient or a
2 patient's primary caregiver for the possession or cultivation of marijuana for the personal medical
3 purposes of the patient within the meaning of Health and Safety Code section 11362.5. If
4 Respondent forms the medical opinion, after an appropriate prior examination and medical
5 indication, that a patient's medical condition may benefit from the use of marijuana, Respondent
6 shall so inform the patient and shall refer the patient to another physician who, following an
7 appropriate prior examination and medical indication, may independently issue a medically
8 appropriate recommendation or approval for the possession or cultivation of marijuana for the
9 personal medical purposes of the patient within the meaning of Health and Safety Code section
10 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that
11 Respondent is prohibited from issuing a recommendation or approval for the possession or
12 cultivation of marijuana for the personal medical purposes of the patient and that the patient or
13 the patient's primary caregiver may not rely on Respondent's statements to legally possess or
14 cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully
15 document in the patient's chart that the patient or the patient's primary caregiver was so
16 informed. Nothing in this condition prohibits Respondent from providing the patient or the
17 patient's primary caregiver information about the possible medical benefits resulting from the use
18 of marijuana.

19 2. EDUCATION COURSE. Within 60 calendar days of the effective date of this
20 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
21 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
22 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
23 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
24 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
25 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
26 completion of each course, the Board or its designee may administer an examination to test
27 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
28 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

15 Respondent shall submit a certification of successful completion to the Board or its
16 designee not later than 15 calendar days after successfully completing the course, or not later than
17 15 calendar days after the effective date of the Decision, whichever is later.

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

27 A medical record keeping course taken after the acts that gave rise to the charges in the
28 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

1 or its designee, be accepted towards the fulfillment of this condition if the course would have
2 been approved by the Board or its designee had the course been taken after the effective date of
3 this Decision.

4 Respondent shall submit a certification of successful completion to the Board or its
5 designee not later than 15 calendar days after successfully completing the course, or not later than
6 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

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

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

12 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
13 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
14 name and qualifications of a replacement monitor who will be assuming that responsibility within
15 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
16 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
17 notification from the Board or its designee to cease the practice of medicine within three (3)
18 calendar days after being so notified. Respondent shall cease the practice of medicine until a
19 replacement monitor is approved and assumes monitoring responsibility.

20 In lieu of a monitor, Respondent may participate in a professional enhancement program
21 approved in advance by the Board or its designee that includes, at minimum, quarterly chart
22 review, semi-annual practice assessment, and semi-annual review of professional growth and
23 education. Respondent shall participate in the professional enhancement program at Respondent's
24 expense during the term of probation.

25 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
26 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
27 Chief Executive Officer at every hospital where privileges or membership are extended to
28 Respondent, at any other facility where Respondent engages in the practice of medicine,

1 including all physician and locum tenens registries or other similar agencies, and to the Chief
2 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
3 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
4 calendar days.

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

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

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

12 9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
13 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
14 limited to, expert review, amended accusations, and legal reviews, as applicable, in the amount of
15 \$12,027.50 (twelve thousand twenty-seven dollars and fifty cents). Costs shall be payable to the
16 Medical Board of California. Failure to pay such costs shall be considered a violation of
17 probation.

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

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

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

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

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1 11. GENERAL PROBATION REQUIREMENTS.

2 Compliance with Probation Unit

3 Respondent shall comply with the Board's probation unit.

4 Address Changes

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

10 Place of Practice

11 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
12 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
13 facility.

14 License Renewal

15 Respondent shall maintain a current and renewed California physician's and surgeon's
16 license.

17 Travel or Residence Outside California

18 Respondent shall immediately inform the Board or its designee, in writing, of travel to any
19 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
20 (30) calendar days.

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

24 12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
25 available in person upon request for interviews either at Respondent's place of business or at the
26 probation unit office, with or without prior notice throughout the term of probation.

27 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
28 its designee in writing within 15 calendar days of any periods of non-practice lasting more than

1 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
2 defined as any period of time Respondent is not practicing medicine as defined in Business and
3 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
4 patient care, clinical activity or teaching, or other activity as approved by the Board. If
5 Respondent resides in California and is considered to be in non-practice, Respondent shall
6 comply with all terms and conditions of probation. All time spent in an intensive training
7 program which has been approved by the Board or its designee shall not be considered non-
8 practice and does not relieve Respondent from complying with all the terms and conditions of
9 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
10 on probation with the medical licensing authority of that state or jurisdiction shall not be
11 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
12 period of non-practice.

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

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

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

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

24 14. COMPLETION OF PROBATION. Respondent shall comply with all financial
25 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
26 completion of probation. Upon successful completion of probation, Respondent's certificate shall
27 be fully restored.

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

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

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


23 18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
24 a new license or certification, or petition for reinstatement of a license, by any other health care
25 licensing action agency in the State of California, all of the charges and allegations contained in
26 the First Amended Accusation No. 800-2019-058719 shall be deemed to be true, correct, and
27 admitted by Respondent for the purpose of any Statement of Issues or any other proceeding
28 seeking to deny or restrict license.

1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Raymond J. McMahon, Esq. I fully understand the stipulation and
4 the effect it will have on my Physician's and Surgeon's Certificate No. C 37249. I enter into this
5 Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree
6 to be bound by the Decision and Order of the Medical Board of California.


7
8 DATED: 05-04-2022 
9 RICHARD JOSEPH KEMPERT, M.D.
Respondent

10 I have read and fully discussed with Respondent Richard Joseph Kempert, M.D., the terms
11 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary
12 Order. I approve its form and content.

13
14 DATED: May 4, 2022 
15 RAYMOND J. MCMAHON, ESQ.
16 Attorney for Respondent

17 ENDORSEMENT

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

20 DATED: May 4, 2022 Respectfully submitted,
21
22 ROB BONTA
Attorney General of California
23 MATTHEW M. DAVIS
Supervising Deputy Attorney General
24
25 
26 LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

27 SD2021801273
28 83376674.docx

Exhibit A

First Amended Accusation No. 800-2019-058719

1 ROB BONTA
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2 MATTHEW M. DAVIS
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8 *Attorneys for Complainant*

9
10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the First Amended Accusation
14 Against:

15 **RICHARD JOSEPH KEMPert, M.D.**
34052 La Plaza, Suite 101
16 Dana Point, CA 92629

17 **Physician's and Surgeon's Certificate**
18 **No. C 37249,**

19 Respondent.

Case No. 800-2019-058719
OAH No. 2021110587

FIRST AMENDED ACCUSATION

[Cal. Gov. Code, § 11507.]

20 Complainant alleges:

21 **PARTIES**

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

25 2. On or about January 31, 1977, the Board issued Physician's and Surgeon's
26 Certificate No. C 37249 to Richard Joseph Kempert, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate No. C 37249 was in full force and effect at all times relevant to the charges
28 brought herein and will expire on August 31, 2023, unless renewed.

1 JURISDICTION

2 3. This First Amended Accusation, which supersedes Accusation No. 800-2019-058719
3 filed on September 28, 2021, in the above-entitled matter, is brought before the Board, under the
4 authority of the following laws. All section references are to the Business and Professions Code
5 (Code) unless otherwise indicated.

6 4. Section 2227 of the Code states:

7 (a) A licensee whose matter has been heard by an administrative law judge of
8 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
9 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:

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

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

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

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

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

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

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

27 The board shall take action against any licensee who is charged with
28 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 (1) An initial negligent diagnosis followed by an act or omission medically
2 appropriate for that negligent diagnosis of the patient shall constitute a single
negligent act.

3 (2) When the standard of care requires a change in the diagnosis, act, or
4 omission that constitutes the negligent act described in paragraph (1), including, but
5 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.

6 ...

7 6. Section 2242 of the Code states, in pertinent part:

8 (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
9 4022 without an appropriate prior examination and a medical indication, constitutes
unprofessional conduct.

10 ...

11 7. Section 2052 of the Code states, in pertinent part:

12 (a) Notwithstanding Section 146, any person who practices or attempts to
13 practice, or who advertises or holds himself or herself out as practicing, any system or
14 mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates
15 for, or prescribes for any ailment, blemish, deformity, disease, disfigurement,
16 disorder, injury, or other physical or mental condition of any person, without having
17 at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in
18 this chapter [Chapter 5, the Medical Practice Act], or without being authorized to
perform the act pursuant to a certificate obtained in accordance with some other
19 provision of law, is guilty of a public offense, punishable by a fine not exceeding ten
20 thousand dollars (\$10,000), by imprisonment pursuant to subdivision (h) of Section
21 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or
22 by both the fine and either imprisonment.

23 (b) Any person who conspires with or aids or abets another to commit any act
24 described in subdivision (a) is guilty of a public offense, subject to the punishment
25 described in that subdivision.

26 ...

27 8. Section 2264 of the Code states:

28 The employing, directly or indirectly, the aiding, or the abetting of any
unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in
the practice of medicine or any other mode of treating the sick or afflicted which
requires a license to practice constitutes unprofessional conduct.

9. 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.

1 10. Section 2228.1 of the Code states, in pertinent part:

2 (a) On or after July 1, 2019, except as otherwise provided in subdivision (c), the
3 board shall require a licensee to provide a separate disclosure that include the
4 licensee's probation status, the length of probation, the probation end date, all
5 practice restrictions placed on the licensee by the board, the board's telephone
6 number, and an explanation of how the patient can find further information on the
7 licensee's probation on the licensee's profile page on the board's online license
8 information Internet Web site, to a patient or the patient's guardian or health care
9 surrogate before the patient's first visit following the probationary order while the
10 licensee is on probation pursuant to a probationary order made on or after July 1,
11 2019, in any of the following circumstances:

12 (1) A final adjudication by the board following an administrative hearing or
13 admitted findings or prima facie showing in a stipulated settlement establishing any
14 of the following:

15 ...

16 (D) Inappropriate prescribing resulting in harm to patients and a probationary
17 period of five years or more.

18 (2) An accusation or statement of issues alleged that the licensee committed any
19 of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a
20 stipulated settlement based upon a nolo contendere or other similar compromise that
21 does not include any prima facie showing or admission of guilt or fact but does
22 include an express acknowledgment that the disclosure requirements of this section
23 would serve to protect the public interest.

24 (b) A licensee required to provide a disclosure pursuant to subdivision (a) shall
25 obtain from the patient, or the patient's guardian or health care surrogate, a separate,
26 signed copy of that disclosure.

27 ...

28 (d) On and after July 1, 2019, the board shall provide the following
information, with respect to licensees on probation and licensees practicing under
probationary licenses, in plain view on the licensee's profile page on the board's
online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes
alleged in the operative accusation along with a designation identifying those causes
by which the licensee has expressly admitted guilt and a statement that acceptance of
the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes
for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the
probationary license was imposed.

1 (4) The length of the probation and end date.

2 (5) All practice restrictions placed on the license by the board.

3 ...

4
5 11. Unprofessional conduct under Business and Professions Code section 2234 is conduct
6 which breaches the rules or ethical code of the medical profession, or conduct which is
7 unbecoming a member in good standing of the medical profession, and which demonstrates an
8 unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564,
9 575.)

10 COST RECOVERY

11 12. Section 125.3 of the Code states:

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

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

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

26 (d) The administrative law judge shall make a proposed finding of the amount
27 of reasonable costs of investigation and prosecution of the case when requested
28 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.

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

3 (2) Notwithstanding paragraph (1), the board may, in its discretion,
4 conditionally renew or reinstate for a maximum of one year the license of any
5 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.

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

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

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

12 FACTUAL ALLEGATIONS¹

13 13. In or around 1987, Respondent formed a medical group, Pacific Crest Medical Group
14 (PCMG). At PCMG, Respondent supervises a medical assistant, S.M., who is not a licensed
15 physician. As recently as 2020, Respondent's custom and practice was to allow S.M. to approve
16 and deny prescription refills to Respondent's patients without physician involvement.

17 14. On or about May 26, 2020, during an interview with investigators with the Health
18 Quality Investigation Unit (HQIU), Department of Consumer Affairs (DCA), S.M. indicated,
19 when a request for a prescription refill was received, S.M. would review the patient's record to
20 determine when the patient was last seen by Respondent, then, depending on the length of time,
21 S.M. would authorize the prescription refill without consulting Respondent. If S.M. determined
22 the patient was due for an office visit, S.M. would deny the refill request or authorize a partial
23 refill in order to prompt the patients to schedule an office visit with Respondent. S.M. indicated
24 she only consulted Respondent if she had a question or concern about the combination of
25 medications.

26
27 ¹ Conduct occurring more than seven (7) years from the filing date of the original Accusation filed
28 on September 28, 2021, is for informational purposes only and is not alleged as a basis for disciplinary
action.

1 15. On or about August 25, 2020, during an interview with HQUI investigators,
2 Respondent also described S.M.'s duties to include the refilling of routine prescription
3 medications for Respondent's patients. According to Respondent, S.M. authorized refills for
4 routine medications without his involvement. Respondent indicated S.M. was not authorized to
5 issue refills for controlled substances, that requests to refill controlled substances were reviewed
6 and authorized by Respondent.

7 **Patient A**²

8 16. On or about October 28, 2016, Patient A, a then 32-year-old female, an established
9 patient with Respondent since Patient A was approximately 15 years old, presented for an office
10 visit with Respondent. Patient A's medical history was significant for, among other things, over
11 twenty (20) surgical procedures, and numerous diagnoses including, but not limited to, complex
12 regional pain syndrome (CRPS),³ phlebitis,⁴ paresthesia,⁵ dysesthesia,⁶ allodynia,⁷ Stevens-
13 Johnson syndrome (SJS),⁸ osteoporosis, and neuropathy. Patient A also had a Hickman catheter⁹
14 in place through which she received intravenous medications, including, but not limited to,
15 Benadryl and antibiotics. According to records for this visit, Patient A presented for a review of

16
17 ² For patient privacy purposes, patients' true names are not used in the instant Accusation to
18 maintain patient confidentiality. The patients' identities are known to Respondent or will be disclosed to
19 Respondent upon receipt of a duly issued request for discovery and in accordance with Government Code
20 section 11507.6.

21 ³ Complex regional pain syndrome is a form of chronic pain that usually affects the extremities,
22 such as an arm or leg, but can affect any part of the body, typically developing after an injury or surgery.

23 ⁴ Phlebitis involves the inflammation of the veins.

24 ⁵ Paresthesia involves a burning or prickling sensation.

25 ⁶ Dysesthesia involves a cutaneous symptom such as burning, tingling, without a cutaneous
26 condition in a well-defined location that is often caused by nerve trauma, impingement or irritation.

27 ⁷ Allodynia involves the experience of pain from stimuli that is not normally painful.

28 ⁸ Stevens-Johnson syndrome (SJS) is a serious skin condition that causes the skin to develop
rashes and blisters. It also causes extensive damage to the mucous membranes resulting in sores and
blisters in the mouth, nose, eyes and genitals.

⁹ Hickman catheter is a central line catheter placed on the right side of the chest wall, to allow long
term access to veins typically to provide intravenous medications and to draw labs.

1 laboratory results and was diagnosed with central vein thrombosis as a complication from her
2 Hickman catheter. According to records for this visit, Respondent was prescribing several
3 medications to Patient A, including, but not limited to, fentanyl citrate,¹⁰ MS Contin,¹¹ warfarin
4 sodium,¹² atenolol,¹³ and Zofran.¹⁴ According to records for this visit, Respondent continued
5 Patient A's diagnoses for CRPS and phlebitis.

6 17. On or about November 4, 2016, Patient A presented for an office visit with
7 Respondent. According to records, Patient A suffered from an infection at or near the insertion
8 site of her Hickman catheter and required suture removal.

9 18. On or about December 16, 2016, Patient A presented for an office visit with
10 Respondent to refill her prescriptions and discuss a timeline for tapering down her intravenous
11 Benadryl and fentanyl citrate. According to records, Respondent indicated the benefits of Patient
12 A's opiate prescriptions outweighed the risks, and a plan to continue Patient A's current
13 medication regimen with a possible tapering down in the near future. In his review of systems,
14 Respondent noted Patient A was positive for nausea, vomiting, fatigue, insomnia and chronic
15 paresthesia. Respondent notes a recommendation for Patient A to begin an exercise program for
16 weight loss and to cease smoking.

17 _____
18 ¹⁰ Fentanyl citrate lozenges, brand name Actiq, are a transmucosal immediate release fentanyl.
19 Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055,
20 subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl
21 is classified as a potent synthetic opioid. When properly prescribed and indicated, it is used for the
22 treatment of pain relief. It is approximately 100 times more potent than morphine and considered a drug
23 of abuse. (Drugs of Abuse, DEA Resource Guide (2017 edition), at p. 40.)

24 ¹¹ MS Contin is a brand name for morphine, a Schedule II controlled substance pursuant to Health
25 and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and
26 Professions Code section 4022.

27 ¹² Warfarin is an anticoagulant, or blood thinner, commonly prescribed to prevent blood
28 clot formations. It is a dangerous drug pursuant to Business and Professions Code section 4022.

¹³ Atenolol is commonly prescribed to treat high blood pressure and chest pain. It is a
dangerous drug pursuant to Business and Professions Code section 4022.

¹⁴ Zofran is an anti-nausea medication commonly prescribed to prevent nausea and
vomiting caused by cancer medication. It is a dangerous drug pursuant to Business and Professions
Code section 4022.

1 19. On or about March 24, 2017, Patient A presented for an office visit with Respondent
2 to refill her prescriptions. According to records, Respondent noted Patient A still needed to
3 maintain her prescriptions for MS Contin and fentanyl citrate for pain, and intravenous Benadryl
4 for hives and swelling. According to records, Respondent documented a plan to remove Patient
5 A's Hickman catheter in the near future.

6 20. On or about October 9, 2017, Patient A presented for an office visit with Respondent.
7 According to records, Patient A had moved to northern California where culture testing revealed
8 the presence of E. coli and staph in her sinuses. According to records, Respondent was still
9 prescribing intravenous Benadryl and oral narcotics to Patient A, with a plan to taper over the
10 next three (3) months. In his review of systems, Respondent noted Patient A was negative for
11 anxiety and positive for nausea, vomiting, fatigue, insomnia and chronic paresthesia. According
12 to records, Patient A's current medication list for this date identified alprazolam¹⁵ in addition to
13 the other previous medications, including, but not limited to, fentanyl citrate and MS Contin.¹⁶
14 Records do not reflect the performance of an evaluation by Respondent to support Patient A's
15 prescription for alprazolam.

16 21. On or about December 8, 2017, Patient A presented for an office visit with
17 Respondent. According to records, Patient A was concerned about her Hickman catheter being
18 infected. According to records, Patient A's medications at this time included, but was not limited

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22 ¹⁵ Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to Health and
23 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
24 Code section 4022. Alprazolam is classified as a short-acting benzodiazepine. When properly prescribed
and indicated, it is commonly used to relieve anxiety.

25 ¹⁶ All opioids carry a Black Box Warning that states, in part, "assess opioid abuse or addiction risk
26 prior to prescribing; monitor all patients for misuse, abuse, and addiction." The combination of opioids
27 with benzodiazepines is among the most common causes of death due to prescription drug overdose. The
28 Black Box Warning for opioids states, "Concomitant opioid use with benzodiazepines... may result in
profound sedation, respiratory depression, coma, and death; reserve concomitant use for patients with
inadequate alternative treatment options; limit to minimum required dosage and duration."

1 to, fentanyl citrate (0.6 mg, #120) and MS Contin (100 mg, #120), equating to a morphine
2 equivalent dose (MED)¹⁷ over 700 mg per day, in addition to alprazolam (2 mg, #120).

3 22. On or about December 27, 2017, Patient A presented for an office visit with
4 Respondent to follow up about her Hickman catheter infection site. According to records, Patient
5 A's medications at this time included, but was not limited to, fentanyl citrate (0.6 mg, #120) and
6 MS Contin (100 mg, #120), equating to an MED over 700 mg per day, and alprazolam (2 mg,
7 #120). According to records, Respondent and Patient A discussed a plan to taper Patient A off
8 her intravenous Benadryl over the next thirty (30) days.

9 23. On or about March 12, 2018, Patient A presented for an office visit with Respondent
10 after being diagnosed with pneumonia in northern California where Patient A was living at the
11 time. According to records, Respondent noted Patient A appeared to be in distress, with an
12 oxygen saturation of approximately 84%. Respondent confirmed the diagnosis of pneumonia and
13 referred Patient A to a local emergency department for treatment.

14 24. On or about April 5, 2018, Patient A presented for an office visit with Respondent for
15 follow up after her recent hospitalization. According to records, Patient A's current medication
16 list for this date identified the continuation of Patient A's prescription for MS Contin (100 mg,
17 #90), and the addition of Oxycodone¹⁸ (20 mg, #120), equating to an MED of 420 mg per day.
18 Records for this date do not identify alprazolam under Patient A's current medications, despite

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21
22 ¹⁷ Morphine Equivalent Dose (MED), also commonly referred to as Morphine Milligram
23 Equivalent (MME or MEQ), is a calculation used to equate different opioids into one standard value,
24 based on morphine and its potency, referred to as MED. MED calculations permit all opioids to be
converted to an equivalent of one medication, for ease of comparison and risk evaluations. In general, the
standard of practice is to limit a patient's daily opioid dose to less than 50 MED in most patients receiving
opioid treatment for chronic pain, and to exceed 90 MED in only the most unusual circumstances.

25 ¹⁸ Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section
26 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.
27 When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.
28 Oxycodone is classified as a synthetic opioid. The Drug Enforcement Administrative (DEA) has
identified opioids, such as Oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017
Edition), p. 47.)

1 being continuously prescribed by Respondent to Patient A per the Controlled Substance
2 Utilization Review and Evaluation System¹⁹ (CURES).

3 25. On or about May 15, 2018, Patient A presented for an office visit with Respondent.
4 According to records, Patient A's current medication list for this date indicated MS Contin (100
5 mg, #90), Oxycodone (20 mg, #120), equating to an MED of 420 mg per day, and alprazolam (2
6 mg, #120). According to records, Patient A had discontinued her intravenous Benadryl and
7 informed Respondent that she rarely took alprazolam and only took MS Contin twice a day,
8 relying mostly on Oxycodone for pain control. According to records, Patient A indicated her self-
9 reduction in medications was due to Patient A's fear of increasing tolerance. According to
10 records, despite Patient A's lowered intake, Respondent continued Patient A's prescriptions,
11 including, but not limited to, MS Contin (100 mg, #90), Oxycodone (20 mg, #120), and
12 alprazolam (2 mg, #90).

13 26. On or about August 16, 2018, Patient A presented for an office visit with Respondent.
14 According to records, Patient A had reduced her use of alprazolam and exhibited significant
15 weight loss. According to records, Respondent's plan for Patient A was to reduce and eventually
16 stop her prescription for Oxycodone and increase her prescription for MS Contin. According to
17 records, Respondent issued prescriptions to Patient A for MS Contin (100 mg, #90), Oxycodone
18 (20 mg, #120), equating to an MED of 420 mg per day, and alprazolam (2 mg, #90).

19 27. On or about January 28, 2019, Patient A presented for an office visit with Respondent
20 to discuss her medications. According to records, Respondent discontinued Patient A's
21 prescription for Oxycodone and increased her prescription for MS Contin from three (3) per day
22 to four (4) per day (100 mg, #120), equating to an MED of 400 mg per day. According to

23
24 ¹⁹ The Controlled Substance Utilization Review and Evaluation System (CURES) is a program
25 operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to
26 ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in
27 their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.)
28 California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and
IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf.
Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a
specific patient based on the data contained in CURES is available to a health care practitioner who is
treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

1 records, Respondent also issued a prescription for Narcan²⁰ to Patient A, but Respondent's
2 records do not reflect or document any discussion with Patient A regarding this prescription for
3 Narcan. According to records, Respondent continued Patient A's prescription for alprazolam (2
4 mg, #120) without any documentation of an assessment of her anxiety levels or explanation for
5 the increase in quantity.

6 28. On or about July 18, 2019, Patient A presented for an office visit with Respondent.
7 According to records, since the last visit, Patient A had been placed in a coma due to sepsis in her
8 intravenous line, fractured her right ankle, and gained significant weight. Records also note
9 Patient A now suffered from a chronic bladder infections, yeast infections and frequent diarrhea.
10 According to records, Respondent and Patient A discussed alternative medications and decided to
11 add liquid morphine concentrate (20 mg/5 mL) for breakthrough episodes. According to records,
12 Respondent issued prescriptions to Patient A for MS Contin (100 mg, #120) and morphine sulfate
13 (20 mg/5 mL, #200), equating to an MED of 520 mg per day, and alprazolam (2 mg, #100).

14 29. On or about January 24, 2020, Patient A presented for an office visit with
15 Respondent. According to records, Patient A complained of persistent pain in the pelvic and
16 vaginal area. According to records, Respondent continued Patient A's prescriptions but noted a
17 plan to switch alprazolam for lorazepam²¹ at the next visit. Records for this visit do not document
18 the reason for this change or any assessment of Patient A's anxiety. According to records, Patient
19 A's current medication list as prescribed by Respondent included MS Contin (100 mg, #120) and
20 morphine sulfate (20 mg/5 mL, #200), equating to an MED of 520 mg per day, and alprazolam (2
21 mg, #60).

22 30. On or about May 19, 2020, Patient A presented for an office visit with Respondent.
23 According to records, Patient A was still living in northern California and had recently sustained
24

25 ²⁰ Narcan, brand name for naloxone, is a medication used to counteract and treat suspected opioid
26 overdose. It is a dangerous drug pursuant to Business and Professions Code section 4022.

27 ²¹ Lorazepam, brand name Ativan, is a Schedule IV controlled substance pursuant to Health and
28 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
Code section 4022. It belongs to a group of drugs called benzodiazepines. When properly prescribed and
indicated, it is commonly used to relieve anxiety.

1 another ankle fracture. According to records, Respondent had a discussion with Patient A about
2 her "high dose opiate medication regimen." According to records, Respondent diagnosed Patient
3 A with anxiety disorder but still did not document an appropriate assessment of Patient A's
4 anxiety levels. According to records, Respondent continued Patient A's prescriptions, including,
5 but not limited to, MS Contin (100 mg, #120) and morphine sulfate (20 mg/5 mL, #200), equating
6 to an MED of 520 mg per day, and alprazolam (2 mg, #60).

7 31. At no time throughout Respondent's care and treatment of Patient A did Respondent
8 perform and/or document the performance of an in depth discussion with Patient A regarding the
9 risks associated with taking high dose opioids and the risks of combining opioids with
10 benzodiazepines.

11 32. At no time throughout Respondent's care and treatment of Patient A did Respondent
12 obtain and/or document the obtaining of a pain agreement between Patient A and Respondent
13 regarding her use of controlled substances and multiple pharmacies.

14 33. At no time throughout Respondent's care and treatment of Patient A did Respondent
15 review and/or document any review of CURES, any requests for urine drug screens, or any other
16 careful review for aberrant behaviors as indications of possible diversion, abuse or tolerance.

17 34. At no time throughout Respondent's care and treatment of Patient A did Respondent
18 refer and/or document a referral for Patient A to a pain management specialist, psychiatrist, or
19 any other physician in northern California where Patient A was living.

20 35. On or about August 25, 2020, Respondent attended a subject interview with HQUI
21 investigators. During the interview, Respondent admitted he rarely reviewed CURES, and when
22 he was inclined to review CURES, this review was not documented. Respondent also indicated
23 he did not have a written pain agreement with Patient A, but a verbal understanding to the same
24 effect. Respondent admitted he failed to document Patient A's opioid dependence or tolerance, or
25 any referrals to psychiatry or a pain management. Respondent also indicated he often
26 communicated with Patient A by phone and text after her move to northern California, but these
27 communications were not documented in Patient A's record. Respondent also admitted not

28 ///

1 having a signed release by Patient A to authorize his communications with Patient A's mother
2 about Patient A's health.

3 36. From as early as May 2014, through in or around December 2015, according to
4 CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances,
5 including, but not limited to, MS Contin, fentanyl citrate, and alprazolam.

6 37. From in or around January 2016, through in or around December 2016, according to
7 CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances,
8 including, but not limited to, twelve (12) prescriptions for MS Contin (100 mg, #120), thirteen
9 (13) prescriptions for fentanyl citrate (0.6 mg, #120), and five (5) prescriptions for alprazolam (2
10 mg, #120).

11 38. From in or around January 2017, through in or around December 2017, according to
12 CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances,
13 including, but not limited to, eleven (11) prescriptions for MS Contin (100 mg, #120), fourteen
14 (14) prescriptions for fentanyl citrate (0.6 mg, #120), and nine (9) prescriptions for alprazolam (2
15 mg, #120). From in or around January 2017, through in or around December 2017, according to
16 records, Patient A had office visits with Respondent on four (4) separate occasions, March 24,
17 2017; October 9, 2017; December 8, 2017; and December 27, 2017.

18 39. From in or around January 2018, through in or around December 2018, according to
19 CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances,
20 including, but not limited to, twelve (12) prescriptions for MS Contin (100 mg, #90-120), two (2)
21 prescriptions for fentanyl citrate (0.6 mg, #120), twelve (12) prescriptions for alprazolam (2 mg,
22 #90-120), and ten (10) prescriptions for oxycodone (20 mg, #120). From in or around January
23 2018, through in or around December 2018, according to records, Patient A had office visits with
24 Respondent on four (4) separate occasions, March 12, 2018; April 5, 2018; May 15, 2018; and
25 August 16, 2018.

26 40. From in or around January 2019, through in or around December 2019, according to
27 CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances,
28 including, but not limited to, thirteen (13) prescriptions for MS Contin (100 mg, #90-120), five

1 (5) prescriptions for morphine sulfate (20 mg/5 mL, #200), one (1) prescription for oxycodone
2 (20 mg, #120), and thirteen (13) prescriptions for alprazolam (2 mg, #60-120). From in or around
3 January 2019, through in or around December 2019, according to records, Patient A had office
4 visits with Respondent on two (2) separate occasions, January 28, 2019 and July 18, 2019.

5 41. From in or around January 2020, through in or around December 2020, according to
6 CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances,
7 including, but not limited to, thirteen (13) prescriptions for MS Contin (100 mg, #80-120), ten
8 (10) prescriptions for morphine sulfate (20 mg/5 mL, #200), and twelve (12) prescriptions for
9 alprazolam (2 mg, #60). From in or around January 2020, through in or around December 2020,
10 according to records, Patient A had office visits with Respondent on two (2) separate occasions,
11 January 24, 2020 and May 19, 2020.

12 **Patient B**

13 42. On or about June 9, 2016, Patient B, a then 67-year-old female, an established patient
14 with Respondent since in or around 2012, presented for an office visit with Respondent. Patient
15 B's medical history was significant for, among other things, chronic pain syndrome, lumbar disc
16 degeneration, hypertension, diabetes, diabetic neuropathy, chronic arthritis, anxiety, depression
17 and ankle fracture. In or around 2014, Respondent took over the care of Patient B's pain
18 management, in addition to continuing as her primary care physician. According to records for
19 this visit with Respondent, Patient B presented for a review of laboratory results and complaints
20 of perineal itching. According to records, Respondent was prescribing several medications to
21 Patient B, including, but not limited to, hydrocodone-acetaminophen (10/325),²² fentanyl

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25 ²² Hydrocodone-acetaminophen (10/325), brand name Norco, is a drug combination of
26 hydrocodone (10 mg) and acetaminophen (325 mg). Hydrocodone is a Schedule II controlled substance
27 pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to
28 Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the
treatment of moderate to moderately severe pain. The DEA has identified opioids, such as hydrocodone,
as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

1 transdermal patch (50 mcg/hour),²³ lisinopril hydrochlorothiazide,²⁴ citalopram.²⁵ According to
2 CURES, Respondent was also issuing regular prescriptions to Patient B for alprazolam beginning
3 in or around 2014. According to records for this visit, Respondent's assessment of Patient B
4 determined Patient B was negative for anxiety, depression and sleep disturbances. According to
5 records, Respondent continued Patient B's diagnoses for chronic pain syndrome and diabetes.
6 Respondent also assessed Patient B with pruritus²⁶ and prescribed Diflucan.²⁷

7 43. On or about December 27, 2016, Patient B presented for an office visit with
8 Respondent. According to records, Patient B presented with complaints of experiencing
9 difficulty swallowing. According to records for this visit, Respondent noted Patient B was
10 positive for anxiety, continued Patient B's diagnosis of chronic pain and added a new diagnosis
11 for dysphagia.²⁸ According to records, Patient B's current medication list for this date remained
12 unchanged and still did not reflect Respondent's regular prescriptions of alprazolam to Patient B.

13 44. On or about May 2, 2017, Patient B presented for an office visit with Respondent.
14 According to records, Patient B presented with complaints of a rash. According to records,
15 Respondent noted Patient B was negative for anxiety, depression and sleep disturbances.
16 According to records, Patient B's current medication list for this date remained unchanged and
17 still did not reflect Respondent's regular prescriptions of alprazolam to Patient B.

18 45. On or about May 9, 2017, Patient B presented for an office visit with Respondent for
19 a follow up on her recent past conditions. According to records, Respondent noted Patient B was

20
21 ²³ Fentanyl transdermal patch, brand name Duragesic, is a transdermal patch commonly used to
22 treat chronic and severe pain in opioid tolerant patients. The maximum dose for fentanyl patches is 100
mcg per hour for a maximum dose of 2,400 mcg per day. See Footnote 10.

23 ²⁴ Lisinopril hydrochlorothiazide is commonly prescribed to treat high blood pressure. It is a
dangerous drug pursuant to Business and Professions Code section 4022.

24 ²⁵ Citalopram is commonly prescribed to treat depression. It is a dangerous drug pursuant to
25 Business and Professions Code section 4022.

26 ²⁶ Pruritus is a condition involving itchy skin often caused by dry skin.

27 ²⁷ Diflucan, brand name for fluconazole, is an antifungal medication commonly prescribed to treat
28 fungal infections. It is a dangerous drug pursuant to Business and Professions Code section 4022.

²⁸ Dysphagia is the medical term for swallowing difficulties.

1 negative for anxiety, depression and sleep disturbances. According to records, Patient B's current
2 medication list for this date remained unchanged and still did not reflect Respondent's regular
3 prescriptions of alprazolam to Patient B.

4 46. On or about November 21, 2017, Patient B presented for an office visit with
5 Respondent. According to records, Patient B presented for her annual exam. According to
6 records for this visit, Respondent noted Patient B had an onset of depression since in or around
7 2013, but in his history of present illness and evaluation of Patient B, Respondent noted Patient B
8 showed no signs or symptoms of depression, no history of depression, and normal mood and
9 affect. Respondent further noted Patient B had no history of fractures or prior musculoskeletal
10 injuries. According to records, Respondent's list of diagnoses for Patient B, included, but was not
11 limited to, chronic pain, anxiety, and mixed anxiety and depressive disorder. According to
12 records, Respondent issued prescriptions to Patient B for, among other things, alprazolam and
13 hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks
14 associated with combining opioids and benzodiazepines.

15 47. On or about February 2, 2018, Patient B presented for an office visit with
16 Respondent. According to records, Patient B presented with complaints of an infection on her
17 foot. According to records, Respondent continued Patient B's medications, but no longer listed
18 diagnoses for anxiety or depression.

19 48. On or about April 6, 2018, Patient B presented for an office visit with Respondent.
20 According to records, Respondent noted Patient B did not show signs of depression or anxiety.
21 According to records, Patient B's current medication list for this date remained unchanged and
22 continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl
23 transdermal patches and hydrocodone-acetaminophen.

24 49. On or about April 13, 2018, Patient B presented for an office visit with Respondent
25 for a follow up on her recent past conditions. According to records, Patient B's diagnosis for
26 mixed anxiety and depressive disorder is listed under assessment and plan without any further
27 details regarding Respondent's assessment.

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1 50. On or about June 5, 2018, Patient B presented for an office visit with Respondent for
2 a follow up on her recent past conditions. According to records, Patient B's diagnosis for mixed
3 anxiety and depressive disorder is removed and Respondent now indicated a diagnosis for
4 anxiety, without any further details regarding Respondent's assessment. According to records,
5 Patient B's current medication list for this date remained unchanged and continued to show
6 current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal
7 patches and hydrocodone-acetaminophen.

8 51. On or about July 5, 2018, Patient B presented for an office visit with Respondent.
9 According to records, Patient B presented with complaints of foot issues. According to records,
10 Patient B's current medication list for this date remained unchanged and continued to show
11 current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal
12 patches and hydrocodone-acetaminophen.

13 52. On or about July 26, 2018, Patient B presented for an office visit with Respondent to
14 follow up on her foot issues. According to records, Respondent's plan and assessment for Patient
15 B included directions to continue taking citalopram for her diagnosis of major depressive
16 disorder, with no further documentation or details regarding Respondent's assessment of Patient
17 B's mental condition. According to records, Patient B's current medication list for this date
18 remained unchanged and continued to show current prescriptions for, among other things,
19 alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen.

20 53. On or about October 1, 2018, Patient B presented for an office visit with Respondent
21 to follow up on her foot issues. According to records, Respondent's plan and assessment for
22 Patient B included directions to continue taking alprazolam for her diagnosis of anxiety, with no
23 further documentation or details regarding Respondent's assessment of Patient B's mental
24 condition.

25 54. On or about October 30, 2018, according to CURES, this was the last prescription by
26 Respondent filled to Patient B for fentanyl transdermal patches.

27 55. On or about November 5, 2018, Patient B presented for an office visit with
28 Respondent. According to records, Respondent's plan and assessment for Patient B included

1 directions to continue taking alprazolam for her diagnosis of anxiety, with no further
2 documentation or details regarding Respondent's assessment of Patient B's mental condition.
3 According to records, Patient B's current medication list for this date remained unchanged and
4 continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl
5 transdermal patches and hydrocodone-acetaminophen.

6 56. On or about December 11, 2018, Patient B presented for an office visit with
7 Respondent. According to records, Respondent's plan and assessment for Patient B included
8 directions to continue taking alprazolam for her diagnosis of anxiety, with no further
9 documentation or details regarding Respondent's assessment of Patient B's mental condition, and
10 to continue taking hydrocodone-acetaminophen for her chronic low back pain, with no further
11 documentation or details regarding Respondent's assessment of Patient B's pain levels.
12 According to records, Patient B's current medication list for this date remained unchanged and
13 continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl
14 transdermal patches and hydrocodone-acetaminophen. Records for this visit do not reflect a
15 discussion regarding the risks associated with combining opioids and benzodiazepines.

16 57. On or about February 12, 2019, Patient B presented for an office visit with
17 Respondent. According to records, Patient B's current medication list for this date remained
18 unchanged and continued to show current prescriptions for, among other things, alprazolam,
19 citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen. Records for this visit
20 do not reflect a discussion regarding the risks associated with combining opioids and
21 benzodiazepines.

22 58. On or about March 5, 2019, Patient B presented for an office visit with Respondent.
23 According to records, Patient B requested a refill of her fentanyl transdermal patches for her
24 chronic pain. According to records for this visit, Respondent issued a prescription to Patient B
25 for fentanyl transdermal patches. However, according to CURES, Patient B's last prescription
26 filled for fentanyl transdermal patches was on October 30, 2018.

27 59. On or about March 15, 2019, Patient B presented for an office visit with Respondent.
28 According to records for this visit, Respondent issued a prescription to Patient B for fentanyl

1 transdermal patches. However, according to CURES, Patient B's last prescription filled for
2 fentanyl transdermal patches was on October 30, 2018. According to records, Patient B's current
3 medication list for this date remained unchanged and continued to show current prescriptions for,
4 among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-
5 acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated
6 with combining opioids and benzodiazepines.

7 60. On or about May 7, 2019, Patient B presented for an office visit with Respondent.
8 According to records, Respondent issued a prescription to Patient B for alprazolam without any
9 documented discussion or assessment of Patient B's anxiety. Records for this visit no longer
10 reflect fentanyl transdermal patches among Patient B's current medications and show no
11 documentation regarding the termination of this prescription.

12 61. On or about June 24, 2019, Patient B presented for an office visit with Respondent.
13 According to records, Patient B's current medication list for this date remained unchanged and
14 continued to show current prescriptions for, among other things, alprazolam, citalopram, and
15 hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks
16 associated with combining opioids and benzodiazepines. Records for this visit do not reflect a
17 discussion or assessment of Patient B's anxiety.

18 62. On or about July 12, 2019, Patient B presented for an office visit with Respondent.
19 According to records, Respondent issued a prescription to Patient B for alprazolam without any
20 documented discussion or assessment of Patient B's anxiety.

21 63. On or about October 3, 2019, Patient B presented for an office visit with Respondent.
22 According to records, Patient B reported experiencing severe nausea for several weeks.
23 According to records, Patient B's current medication list for this date remained unchanged and
24 continued to show current prescriptions for, among other things, alprazolam, citalopram, and
25 hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks
26 associated with combining opioids and benzodiazepines.

27 64. On or about October 10, 2019, Patient B presented for an office visit with
28 Respondent. According to records, Patient B's current medication list for this date remained

1 unchanged and continued to show current prescriptions for, among other things, alprazolam,
2 citalopram, and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion
3 regarding the risks associated with combining opioids and benzodiazepines.

4 65. On or about December 31, 2019, Patient B presented for an office visit with
5 Respondent. According to records, Patient B's current medication list for this date remained
6 unchanged and continued to show current prescriptions for, among other things, alprazolam,
7 citalopram, and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion
8 regarding the risks associated with combining opioids and benzodiazepines.

9 66. On or about May 15, 2020, Patient B presented for an office visit with Respondent.
10 According to records, Patient B's current medication list for this date remained unchanged and
11 continued to show current prescriptions for, among other things, alprazolam, citalopram, and
12 hydrocodone-acetaminophen. According to records, Respondent's plan and assessment for
13 Patient B's lumbar spine degeneration was to continue with her current opiate regimen, and to
14 continue with citalopram and alprazolam for Patient B's depressive disorder. Records for this
15 visit do not reflect a discussion or assessment of Patient B's depression or anxiety. Records for
16 this visit do not document a discussion regarding the risks associated with combining opioids and
17 benzodiazepines.

18 67. At no time throughout Respondent's care and treatment of Patient B did Respondent
19 perform and/or document the performance of an in depth discussion with Patient B regarding the
20 risks associated with combining opioids with benzodiazepines.

21 68. At no time throughout Respondent's care and treatment of Patient B did Respondent
22 obtain and/or document the obtaining of a pain agreement between Patient B and Respondent
23 regarding Patient B's use of controlled substances and multiple pharmacies.

24 69. At no time throughout Respondent's care and treatment of Patient B did Respondent
25 review and/or document any review of CURES, any requests for urine drug screens, or any other
26 careful review for aberrant behaviors as indications of possible diversion, abuse or tolerance.

27 70. On or about November 4, 2020, Respondent attended a subject interview with HQIU
28 investigators. During the interview, Respondent admitted he rarely reviewed CURES, and when

1 he was inclined to review CURES, this review was not documented. Respondent also indicated
2 he did not have a written pain agreement with Patient B. Respondent also indicated he often
3 communicated with Patient B by phone and text, but these communications were not documented
4 in Patient B's record. When asked about the termination of Patient B's prescription for fentanyl
5 transdermal patches, Respondent indicated Patient B weaned herself off of fentanyl on her own,
6 and that there was no coordination with pain management physicians.

7 71. From as early as May 2014, through in or around December 2015, according to
8 CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,
9 including, but not limited to, fentanyl transdermal patches, hydrocodone-acetaminophen, and
10 alprazolam.

11 72. From in or around January 2016, through in or around December 2016, according to
12 CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,
13 including, but not limited to, eight (8) prescriptions for hydrocodone-acetaminophen (10/325 mg,
14 #120), four (4) prescriptions for fentanyl transdermal patches (50 mcg/hr, #15), and two (2)
15 prescriptions for alprazolam (0.5 mg, #60).

16 73. From in or around January 2017, through in or around December 2017, according to
17 CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,
18 including, but not limited to, ten (10) prescriptions for hydrocodone- acetaminophen (10/325 mg,
19 #120), four (4) prescriptions for fentanyl transdermal patches (50 mcg/hr, #15), and nine (9)
20 prescriptions for alprazolam (0.5 mg, #60-120).

21 74. From in or around January 2018, through in or around December 2018, according to
22 CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,
23 including, but not limited to, twelve (12) prescriptions for hydrocodone-acetaminophen (10/325
24 mg, #120), four (4) prescriptions for fentanyl transdermal patches (50 mcg/hr, #15), and five (5)
25 prescriptions for alprazolam (0.5 mg, #60).

26 75. From in or around January 2019, through in or around December 2019, according to
27 CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,

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1 including, but not limited to, twelve (12) prescriptions for hydrocodone-acetaminophen (10/325
2 mg, #120), and six (6) prescriptions for alprazolam (0.5 mg, #60).

3 76. From in or around January 2020, through in or around December 2020, according to
4 CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,
5 including, but not limited to, twelve (12) prescriptions for hydrocodone-acetaminophen (10/325
6 mg, #120), and eight (8) prescriptions for alprazolam (0.5 mg, #60).

7 **FIRST CAUSE FOR DISCIPLINE**

8 **(Gross Negligence)**

9 77. Respondent has subjected his Physician's and Surgeon's Certificate No. C 37249 to
10 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of
11 the Code, in that he committed gross negligence in his care and treatment of Patient A, which
12 included, but was not limited to, the following:

13 A. Paragraphs 16 through 41, above, are hereby incorporated by reference and
14 realleged as if fully set forth herein;

15 B. Respondent prescribed opioids in excessive amounts to Patient A over several
16 years without corresponding office appointments, ongoing monitoring, appropriate
17 risk mitigation, or risk stratification;

18 C. Respondent prescribed benzodiazepines in extremely high levels to Patient A
19 over several years without an appropriate evaluation to support a diagnosis to justify
20 high dose benzodiazepines, an evaluation by a mental health expert or psychiatrist,
21 corresponding office appointments, ongoing monitoring, appropriate risk mitigation,
22 or risk stratification;

23 D. Respondent prescribed a combination of high dose opioids in combination with
24 high levels of benzodiazepines to Patient A over several years without corresponding
25 office appointments, ongoing monitoring, appropriate risk mitigation, or risk
26 stratification; and

27 E. Respondent failed to perform appropriate ongoing monitoring of Patient A
28 while prescribing controlled substances, including, but not limited to, CURES

1 database review, urine drug screens, pain evaluations, and regular monthly office
2 visits.

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Repeated Negligent Acts)**

5 78. Respondent has further subjected his Physician's and Surgeon's Certificate No.
6 C 37249 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
7 subdivision (c), of the Code, in that Respondent committed repeated negligent acts as more
8 particularly alleged hereinafter.

9 79. Respondent committed repeated negligent acts in his supervision of his medical
10 assistant, S.M., in that he permitted his medical assistant, S.M., an unlicensed person, to engage
11 in the practice of medicine, including, but not limited to, permitting S.M. to approve, deny, and/or
12 issue prescription refills for patients without Respondent's involvement, as more particularly
13 alleged in paragraphs 13 through 15, above, which are hereby incorporated by reference and
14 realleged as if fully set forth herein.

15 80. Respondent committed repeated negligent acts in his care and treatment of Patient A,
16 which included, but was not limited to, the following:

17 A. Paragraphs 16 through 41, and 77, above, are hereby incorporated by reference
18 and realleged as if fully set forth herein;

19 B. Respondent failed to discuss and/or document a discussion with Patient A
20 regarding the risks of taking controlled substances, risks associated with the high
21 doses prescribed, and risks presented when combining opioids with benzodiazepines;
22 and

23 C. Respondent failed to accurately and thoroughly document his care and
24 treatment with Patient A, including, but not limited to, failure to document an
25 adequate and appropriate history and physical examination prior to refilling
26 controlled substances on a monthly basis, failure to document the performance of
27 musculoskeletal examinations during office visits, failure to accurately document all
28 medications prescribed to Patient A during office visits, failure to document his basis

1 for prescribing alprazolam and Narcan, failure to document informed consent, and
2 failure to document telephone conversations and text messages with Patient A.

3 81. Respondent committed repeated negligent acts in his care and treatment of Patient B,
4 which included, but was not limited to, the following:

5 A. Paragraphs 42 through 76, above, are hereby incorporated by reference and
6 realleged as if fully set forth herein;

7 B. Respondent prescribed a combination of opioids and benzodiazepines to Patient
8 B without appropriate ongoing monitoring, risk mitigation, and accurate
9 documentation;

10 C. Respondent failed to discuss and/or document a discussion with Patient B
11 regarding the risks of taking controlled substances, and risks presented when
12 combining opioids with benzodiazepines;

13 D. Respondent failed to accurately and thoroughly document his care and
14 treatment with Patient B, including, but not limited to, failure to document an
15 adequate and appropriate history and physical examination prior to refilling
16 controlled substances on a monthly basis, failure to accurately document all
17 medications prescribed to Patient B during office visits (identifying fentanyl on
18 Patient B's medication list long after it has been discontinued, and not identifying
19 alprazolam for months after first prescribing alprazolam to Patient B), failure to
20 document his basis for prescribing alprazolam, failure to document informed consent,
21 and failure to document telephone conversations and text messages with Patient B;
22 and

23 E. Respondent failed to perform appropriate ongoing monitoring of Patient B
24 while prescribing controlled substances, including, but not limited to, CURES
25 database review, urine drug screens, pain evaluations, attempts at risk mitigation, and
26 regular monthly office visits.

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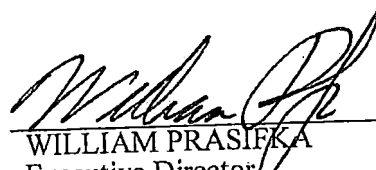
1 an unfitness to practice medicine, as more particularly alleged in paragraphs 13 through 84,
2 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

3 P R A Y E R

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

- 6 1. Revoking or suspending Physician's and Surgeon's Certificate No. C 37249, issued to
7 Respondent Richard Joseph Kempert, M.D.;
- 8 2. Revoking, suspending or denying approval of Respondent Richard Joseph Kempert,
9 M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 10 3. Ordering Respondent Richard Joseph Kempert, M.D., to pay the Board the costs of
11 the investigation and enforcement of this case, and if placed on probation, to pay the Board
12 the costs of probation monitoring;
- 13 4. Ordering Respondent Richard Joseph Kempert, M.D., if placed on probation, to
14 disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and
- 15 5. Taking such other and further action as deemed necessary and proper.

16
17 DATED: FEB 0 2 2022



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

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