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

In the Matter of the Accusation Against: Dennis Scott Dasher, M.D. Physician's and Surgeon's Certificate No. G 39813 Respondent.	Case No. 800-2019-056050

DECISION

The attached Stipulated Surrender of License 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 May 01, 2023.

IT IS SO ORDERED April 24, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D.
Panel A

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
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Attorneys for Complainant

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

In the Matter of the Accusation Against: DENNIS SCOTT DASHER, M.D. 321 North Larchmont Blvd., Suite 404 Los Angeles, CA 90004 Physician's and Surgeon's Certificate G 39813, Respondent.	Case No. 800-2019-056050 OAH No. 2022100230 **STIPULATED SURRENDER OF LICENSE AND 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. This action was commenced by William Prasifka in his capacity as the Executive Director of the Medical Board of California (Board). Following his retirement, he was replaced by Reji Varghese, the Board's Interim Executive Director, who maintains this action solely in his official capacity, and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Dennis Scott Dasher, M.D. (Respondent) is represented in this proceeding by attorney Harold Greenberg, 2263 South Harvard Blvd. Los Angeles, CA 90018.

3. On July 2, 1979, the Board issued Physician's and Surgeon's Certificate No. G 39813 to Dennis Scott Dasher, M.D. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-056050 and will expire on February 28, 2025.

JURISDICTION

4. Accusation No. 800-2019-056050 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about April 20, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2019-056050 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-056050. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2019-056050, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

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

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

ORDER

IT IS HEREBY ORDERED THAT Respondent shall immediately surrender his DEA permit and shall provide documentary proof to the Board or its designee that Respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms.

Physician's and Surgeon's Certificate No. G 39813, issued to Respondent Dennis Scott Dasher, M.D., is surrendered and accepted by the Board, effective on April 30, 2023.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2019-056050 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $33,880 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2019-056050 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 3/14/2023

DENNIS SCOTT DASHER, M.D.
Respondent

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

DATED: 14 MAR 23

HAROLD GREENBERG
Attorney for Respondent

ENDORSEMENT

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

DATED: March 15, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-056050

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

In the Matter of the Accusation Against: **DENNIS SCOTT DASHER, M.D.** **321 North Larchmont Blvd., Suite 404** **Los Angeles, CA 90004** **Physician's and Surgeon's Certificate No. G 39813,** Respondent.	Case No. 800-2019-056050 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this 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 2, 1979, the Board issued Physician's and Surgeon's Certificate Number G 39813 to Dennis Scott Dasher, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2023, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

STATUTORY PROVISIONS

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

7. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from,

prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

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

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

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

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

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

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

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

9. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

10. 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.

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COST RECOVERY

11. Business and Professions Code section 125.3 states that:

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

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

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

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

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

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

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

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

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

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

(j) This section does not apply to any board if a specific statutory provision in

that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts – 6 Patients)

12. Respondent Dennis Scott Dasher, M.D. is subject to disciplinary action under section 2234, subdivisions (b) and (c), of the Code for the commission of acts or omissions involving gross negligence/repeated negligent acts in the care and treatment of Patients 1, 2, 3, 4, 5, and 6.[1] The circumstances are as follows:

Patient 1

13. Patient 1 (or "patient") is a fifty-five-year-old male,[2] who treated with Respondent from approximately 2013 through 2020.[3] Patient 1 had a history of AIDS neuropathy and was reported to be on oxycodone (an opiate painkiller, a Schedule II controlled substance, and a dangerous drug pursuant to section 4022 of the code), for the past six years, while he treated at the AIDS Healthcare Foundation (AHCF). AHCF would no longer give Patient 1 oxycodone, and the patient subsequently came to Respondent for treatment for various conditions, but primarily for pain management, although Respondent is an internal medicine doctor, and not a pain specialist.[4]

14. Per CURES (Controlled Substance Utilization Review and Evaluation System, a drug monitoring database for Schedule II through V controlled substances dispensed in California), Respondent was prescribing to Patient 1 dangerous controlled medications. Respondent did not

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[1] The patients are identified by number to protect their privacy.

[2] Patient 1's age is unclear as the records for this patient listed different dates, and Respondent verbally described a different age than the dates in the records.

[3] These are approximate dates based on the records available to the Board. It should be noted that the handwritten medical records for the six patients named in this Accusation were also transcribed by Respondent and/or his staff because the written records were illegible. There were many discrepancies/inconsistencies between the handwritten records and the transcribed records, as the transcriptions were not a literal "word for word" interpretation of the written records, but instead an "encapsulation" (Respondent's words), and that Respondent added material that was from his "best recollection."

[4] Specifically, Respondent told Board staff in an interview that Patient 1 came to him [Respondent] for pain management, and not internal medicine care. It appears that Respondent also treated the patient for other conditions (e.g., erectile dysfunction, hypertension, constipation) besides pain management, but the exams and histories were typically very limited and cursory, and did not adequately document the treatment(s), diagnoses, which were received by the patient.

have an opiate treatment agreement (e.g., in order to explain to the patient about the dangers of controlled medications, not to obtain multiple prescriptions/combinations from different doctors, to only use one pharmacy, etc.), with Patient 1 and failed to check CURES to see if other doctors were also prescribing dangerous controlled medications to the patient.

15. For example, CURES shows that on March 19, 2014,[5] Respondent prescribed 120 tablets of oxycodone to Patient 1, and that the patient was also prescribed the same controlled medication (i.e. oxycodone) by another doctor on the same day. Also, on October 12, 2015, Patient 1 was prescribed diazepam (a controlled medication used to treat anxiety and a dangerous drug pursuant to Code section 4022), and Percocet (a brand name of oxycodone) by another doctor, just three days after Respondent had prescribed 150 oxycodone tablets to Patient 1.[6]

16. Overall, Respondent's care and treatment of Patient 1 represents an extreme departure from the standard of care for Respondent's inappropriate prescribing of controlled substances to Patient 1, as well as for Respondent's maintenance of records and practice of editing his transcribed medical records. Respondent's inadequate assessment and documentation of Patient 1's pain condition and other illnesses also represents repeated negligent acts.

Patient 2

17. Patient 2 (or "patient") is a fifty-eight-year-old male, who treated with Respondent from approximately 2011 through 2019. The patient was, at times, homeless and had initial complaints of knee and shoulder pain. Patient 2 was also noted to drink alcohol heavily, in order to go to sleep. He also had a urine toxicology screen which was positive for methamphetamine. Patient 2 complained of depression and had a past history of using Zyprexa (antipsychotic used to treat mental disorders), Depakote (used to treat bipolar disorder), and Prozac (antidepressant).

18. Throughout Respondent's treatment of Patient 2, Respondent prescribed multiple controlled medications to Patient 2. Respondent told Patient 2 that he could not drink alcohol during treatment. Despite this, records showed that Respondent continued to prescribe Klonopin

[5] Care and treatment outside the statute of limitations is offered as examples of Respondent's pattern and practice of substandard care.

[6] This example of "doctor shopping" by Patient 1 is often a sign of substance abuse/illicit behavior.

(a.k.a. clonazepam, a Schedule IV benzodiazepine drug used for anxiety and a dangerous drug pursuant to Code section 4022), Norco/Vicodin[7] (an opiate painkiller, Schedule II drug and a dangerous drug pursuant to Code section 4022), and other controlled medications to Patient 2, despite noncompliance by the patient regarding treatment, and despite recent heavy drinking reported by the patient, who at times also reported multiple assaults, head trauma, falls, loss of consciousness, fractures, seizures, and other adverse effects from the medications prescribed.[8] Respondent also failed to adequately treat Patient 2's other conditions (e.g., alcoholic hepatitis, hepatic encephalopathy, lobar pneumonia, and other chest/lung problems, as well as psychiatric problems). Respondent's transcribed notes of his treatment of Patient 2 were often inconsistent from his handwritten notes for the same date/visit.

19. Overall, Respondent's care and treatment of Patient 2 represents an extreme departure from the standard of care for Respondent's inappropriate prescribing of controlled substances to Patient 2, who displayed signs of overt substance abuse (i.e., alcoholism), as well as for Respondent's inadequate documentation and inadequate treatment of Patient 2's conditions/illnesses, which represents repeated negligent acts.

Patient 3

20. Patient 3 (or "patient") is a fifty-seven-year-old female, who treated with Respondent from approximately 2010 to 2020, for various ailments. Respondent prescribed medications to Patient 3 primarily for pain and depression. Per Respondent, Patient 3 was a very "difficult" and "troublesome" patient who was previously on multiple controlled medications (e.g., Vicodin, temazepam, and Ambien, all dangerous drugs pursuant to Code section 4022), and would request early refills of her medications on numerous occasions. Patient 3's daughter accompanied the patient on every visit, and appeared to be in charge of Patient 3's medication.

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[7] The combination of benzodiazepines (e.g., Klonopin), and opiates (e.g., Norco), in conjunction with alcohol can be lethal.

[8] For example, on May 29, 2018, a caregiver for Patient 2 notified Respondent that Patient 2 was overusing the Klonopin and had another relapse of drinking alcohol. Despite this, records showed that Respondent continued to prescribe controlled medications (e.g., more Klonopin and Ambien (sleep aid)) to the patient.

21. During his treatment of Patient 3, Respondent prescribed multiple controlled medications (both opioids and benzodiazepines) to the patient, including Vicodin, Ativan, Norco, Xanax, Oxycontin, Percocet, fentanyl (all dangerous drugs pursuant to Code section 4022), among other medications. Patient 3 was also displaying signs of overt substance abuse. For example, on numerous occasions Patient 3 would come in earlier than scheduled to request early refills, would refuse/decline numerous treatments and less addictive medications (e.g., nonsteroidal anti-inflammatory drugs, such as aspirin or ibuprofen), or selective serotonin reuptake inhibitors (SSRIs),[9] for her pain and other conditions. Also, the patient would claim that she had lost her pills on multiple occasions. Records showed that Patient 3 was also receiving controlled substance prescriptions from other doctors, while the patient was treating with Respondent (Patient 3 even signed a pain agreement with one of the other doctors that she would not be receiving certain controlled medications from another physician).

22. Patient 3 had urine toxicology reports which were inconsistent with the prescriptions given. For example, screenings for the patient (as far back as 2014) were positive for [illegible], benzodiazepines, opiates, and alcohol. A screening on March 2018 noted that no opiates were present in Patient 3's system (although opiates were prescribed to the patient). It appeared that Respondent had concerns of diversion/illicit use of drugs from these inconsistent screenings, as far back as 2018, and even noted that the patient may have to find another doctor.[10] Despite these "red flags," Respondent failed to take active steps (e.g., pill counts, regular reviewing of CURES, etc.), to determine if he should stop prescribing controlled substances to the patient, nor did Respondent immediately cease treatment of the patient. Instead, records showed that Respondent continued to prescribe/refill dangerous medications for Patient 3.[11]

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[9] An example of an SSRI is Lexapro, a medication used to treat depression and generalized anxiety disorder. Lexapro is considered less dangerous than Xanax, which is a benzodiazepine.

[10] Respondent asserts that Patient 3 had an inability to pay for many treatments for her [illegible] conditions (e.g., physical therapy, acupuncture, psychiatry visits, workups for tachycardia, bowel problems, etc.), and that the patient had declined a referral to County where she could receive low cost treatment, but this referral is not documented.

[11] Respondent also asserts that the patient declined a referral to a methadone clinic, and that he believed the patient was not on methadone (medication used to treat narcotic addiction).

23. Overall, Respondent's care and treatment of Patient 3 represents an extreme departure from the standard of care for Respondent's inappropriate and excessive prescribing of controlled substances to Patient 3, as outlined above. Also, Respondent's continuous prescribing of addictive controlled substances to Patient 3 despite her signs of addiction and illicit behavior, represents repeated acts of negligence.

Patient 4

24. Patient 4 (or "patient") is a forty-nine-year-old male, who treated with Respondent from approximately 2016 to 2020. Patient 4 had a past history which included myocardial infarction, pulmonary embolism, obesity, anxiety, insomnia, and degenerative joint disease of the lumbar spine, for which he was reportedly taking oxycodone. Respondent prescribed controlled medications to Patient 4, including Halcion (for sleep), and later Ambien, Xanax (a benzodiazepine used for anxiety), and oxycodone (opiate pain medication).[12] Respondent had no documentation of the patient's high oxycodone dosing on presentation and did not check CURES. Nevertheless, Respondent prescribed to Patient 4 large doses of oxycodone, and gradually increased the dosage over time.

25. Patient 4 was also displaying signs of overt substance abuse. For example, on February 13, 2018, the patient complained that his medications had been stolen one week after receiving them and Respondent gave the patient an early refill of oxycodone and Xanax tablets. Patient 4 was also given early refills on multiple other occasions, despite warnings to the patient that he should not make such a request. Per Respondent, Patient 4 was also asked to have an MRI of his lumbar spine several times, but the patient did not ever complete an MRI. Despite these "red flags," and despite Respondent admitting that the patient may have been overusing the medications, Respondent did not check CURES or perform any toxicology screens for the patient.

26. Respondent also departed from the standard of care by not referring Patient 4 to a psychiatrist for management of anxiety/depression, not evaluating the patient for other causes of anxiety when Respondent increased the patient's anti-anxiety mediations, not adequately treating

[12] All dangerous drugs pursuant to section 4022 of the Code.

or documenting his treatment of the patient's weight/weight management (e.g., tracking the patient's weight via objective measures via scale,[13] medications, lifestyle, referral to nutritionist, etc.). Also, there was no documentation that Respondent adequately evaluated the patient's other conditions such as tachycardia and sleep management.

27. Overall, Respondent's care and treatment of Patient 4 represents an extreme departure from the standard of care for Respondent's inappropriate prescribing of controlled substances to the patient, who displayed signs of overt substance abuse, as well as for Respondent's inadequate documentation and inadequate treatment of Patient 4's conditions/illnesses, as outlined above, which represents repeated negligent acts.

Patient 5

28. Patient 5 (or "patient") is a forty-four-year-old male, who treated with Respondent from approximately 2010 through 2020. Patient 5 admitted to drinking alcohol three times a week and had various ailments including blood in stools, hemorrhoids, hyperlipidemia (high levels of fat in the blood), abdominal pain, back pain, and had hepatomegaly (enlarged liver). Respondent prescribed to Patient 5 multiple controlled medications (both opioids and benzodiazepines) including Norco, oxycodone/Percocet, Duragesic patch (fentanyl), Ativan (a sedative used to treat anxiety), Xanax, Zoloft, and naproxen (a powerful anti-inflammatory painkiller).[14]

29. Patient 5 was also displaying signs of overt substance abuse. For example, on June 30, 2016, the patient noted that he had used up his 100 tablets of Percocet in 23 days, and about two months later, on August 26, 2016, the patient claimed that airport staff had taken his Percocet. On each occasion, Respondent gave Patient 5 more pills. On June 19, 2017, the patient stated that he was using four to five oxycodone pills a day (approximately 200 morphine milligram equivalents (MME)[15] per day). Despite this, records show that a few months later, the

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[13] Respondent admitted that he often relied on the patient's self-reported weights because his office scale would not go over 300 lbs.

[14] All dangerous drugs pursuant to section 4022 of the Code.

[15] MME are values that represent the potency of an opioid dose relative to morphine. Patients taking 50 or greater MME daily are more at risk for problems related to opioid use. Very high dosages are 90 or greater MME a day.

patient's Duragesic frequency and oxycodone were both increased. On January and July of 2018, the patient also claimed that he had lost his oxycodone or had his medications stolen. Respondent stated that he could no longer give the patient oxycodone. However, Respondent prescribed the patient Percocet instead. Also, on November 29, 2018, a foot surgeon asked for the patient's pain medication to be reduced. Following the foot operation, records showed that Respondent increased Patient 5's Duragesic, and again prescribed oxycodone and Xanax for the patient. Patient 5 also had a toxicology screen that showed marijuana in his system.[16] On January 22, 2020, Patient 5 was felt to have opiate withdrawals. Yet, the patient was subsequently treated with Adderall[17] for possible attention deficit disorder (ADD), and later was diagnosed with COPD (chronic obstructive pulmonary disease), despite tests showing the contrary.

30. Overall, Respondent's care and treatment of Patient 5 represents an extreme departure from the standard of care for Respondent's inappropriate prescribing of controlled substances to the patient, who displayed signs of overt substance abuse, as well as for Respondent's inadequate documentation and inadequate treatment of Patient 5's conditions/illnesses, as outlined above, which represents repeated negligent acts.

Patient 6

31. Patient 6 (or "patient") is a fifty-six-year-old male, who treated with Respondent from approximately 2012 through 2020 for a knee injury, anxiety, insomnia, and other illnesses. The patient was referred to several different orthopedists for various musculoskeletal problems, and also saw a cardiologist.

32. Despite completing a knee operation back in 2012, Respondent was still prescribing dangerous controlled medications to the patient including Norco, oxycodone, Oxycontin, fentanyl patch, Percocet, Xanax, Ativan, Klonopin (a benzodiazepine for anxiety), trazadone (antidepressant), sertraline (for depression), Phenergan with codeine cough syrup, and other

[16] Despite these "red flags," Respondent did not check CURES on Patient 5, and felt that the patient's appearance and demeanor did not support drug diversion. Although Respondent asserts that alternative (non-opiate) treatment such as physical therapy was discussed, there was no documentation that Respondent followed up with same.

[17] A dangerous drug pursuant to section 4022 of the Code.

medications.[18] In a span of less than two months in 2017, Patient 6 had experienced two falls involving head trauma, syncope, and bone fracture. Despite these falls (which may have been the result of the patient experiencing adverse effects from the medications) records showed that after said falls, Respondent prescribed excessive amounts of controlled medications such as Percocet, Duragesic, and Klonopin, which amounted to more than 270 MME daily.

33. Overall, Respondent's care and treatment of Patient 6 represents an extreme departure from the standard of care for Respondent's inappropriate prescribing of controlled substances to the patient, as well as for Respondent's inadequate documentation and inadequate treatment of Patient 6's conditions/illnesses, as outlined above, which represents repeated negligent acts.

SECOND CAUSE FOR DISCIPLINE

(Excessive Prescribing – 6 Patients)

34. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Dennis Scott Dasher, M.D. is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to Patients 1, 2, 3, 4, 5, and 6 above.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Drugs to an Addict – 5 Patients)

35. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Dennis Scott Dasher, M.D. is subject to disciplinary action under section 2241 of the Code, in that Respondent furnished dangerous drugs to Patients 1, 2, 3, 4, and 5, who had signs of addiction to and/or diversion of controlled substances.

FOURTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prior Examination or Medical Indication – 6 Patients)

36. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Dennis Scott Dasher, M.D. is subject to disciplinary action under section 2242 of the

[18] All dangerous drugs pursuant to section 4022 of the Code.

Code, in that Respondent furnished dangerous drugs to Patients 1, 2, 3, 4, 5, and 6 above, without conducting an appropriate prior examination and/or medical indication.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records – 6 Patients)

37. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Dennis Scott Dasher, M.D. is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1, 2, 3, 4, 5, and 6 above, as well as for Respondent's practice of editing his transcribed medical records.

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 39813, issued to Respondent Dennis Scott Dasher, M.D.;

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

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

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

DATED: APR 20 2022

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