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

In the Matter of the First Amended Accusation Against: **Timothy John Killeen, M.D.** **Physician's and Surgeon's Certificate No. G 55364** **Respondent.**	**Case No.: 800-2018-049909**

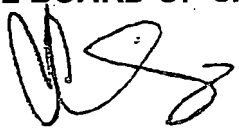
DECISION

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 14, 2022.

IT IS SO ORDERED: September 14, 2022.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the First Amended Accusation Against: **Timothy John Killeen, M.D.** **29645 Rancho California Road, Suite 226** **Temecula, CA 92591** **Physician's and Surgeon's Certificate No. G 55364,** Respondent.	Case No. 800-2018-049909 OAH No. 2021080687 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

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2. Respondent Timothy John Killeen, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, Esq., whose address is: 355 South Grand Ave., Ste. 1750, Los Angeles, CA 90071-1562.

3. On or about July 16, 1985, the Board issued Physician's and Surgeon's Certificate No. G 55364 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-049909, and will expire on February 28, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-049909, which superseded the Accusation filed on June 9, 2021, was filed before the Board on June 23, 2022, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on June 23, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of First Amended Accusation No. 800-2018-049909 is attached hereto as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-049909. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent admits that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in First Amended Accusation No. 800-2018-049909, and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. G 55364 to disciplinary action.

10. Respondent further agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2018-049909 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

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

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the

Board, all of the charges and allegations contained in First Amended Accusation No. 800-2018-049909 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 55364 issued to Respondent Timothy John Killeen, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years from the effective date of the Decision on the following terms and conditions:

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

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

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

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

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

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

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

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

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

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

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

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

notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

6. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $3,658.75 (three thousand six hundred fifty-eight dollars and seventy-five cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

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

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

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

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

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

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

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

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ACCEPTANCE

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

DATED: 7/12/22

TIMOTHY JOHN KILLEEN, M.D.
Respondent

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

DATED: 07/12/2022

DEREK F. O'REILLY-JONES, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 7/13/22

Respectfully submitted,

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

KAROLYN M. WESTFALL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2018-049909

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Timothy John Killeen, M.D.** **29645 Rancho California Road, Suite 226** **Temecula, CA 92591** **Physician's and Surgeon's Certificate No. G 55364,** Respondent.	Case No. 800-2018-049909 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about July 16, 1985, the Medical Board issued Physician's and Surgeon's Certificate Number G 55364 to Timothy John Killeen, M.D. (Respondent). The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2023, unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on June 9, 2021, is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2004 of the Code provides that the Board shall have the responsibility for the enforcement of the disciplinary provisions of the Medical Practice Act.

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

STATUTORY PROVISIONS

6. Section 2234 of the Code states, in part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
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7. Section 2266 of the Code states:

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

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

9. Acetaminophen/butalbital/caffeine (brand names of which include Fiorinal) is a combination medication used to treat certain types of headaches. Aspirin helps to decrease the pain from the headache. Caffeine helps increase the effects of aspirin. Butalbital is a sedative that helps to decrease anxiety and cause sleepiness and relaxation. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (c)(3), and a dangerous drug per Business and Professions Code section 4022.

10. Acetaminophen/codeine (brand names of which include Tylenol with codeine) is a combination of a narcotic pain reliever and a non-narcotic pain-and-fever reliever and is used to relieve pain. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(2), and a dangerous drug per Business and Professions Code section 4022.

11. ALS, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease) is a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord.

12. Butalbital/acetaminophen/caffeine/codeine (brand names of which include Fiorinal with codeine) adds the narcotic pain reliever codeine to acetaminophen/butalbital/caffeine. It is a Schedule III controlled substance pursuant to Health and Safety Code sections 11056, subdivision (c)(3), and 11056, subdivision (e)(2), and a dangerous drug per Business and Professions Code section 4022.

13. Fentanyl (available as a transdermal patch under the brand name Duragesic) is a narcotic drug used to help relieve severe, ongoing pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug per Business and Professions Code section 4022.

14. Hydrocodone/acetaminophen (brand names of which include Vicodin and Norco) is a narcotic pain reliever combined with a non-narcotic pain-and-fever reliever and is used to treat pain. Norco 10/325, for example, contains 10 mg of hydrocodone and 325 mg of acetaminophen. It was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), but as of September 20, 2018, it is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug per Business and Professions Code, section 4022.

15. Hydromorphone hydrochloride (brand names of which include Dilaudid) is a narcotic pain reliever. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug per Business and Professions Code, section 4022.

16. Hyperesthesia presents as a heightened sensitivity to any of the five basic senses: sound, sight, taste, touch and smell. Depending on which sense is affected, the hypersensitivity can cause pain.

17. Lorazepam (brand names of which include Ativan), a benzodiazepine, is a centrally acting hypnotic-sedative used to treat anxiety and insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code, section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code, section 4022.

18. Naloxone is a medication designed to rapidly reverse narcotic overdose. It is a narcotic antagonist, meaning that it binds to opioid receptors and can reverse and block the effects of narcotics. It can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with prescription narcotic pain medications.

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19. Oxycodone/acetaminophen (brand names of which include Percocet) is a narcotic pain reliever combined with a non-narcotic pain-and-fever reducer and is used to treat pain. Oxycodone/acetaminophen 10/325, for example, contains 10 mg of oxycodone and 325 mg of acetaminophen. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Business and Professions Code section 4022.

20. A pulmonary embolism is a blockage of an artery in the lungs by a substance that has moved from elsewhere in the body through the bloodstream.

21. Prednisone is a corticosteroid used to reduce the immune system's response to various diseases and to treat a variety of conditions such as arthritis, breathing problems, swelling, and allergy-type reactions. It is a dangerous drug as defined in Business and Professions Code section 4022.

22. Temazepam (brand names of which include Restoril), a benzodiazepine, is a centrally acting hypnotic-sedative used to treat insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug per Business and Professions Code section 4022.

23. A tracheostomy is a medical procedure that involves creating an opening in the neck in order to place a tube into a person's windpipe, allowing air to enter the lungs. It allows patients to breathe with less effort.

24. Tramadol is a narcotic used to relieve pain. It is a Schedule III controlled substance under Health and Safety Code section 11056, subdivision (e), and a dangerous drug per Business and Professions Code, section 4022.

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FACTUAL ALLEGATIONS

25. During the periods discussed below, Respondent practiced internal medicine with a subspecialty in pulmonary disease.

Patient P-1

26. Respondent treated patient P-1[1] intermittently for respiratory problems, beginning in the 1990's. More recently, during the period of review of Respondent's treatment of this patient, from 2015 through October 2019, Respondent was her primary care provider.

27. As of her March 4, 2015, visit, P-1 was 57 years old and had a history of asthma, breast cancer, insomnia, degenerative arthritis, diabetes, hypertension, and obesity. According to Respondent's June 24, 2020, interview with Board investigators (the "Board Interview"), P-1 also had a history of a myocardial infarction, chronic headaches, anxiety disorder, and depression. Among other medications, Respondent prescribed P-1 120 tablets of Vicodin 5 mg-500 mg every six hours as needed for unspecified "pain," and Fiorinal every six hours as needed for headaches. P-1 was concurrently being prescribed acetaminophen/codeine and lorazepam by another provider. Respondent did not document the patient's concurrent use of acetaminophen-codeine.

28. Respondent continued to prescribe the patient Fiorinal while she was concurrently being prescribed acetaminophen/codeine and lorazepam by another provider while seeing the patient approximately two to three times each year.

29. At her November 16, 2015, visit, Respondent recorded that the patient was also being prescribed a second benzodiazepine, temazepam, by another provider.

30. At her February 24, 2016, visit, the patient told Respondent that she would like to have just one doctor and asked Respondent to review her medications. Respondent noted that the patient "unfortunately has been on multiple medications for years and has seen multiple physicians and self prescribes and has been noncompliant with medications frequently."

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[1] The patients are designated in this document as patients P-1, P-2, P-3, and P-4 to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

31. Shortly thereafter, Respondent took over the patient's prescriptions by other providers. As of the patient's August 2, 2016, visit, Respondent prescribed the patient acetaminophen/codeine, lorazepam, and temazepam, in addition to Fiorinal.

32. At the patient's April 11, 2017, visit Respondent documented prescribing P-1 tramadol 50 mg every 4 hours as needed. Respondent noted his concern about the number of medications the patient had been using and that he had recently denied a number of her refill requests. Respondent documented discussing this issue with the patient, including his view that she does not need multiple medications for headaches and multiple pain relievers. The patient also asked for an excessive amount of anxiety medication for her brother. Last, Respondent noted that the patient showed signs of addiction to multiple medications when he had first met her.

33. Nonetheless, Respondent continued prescribing the patient Fiorinal, acetaminophen/codeine, lorazepam, and temazepam. Several of his records do not accurately reflect his ongoing prescriptions of each of these substances. In addition, Respondent's records routinely fail to state an indication for the medications, including even a related patient complaint.

34. At P-1's August 30, 2018, visit, Respondent documented his concern that the patient's medication misuse/overuse continued to be a problem and that her medications for migraines and temazepam should be discontinued. Nonetheless, Respondent continued to prescribe her these medications.

35. At P-1's November 19, 2018, visit, Respondent documented that he would like to discontinue the patient on Fiorinal and temazepam. He was concerned that an intervention would be needed to get her off some of her medications. Respondent ceased prescribing the patient Fiorinal, but continued prescribing her acetaminophen/codeine, lorazepam, and temazepam.

36. At the patient's June 3, 2019, visit, Respondent documented that he had been contacted by the Medical Board about an investigation of his narcotic prescriptions. The patient admitted that she had become dependent on narcotics. Respondent offered to send her to see a pain specialist. Respondent stopped prescribing temazepam but continued to prescribe her acetaminophen/codeine and lorazepam.

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Patient P-2

37. Respondent has treated patient P-2 since approximately 2002. During the period of review of Respondent's treatment of this patient, from 2015 through October 2019, Respondent was her primary care provider.

38. As of her July 28, 2016, visit, P-2 was 74 years old and had a history of severe hyperesthesia with related pain, fibromyalgia, chronic headaches, degenerative arthritis, and depression. The patient saw a rheumatologist who confirmed her fibromyalgia, but the patient did not want to continue seeing the rheumatologist. Among other medications, Respondent prescribed the patient Fiorinal with codeine for her headaches.

39. At the patient's next visit, on October 27, 2016, she complained of increasing pain. The pain was diffuse and included, in part, her chronic headaches, which neurology has evaluated. Respondent noted the patient's very low pain threshold and her extreme sensitivity to touch, stating, "There is no medical condition that produces this." The patient declined to return to the rheumatologist and had already seen a neurologist. Respondent's plan was to continue with pain medication as needed, although he noted that her pain will be impossible to control unless her pain threshold changes. Respondent continued to prescribe her Fiorinal with codeine for her headaches and also prescribed Dilaudid for severe pain. The Dilaudid is not reflected in the patient's medication lists in her chart.

40. Respondent saw the patient on February 7, 2017, for follow-up on her pain. The patient described her pain as diffuse and excruciating. Her headaches in particular had been severe. Respondent charted that the pain was likely due to an underlying psychiatric problem. He explained to the patient and her husband that he was not willing to increase the patient's dose of narcotics.

41. The patient filled prescriptions by Respondent for Dilaudid on February 23, 2017, July 7, 2017, January 18, 2018, and April 24, 2019. Respondent's charts and medication lists do not accurately document the timing of these prescriptions.

42. On April 19, 2017, the patient followed up with Respondent for pain in multiple areas. Respondent again documented his belief that there is a major psychiatric component to her

pain. Respondent continued to prescribe her Fiorinal with codeine among other medications. Respondent also documented that the patient has hydrocodone "available as needed," but this medication is not reflected in her medication lists.

43. On May 8, 2017, P-2 followed up with Respondent and reported feeling much better due to the addition of prednisone, which relieved her musculoskeletal pain (but not her headaches). Respondent continued her on the same medications as her last visit, including Fiorinal with codeine.

44. On August 14, 2017, the patient followed up with Respondent for diffuse pain. Respondent again charted that the patient's pain was due to a psychiatric illness and not a medical condition. Respondent prescribed her Fiorinal with codeine as well as Dilaudid.

45. The patient filled prescriptions by Respondent for temazepam on May 8, 2017. Thereafter, Respondent continued to regularly prescribe the patient temazepam, in addition to Fiorinal with codeine, through 2019. Respondent's records, including the medication lists, do not reflect that he prescribed the patient temazepam.

46. Shortly after the patient's November 13, 2017, visit, on November 22, 2017, and again on February 22, 2018, the patient filled prescriptions by Respondent for Fiorinal with codeine, but Respondent's records do not reflect these medications.

47. The patient filled prescriptions by Respondent for hydrocodone/acetaminophen on April 11, 2018, and Fiorinal with codeine on April 24, 2018, and July 3, 2018, but Respondent's records do not reflect these medications.

48. Respondent saw the patient on July 19, 2018, for follow-up on her pain. Respondent's exam revealed her to be depressed and anxious. Respondent documented a discussion about drug addiction. He planned to take her "off medication as opposed to increasing doses." He planned to prescribe tramadol, and he stated that he wanted her off muscle relaxants. He offered pain management but noted his hesitation, as he believes that pain management would prescribe the patient more medications instead of less. Respondent prescribed the patient tramadol.

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49. On April 23, 2019, P-2 followed-up with Respondent to request a refill of Dilaudid. Respondent noted that the patient struggles with narcotics use for pain relief. The plan was to not increase her narcotics dose. Respondent prescribed her tramadol.

50. At the patient's July 22, 2019, visit, Respondent prescribed her tramadol and Fiorinal with codeine. Her medication list does not reflect the Fiorinal with codeine.

51. At her September 23, 2019, visit, the patient again complained of diffuse pain. An exam showed her to be depressed. The plan was not to increase her narcotics dose. Respondent prescribed her tramadol.

Patient P-3

52. Respondent began treating patient P-3 for respiratory failure at the hospital, shortly before the patient's first office visit, on January 16, 2017. At the patient's first visit, he was 36-years-old and had a diagnosis of severe neuromuscular disease consistent with ALS. At the Board Interview, Respondent stated that the patient had ALS, but the patient had been in denial of his diagnosis and regularly sought to find another explanation for his condition. The patient had a history of a pulmonary embolism.

53. The patient complained of shortness of breath despite using a bilevel positive airway pressure machine to assist his breathing most of the time. The patient wanted to continue to aggressively treat his condition and prolong his life. Respondent's plan was to place a tracheostomy tube and start the patient on mechanical ventilation.

54. The patient filled a prescription by Respondent for 30 lorazepam .5 mg the day after his visit. Respondent continued to regularly prescribe the patient lorazepam for the duration of his treatment, through May 2019.

55. Shortly after his first visit, the patient also filled a prescription by Respondent for 60 Norco 5/325, on January 24, 2017. Respondent continued to regularly prescribe the patient Norco for the duration of his treatment, through May 2019. Respondent did not document an indication for these prescriptions, apart from unspecified "pain."

56. At the patient's next visit on May 11, 2017, Respondent documented prescribing him Norco 10/325 to be taken every four hours and lorazepam .5 mg three times per day. Respondent

documented that the lorazepam was "for anxiety," without any further details about the status of the patient's anxiety and the effectiveness of this medication in treating it.

57. The patient filled prescriptions by Respondent for tramadol on October 25, 2017, November 25, 2017, February 8, 2018, and November 20, 2018, none of which are reflected in Respondent's records or medication lists.

58. As of his November 21, 2017, visit, the patient had a tracheostomy placed and was ventilator dependent. Respondent noted that the patient was now quadriplegic, with paralysis in all of his limbs. Respondent documented continuing to prescribe the patient Norco 10/325 to be taken every four hours and lorazepam .5 mg three times per day.

59. The patient filled a prescription by Respondent on December 21, 2017 for oxycodone/acetaminophen, which is not reflected in Respondent's records.

60. The patient returned to Respondent's office on February 7, 2018, and May 8, 2018, and Respondent continued the patient's prescriptions of Norco 10/325 to be taken every four hours and lorazepam .5 mg three times per day.

61. The patient filled a prescription by Respondent on May 15, 2018, for a 30-day supply of Duragesic 50 mcg/hr, which is not reflected in Respondent's records. Respondent also prescribed the patient a 30-day supply of Duragesic 75 mcg/hr patches on November 28, 2018, which is not reflected in Respondent's records.

62. The patient's last visit was on December 26, 2018. At that visit, Respondent noted that the patient's condition continued to decline. The patient wanted to remain on life support but was considering palliative care. Respondent continued the patient's prescriptions of Norco 10/325 to be taken every four hours and lorazepam .5 mg three times per day.

63. According to Respondent's statements at the Board Interview, he continued to treat the patient after his last visit, but the patient could no longer come to the office. Respondent continued to prescribe the patient lorazepam and Norco through March 2019. Respondent also prescribed the patient 30-day supplies of Duragesic 75 mcg/hr patches on December 26, 2018, January 21, 2019, February 21, 2019, March 18, 2019, and May 7, 2019.

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64. According to Respondent's statements at the Board Interview, the patient began hospice care in approximately May 2019, at which point hospice care providers took over management of the patient's treatment and prescribing from Respondent.

Patient P-4

65. Respondent treated patient P-4 beginning in approximately 2010. During the period of review of Respondent's treatment of this patient, from 2015 through October 2019, Respondent was his primary care provider.

66. As of his January 30, 2017, visit, P-4 was 61- years-old and had diagnoses of coronary artery disease, severe chronic obstructive pulmonary disease (COPD), peripheral artery disease, degenerative arthritis, diabetes, and hypertension. The patient had a history of coronary bypass surgery. According to Respondent's statements at the Board Interview, the patient's cardiologist had informed the patient that he would not live much longer. Respondent also stated that the patient had a history of severe spine disease, resulting in musculoskeletal pain that was worsened by back surgery. Respondent stated at the Board Interview that he also provided the patient with palliative care, following the patient's diagnosis with end-stage heart and lung disease.

67. The patient complained of shortness of breath and reported his chest pain to be controlled. Among other medications, Respondent prescribed the patient Norco 10/325 to be taken every 4 hours (180 pills per month) for unspecified pain and 30 mg pills of temazepam to be taken once per day (30 pills per month) for sleep. Respondent continued to regularly prescribe the patient these medications at these dosages for the duration of his treatment, through 2018.

68. At his March 20, 2017, visit, the patient complained of increased chest pain, even at rest. At this and subsequent visits, Respondent continued to prescribe the patient Norco 10/325 and temazepam without documenting a detailed indication for these medications and without documenting their effectiveness.

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69. Respondent continued to see the patient at visits approximately every one to two months, through 2018. During this time, the patient learned that he was not a candidate for another bypass surgery or additional stents and that his only option to address his heart disease was a heart transplant. Ultimately, he chose not to pursue a heart transplant.

70. At the patient's May 31, 2018, visit, Respondent noted that the patient "has chronic pain and narcotic addiction which is becoming more of a problem and is likely a major contributing factor to his chest pains." Respondent noted that he would continue to work on the patient's narcotic addiction and noted his diagnosis of the patient with narcotic addiction in his assessment and plan. Respondent continued to prescribe the patient the same dosage of Norco 10/325 (6 per day) and temazepam.

71. At his August 9, 2018 visit, the patient complained of shortness of breath. Respondent documented that, "Of course it is no surprise that he has a COPD exacerbation with respiratory failure. He still smokes heavily and uses massive doses of narcotics." Respondent noted that the patient was angry because he wanted more narcotics than Respondent prescribed to him. ... Respondent recommended that the patient go to the hospital for his shortness of breath, but the patient declined to do so.

72. At the patient's December 6, 2018, visit, Respondent documented that he had tried to manage the patient's pain with fentanyl, but it did not seem to help so he discontinued it and continued to prescribe the patient Norco 10/325. Although the patient filled prescriptions by Respondent for fentanyl on September 4, 2018, and October 11, 2018, Respondent's records and medication lists do not reflect these prescriptions. Respondent noted the patient's ongoing narcotic dependence. Respondent continued to prescribe the patient both temazepam and 180 Norco 10/325 per month.

73. The patient died on January 17, 2019, due to respiratory arrest, respiratory failure, and COPD, with contributing conditions of severe coronary artery disease, diabetes, and hypertension.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence; Repeated Negligent Acts)

74. Respondent is guilty of unprofessional conduct and subject to disciplinary action under Code section 2234, subdivisions (b) (gross negligence) and (c) (repeated negligent acts), in that Respondent engaged in the conduct described above including but not limited to the following:

Patient P-1

75. Several of Respondent's records do not accurately reflect his prescriptions of narcotics and benzodiazepines to P-1. In addition, Respondent's records routinely fail to state an indication for these medications or their effect on her. Respondent's failure to maintain adequate and accurate records constitutes an extreme departure from the standard of care.

76. Respondent did not document assessing P-1's risk for misusing narcotic medication or her history of previous pain treatment. Nor did he obtain the patient's medical records from her previous provider and re-evaluate her for continued pain therapy. Respondent did not document functional goals for the patient's ongoing treatment with narcotic pain medication. Also, Respondent did not monitor her use of narcotics by checking for concurrent prescribing by other providers or requiring urine toxicology screens. Respondent's failure to adequately monitor and manage P-1's use of narcotic pain medication constitutes an extreme departure from the standard of care.

77. Respondent did not document advising P-1 of the risks and benefits of and alternatives to long term narcotic pain medication treatment. In particular, Respondent did not document warning the patient that her use of narcotics in combination with her asthma raised her risk of suffering from respiratory depression. In addition, Respondent did not require the patient to sign a pain management agreement setting forth expectations for the patient's responsible and safe use of narcotic pain medication. Respondent's failure to obtain written informed consent from the patient for her long-term narcotic pain treatment and to make use of a pain management agreement constitutes an extreme departure from the standard of care.

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78. Respondent's concurrent prescribing to P-1 of both narcotics and two types of benzodiazepines raised her risk of suffering from respiratory depression, particularly given her asthma. Respondent's failure to evaluate the patient for this risk, to discuss the risk and safer alternatives to these medications with her, and to prescribe her naloxone as an antidote for a potentially life-threatening accidental overdose from her prescribed narcotics and benzodiazepines constitutes an extreme departure from the standard of care.

Patient P-2

79. Respondent's records do not accurately reflect his prescriptions of narcotics and benzodiazepines to P-2, and medications are missing from her medication lists. In addition, Respondent's records fail to state an indication for prescribing the patient benzodiazepines or their effect on the patient. Respondent's failure to maintain adequate and accurate records constitutes an extreme departure from the standard of care.

80. Respondent did not document assessing P-2's risk for misusing narcotic medication or her history of previous pain treatment. Nor did he monitor her use of narcotics by checking for concurrent prescribing by other providers or requiring urine toxicology screens. Also, Respondent did not refer the patient to a pain medicine specialist for management of her complicated chronic pain or to a psychiatrist, despite documenting that the patient's pain was likely psychosomatic in nature. Respondent's failure to adequately monitor and manage P-2's use of narcotic pain medication constitutes an extreme departure from the standard of care.

81. Respondent did not document advising P-2 of the risks and benefits of and alternatives to long term narcotic pain medication treatment. In addition, Respondent did not require the patient to sign a pain management agreement setting forth expectations for the patient's responsible and safe use of narcotic pain medication. Respondent's failure to obtain written informed consent from the patient for her long-term narcotic pain treatment and to make use of a pain management agreement constitutes an extreme departure from the standard of care.

82. Respondent's concurrent prescribing to P-2 of both narcotics and benzodiazepines raised her risk of suffering from respiratory depression. Respondent's failure to evaluate the patient for this risk and to discuss the risk and safer alternatives to these medications with her; his

failure to refer the patient to a psychiatrist for exploration of alternatives to prescribing benzodiazepines; and his failure to prescribe her naloxone as an antidote for a potentially life-threatening accidental overdose from her prescribed narcotics and benzodiazepines constitutes an extreme departure from the standard of care.

Patient P-3

83. Respondent's records fail to adequately state an indication for his ongoing prescription of pain medication and benzodiazepines to P-3, or their effect on the patient. In addition, Respondent's records do not accurately reflect his prescriptions of narcotics to P-3, and medications are missing from his medication lists. Respondent's failure to maintain adequate and accurate records constitutes an extreme departure from the standard of care.

84. Respondent did not document assessing P-3's risk for misusing narcotic medication or his history of previous pain treatment. Respondent did not document functional goals for the patient's ongoing treatment with narcotic pain medication. Nor did he monitor his use of narcotics by checking for concurrent prescribing by other providers or requiring urine toxicology screens. Respondent's failure to adequately monitor and manage P-3's use of narcotic pain medication constitutes an extreme departure from the standard of care.

85. Respondent did not document advising P-3 of the risks and benefits of and alternatives to long term narcotic pain medication treatment. In particular, Respondent did not document warning the patient that his use of narcotics in combination with his impending respiratory failure and progressive neuromuscular decline increased his risk of suffering from respiratory depression. In addition, Respondent did not require the patient to sign a pain management agreement setting forth expectations for the patient's responsible and safe use of narcotic pain medication. Respondent's failure to obtain written informed consent from the patient for his long-term narcotic pain treatment and to make use of a pain management agreement constitutes an extreme departure from the standard of care.

86. Respondent's concurrent prescribing to P-3 of both narcotics and benzodiazepines raised his risk of suffering from respiratory depression, particularly given his impending respiratory failure and progressive neuromuscular decline. Respondent's failure to evaluate the

patient for this risk, to discuss the risk and safer alternatives to these medications with him, and to prescribe him naloxone as an antidote for a potentially life-threatening accidental overdose from his prescribed narcotics and benzodiazepines constitutes an extreme departure from the standard of care.

Patient P-4

87. Respondent's records fail to adequately state an indication for his ongoing prescription of pain medication and benzodiazepines to P-4, or their effect on the patient. Respondent's failure to maintain adequate records constitutes an extreme departure from the standard of care.

88. Respondent did not document assessing P-4's risk for misusing narcotic medication or his history of previous pain treatment. Respondent did not document functional goals for the patient's ongoing treatment with narcotic pain medication. Nor did he monitor his use of narcotics by checking for concurrent prescribing by other providers or requiring urine toxicology screens. Respondent's failure to adequately monitor and manage P-4's use of narcotic pain medication constitutes an extreme departure from the standard of care.

89. Respondent did not document advising the patient of the risks and benefits of and alternatives to long term narcotic pain medication treatment. In particular, Respondent did not document warning the patient that his use of narcotics in combination with his severe COPD increased his risk of suffering from respiratory depression. In addition, Respondent did not require the patient to sign a pain management agreement setting forth expectations for the patient's responsible and safe use of narcotic pain medication. Respondent's failure to obtain written informed consent from the patient for his long-term narcotic pain treatment and to make use of a pain management agreement constitutes an extreme departure from the standard of care.

90. Respondent's concurrent prescribing to P-4 of both narcotics and benzodiazepines raised his risk of suffering from respiratory depression, particularly given his severe COPD. Respondent's failure to evaluate the patient for this risk, to discuss the risk and safer alternatives to these medications with him, and to prescribe him naloxone as an antidote for a potentially life-threatening accidental overdose from his prescribed narcotics and benzodiazepines constitutes an

extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Inadequate Recordkeeping)

91. Respondent is subject to disciplinary action under Code section 2266 in that Respondent failed to maintain adequate and accurate records of his care of P-1, P-2, P-3, and P-4, as described above.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 55364, issued to Respondent Timothy John Killeen, M.D.;

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

3. Ordering Respondent Timothy John Killeen, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Timothy John Killeen, M.D., to pay the Medical Board of California the reasonable costs of the enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: JUN 23 2022

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

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