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

In the Matter of the Accusation/Petition to Revoke Probation Against: Thomas Alan Bowhay, **M.D.** Physician's and Surgeon's Certificate No. A 45383 Respondent.	MBC File # 800-2015-018370

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "CASE NUMBER" PORTION OF DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "case number" portion of the Decision in the above-entitled matter and that such clerical error should be corrected so that the case number will conform to the Board's issued license.

IT IS HEREBY ORDERED that the case number 800-2015-018730 contained on the Decision Order Page in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "800-2015-018370".

January 9, 2024

JENNA JONES FOR
Reji Varghese
Executive Director

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

In the Matter of the Accusation/Petition to Revoke Probation Against: Thomas Alan Bowhay, M.D. Physician's and Surgeon's Certificate No. A 45383 Respondent.	Case No. 800-2021-080989 & 800-2021-083070 & 800-2015-018730

DECISION

The attached Stipulated Surrender of License and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 4, 2024.

IT IS SO ORDERED December 29, 2023.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **THOMAS ALAN BOWHAY, M.D.** **820 N. Highway 88** **Jackson, CA 95642-2040** Physician's Surgeon's Certificate No. A 45383 Respondent.	Case Nos. 800-2021-080989 800-2021-083070 800-2015-018730 OAH No. 2023020580 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese ("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 John S. Gatschet, Deputy Attorney General.

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2. Thomas Alan Bowhay, M.D. ("Respondent") is represented in this proceeding by attorney Lawrence S. Giardina, Esq., whose address is:

Schuering, Zimmerman & Doyle LLP
400 University Ave.
Sacramento, CA 95825-6502.

3. On or about October 17, 1988, the Board issued Physician's Surgeon's Certificate No. A 45383 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in the following case numbers:

1. Decision and Order, Case No. 800-2015-018370, in which Respondent's license was placed on probation on July 20, 2018, for five years with various terms and conditions.;

2. Accusation/Petition to Revoke Probation Case 800-2021-083070; and,

3. Accusation/Petition to Revoke Probation No. 800-2021-080989.

Respondent's Certificate will expire on February 29, 2024, unless renewed.

JURISDICTION

4. Accusation/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070 were filed before the Board, and are currently pending against Respondent. Both Accusation/Petition to Revoke Probations and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting Accusation/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070. A copy of Accusation/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070 are attached as Exhibit A and Exhibit B and are fully incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070. Respondent has fully discussed with counsel the consequences of entering into a stipulated settlement as it relates to terms and conditions of probation in Case No. 800-2015-018370. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation/Petition to Revoke Probation; 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/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070, if proven at a hearing, constitute cause for imposing discipline upon his Physician's Surgeon's Certificate. Respondent understands that a finding of unprofessional conduct in Cases No. 800-2021-080989 and 800-2021-083070, if proven at hearing, would constitute cause for the revocation of probation in Case No. 800-2015-018370.

9. For the purpose of resolving the pending Accusation/Petition to Revoke Probation in Case Nos. 800-2021-080989 and 800-2021-083070, 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/Petition to Revoke Probation 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, as set forth in the express terms of this agreement, accepting the surrender of his Physician's Surgeon's Certificate without further process.

11. The Board hereby agrees that the effective date of the Decision and Order in this matter shall be no sooner than **December 31, 2023**, regardless of when the parties originally enter into the stipulated surrender of Respondent's license.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

14. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's Surgeon's Certificate No. A 45383 without further notice to, or opportunity to be heard by, Respondent.

15. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

16. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the

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

ADDITIONAL PROVISIONS

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

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

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

ORDER

IT IS HEREBY ORDERED that Physician's Surgeon's Certificate No. A 45383, issued to Respondent Thomas Alan Bowhay, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's 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 final record of the discipline in the cases involving

Accusation/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070, as well as the Decision and Order in Case No. 800-2015-018370, 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. The parties agree that the effective date of this Decision and Order shall be after **December 31, 2023**.

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. Respondent shall pay the agency its costs of investigation and enforcement in the amount of **$33,245.75** prior to issuance of a new or reinstated license. The Board shall not grant a new or reinstated license until all cost recovery has been paid in full.

5. 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/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070, as well as the Decision and Order in Case No. 800-2015-018370, shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition. Should Respondent seek licensure with any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation/Petition to Revoke Probation Nos. 800-2021-080989 and 800-2021-083070, as well as the Decision and Order in Case No. 800-2015-018370, shall be deemed to be true, correct and admitted in such other proceeding.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney Lawrence S. Giardina, Esq. I understand the stipulation and the effect it will have on my Physician's 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: 8/25/23

THOMAS ALAN BOWHAY, M.D.
Respondent

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

DATED: 9/5/2023

LAWRENCE S. GIARDINA, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 9/21/2023

Respectfully submitted,

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

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Decision and Order

800-2015-018730

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

In the Matter of the Accusation Against:	)	
Thomas Alan Bowhay, M.D.	)	Case No. 800-2015-018370
Physician's and Surgeon's Certificate No. A 45383	)	
Respondent	)	

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 July 20, 2018.

IT IS SO ORDERED: June 21, 2018.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.

Signature
For Custodian of Records
Title
3-22-2022
Date

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **THOMAS ALAN BOWHAY, M.D.** 1245 Jackson Gate Road Jackson, CA 95642 Physician's and Surgeon's Certificate No. A 45383 Respondent.	Case No. 800-2015-018370 OAH No. 2018010831 **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. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

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2. Respondent Thomas Alan Bowhay, M.D. ("Respondent") is represented in this proceeding by attorney Lawrence S. Giardina, of Schuering, Zimmerman & Doyle, LLP, whose address is:

Lawrence S. Giardina, Esq.
Schuering, Zimmerman & Doyle, LLP
400 University Ave.
Sacramento, CA 95825-6502

3. On or about October 17, 1988, the Board issued Physician's and Surgeon's Certificate No. A 45383 to Respondent. That certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-018370, and will expire on February 29, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-018370 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 November 28, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-018370 is attached 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 Accusation No. 800-2015-018370. Respondent has also carefully read, fully discussed with 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 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.

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

CULPABILITY

9. Respondent understands that the charges and allegation in Accusation No. 800-2015-018370, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. A 45383.

10. 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.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 45383 is subject to discipline and he agrees to be bound by the Board's terms as set forth in the Disciplinary Order below.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2015-018370, 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.

CONTINGENCY

13. 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.

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 formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 45383 issued to Respondent Thomas Alan Bowhay, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years from the effective date of the Decision and Order on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours

per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

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

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent.

Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

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

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

The Board or its designee shall provide the approved monitor with copies of the Decision(s)

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

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

Respondent shall also make all mid-level practitioners, including physician assistants and nurse practitioners, that he directly supervises, reasonably available to speak directly with the practice monitor regarding Respondent's practice and his compliance with these terms of probation. Reasonable availability shall mean that Respondent shall identify and provide contact information for all mid-levels he supervises so that the monitor in its discretion can contact the mid-levels as part of the monitoring process. These conversations shall remain confidential between the practice monitor and the mid-level practitioner and Respondent understands that the content of the practice monitor's discussions with the mid-level practitioners will not be shared with Respondent. The practice monitor will then share any areas of concerns raised by the mid-level practitioners with the Medical Board of California as part of the proposed monitoring plan.

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine

safely. 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.

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

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

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

9. 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.

10. 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(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.

11. 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.

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

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

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

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

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

Controlled Substances; and Biological Fluid Testing.

13. 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.

14. 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.

15. 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.

16. 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, Lawrence S. Giardina. 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: May 10, 2018 Thomas Alan Bowhay MD

THOMAS ALAN BOWHAY, M.D.
Respondent

I have read and fully discussed with Respondent Thomas Alan Bowhay, 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: _____

LAWRENCE S. GIARDINA
Attorney for Respondent

ENDORSEMENT

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

Dated: Respectfully submitted.

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Lawrence S. Giardina. 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: _____

THOMAS ALAN BOWHAY, M.D.
Respondent

I have read and fully discussed with Respondent Thomas Alan Bowhay, 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: 5/10/18

LAWRENCE S. GIARDINA
Attorney for Respondent

ENDORSEMENT

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

Dated: 5/11/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-018370

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Attorney General of California
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Supervising Deputy Attorney General
JOHN S. GATSCHET
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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: **Thomas Alan Bowhay, M.D.** 1245 Jackson Gate Road Jackson, CA 95642 Physician's and Surgeon's Certificate No. A 45383, Respondent.	Case No. 800-2015-018370 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about October 17, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number A 45383 to Thomas Alan Bowhay, 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, 2018, 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 unless otherwise indicated.

4. 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.

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

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

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

"(b) Gross negligence.

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

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

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

"..."

6. Section 2266 of the Code provides in pertinent part:

"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."

PERTINENT DRUG INFORMATION

7. Morphine ER – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

8. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and as a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. In part due to its long half-life, variability in the drug's absorption, metabolism, and relative analgesic potency among patients calls for a highly individualized approach to prescribing. Particular vigilance is necessary during treatment initiation and titration. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

9. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[1] Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and

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[1] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

10. Hydrocodone with ibuprofen – Generic name for the drugs Vicoprofen, Ibudone, and Reprexain. Hydrocodone with ibuprofen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with ibuprofen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[2] Hydrocodone with ibuprofen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydrocodone with ibuprofen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

11. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

12. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride ("hcl") is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

13. Tramadol – Generic name for the drug Ultram. Tramadol is a synthetic, centrally acting analgesic pain medication used to treat moderate to moderately severe pain. Effective

[2] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

August 18, 2014, Tramadol was placed into Schedule IV of the Controlled Substances Act and is located at Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

14. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. It is not recommended for long term use. On January 11, 2012, Carisoprodol was classified as a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(e). It is a dangerous drug pursuant to Business and Professions Code section 4022.

15. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short acting benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

16. Temazepam – Generic name for Restoril. Temazepam is an intermediate-acting benzodiazepine used to treat insomnia. Temazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). 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.

17. Armodafinil – Generic name for Nuvigil. Armodafinil is a stimulant used to treat narcolepsy, sleep apnea, and promote wakefulness. Armodafinil is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(f). Armodafinil is a Schedule IV controlled substance pursuant to Health and Safety Code 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section

11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence during the care and treatment of patients, A, B, C, D, E, and F[3] by failing to properly prescribe and/or properly document the prescription of controlled substances. The circumstances are as follows:

Patient A

20. A review of pharmacy records for patient A indicated that on October 1, 2013, Respondent first provided a 150 pill prescription of 5-500 mg. hydrocodone with acetaminophen to patient A. Respondent continued to prescribe hydrocodone on a monthly basis to patient A. In total, patient A received a total of 4 prescriptions for 5-500 mg. pills from Respondent. On January 20, 2014, patient A began receiving a prescription of 150 pills of hydrocodone with acetaminophen 5-325 mg. each month from Respondent. Between January 20, 2014, and October 30, 2015, patient A received 25 separate prescriptions for 150 pills of 5-325 mg. hydrocodone with acetaminophen from Respondent. On November 21, 2015, Respondent increased patient A's prescription to 180 pills of 5-325 mg. hydrocodone with acetaminophen. Respondent provided 5 prescriptions for 180 pills of 5-325 mg. hydrocodone with acetaminophen. In total, between October 1, 2013, and March 17, 2016, Respondent prescribed 5250 pills containing hydrocodone to patient A. Throughout this period of time patient A, resided in an area that was over 150 miles from the location of Respondent's practice.

21. On November 14, 2016, the Medical Board of California requested all medical records related to the care and treatment of patient A. On December 9, 2016, Respondent provided a document entitled, "Certification of No Records," for patient A and attached nine

[3] The six patients are identified by letter ("A,B,C,D,E, and F") in order to protect patient privacy. All patients will be identified in discovery if not already identified during the investigative process.

pages of intake records and pharmacy notes. Respondent did not provide any progress notes, records from prior treating physicians, any testing results or any records that supported the continued prescription of hydrocodone to patient A. Respondent provided a brief note dated November 30, 2016, that stated that he had been unable to find any patient records except for some intake paperwork that had been filled out by patient A. The intake paperwork was not dated. In the note, Respondent explained that patient A was his nephew and that he had provided pain treatment following patient A's discharge from a hospital in San Francisco.

22. On May 2, 2017, Respondent attended a subject interview with the Medical Board of California. During the interview the Respondent described his relationship with his nephew as a "close, close relationship."[4] Respondent admitted that he made a mistake in judgment in prescribing to family. Respondent stated that he didn't have any medical records and that he only was able to provide information based on his recollection. Respondent stated that patient A was seeing a separate primary care physician at the same time that Respondent was prescribing controlled substances but that the primary care physician would not prescribe controlled substances to patient A. Respondent stated he would see patient A on a monthly basis at patient A's place of residence but that patient A had only come to Respondent's clinic, "once or twice." Respondent admitted that he didn't perform full examinations on patient A, and admitted that he "never kept good records on him, no." Respondent admitted that he didn't discuss a pain contract with patient A. Respondent stated that he didn't perform a substance abuse history but stated that he knew patient A quite well and that he was aware of patient A's past history. Respondent admitted that he did not formulate a long term treatment plan for patient A. Respondent admitted that he didn't perform any urine testing on patient A. Respondent admitted that he never referred patient A to a specialist for a pain management consultation.

23. Respondent committed gross negligence in his care and treatment of patient A as follows: (A.) by prescribing controlled substances for more than two years to patient A who has a

[4] Opinion 8.19, American Medical Association Code of Medical Ethics' Opinion on Treating Family Members. "Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members." Issued June 1993.

close family relationship with Respondent; (B.) by failing to properly manage patient A's chronic pain condition by providing controlled substances without performing and/or documenting a history and physical before prescribing controlled substances, without performing and/or documenting a substance abuse history, and without documenting a recognized medical condition for the use of controlled substances; (C.) by failing to properly manage patient A's chronic pain condition by providing controlled substances without documenting treatment objectives, without creating and/or documenting a treatment plan, and without performing and/or documenting any reassessment of patient A's treatment plan while on controlled substances; (D.) by failing to obtain and/or document obtaining informed consent before initiating treatment; (E.) by failing to perform and/or document performing a periodic review of the course of pain treatment of patient A; (F.) by failing to consider and/or document considering additional evaluations and consultations for patient A; and, (G.) by failing to keep accurate and complete medical records for patient A.

Patient B

24. Respondent began treating patient B on December 11, 2008.[5] Respondent's medical records documenting patient B's care are handwritten.[6] The Medical Board reviewed 23 progress notes between December 11, 2008, and October 4, 2016. On May 12, 2009, Respondent began prescribing Xanax to patient B and noted that patient B was "anxious". According to the progress notes, on February 26, 2013, Respondent began prescribing Tramadol to patient B and noted that she had pain in her left arm and numbness in her left forearm. The next visit was documented in the progress notes on April 15, 2013. Respondent documented prescriptions for Tramadol and Xanax and documented that patient B had neck pain. On April 15, 2013, Respondent documented patient B's vital signs, that B had a complaint regarding her hearing, and that she was seeing a chiropractor three times a week. He also documented that she had high blood pressure and that

[5] Any reference to Respondent's treatment of any patient prior to November 1, 2010, is for informational purposes only. While conduct may have led to on-going departures at a time after the relevant statute of limitations, the Board recognizes that no conduct before November 1, 2010 is actionable at this time.

[6] Respondent kept handwritten progress notes for all of his patients that were reviewed by the Medical Board.

she refused blood pressure medications. Respondent did not document performing a history and physical, conducting a substance abuse history, or creating a treatment plan for opiate therapy.

25. According to the pharmacy records obtained as part of the investigation, on May 21, 2013, Respondent provided a prescription for 40 pills of 5-325 mg. hydrocodone with acetaminophen to patient B. On June 10, 2013, the pharmacy documented that patient B refilled her prescription of 40 pills of 5-325 mg. hydrocodone with acetaminophen from Respondent. The next progress note documented by Respondent was dated July 2, 2013. Respondent noted that patient B was receiving Xanax and Tramadol. Respondent failed to list that patient B was now receiving hydrocodone with acetaminophen. Respondent documented that she was present for a follow-up regarding her diabetes and documented some tests related to her diabetes. Respondent documented that patient B was overweight and had high blood pressure. Respondent did not document a history or physical examination setting forth the need for controlled substances. Respondent did not document a treatment plan, a substance abuse history, or informed consent for the prescription of hydrocodone with acetaminophen. Respondent did not document whether he provided any information regarding the potential risk of taking benzodiazepines with narcotic medications to patient B despite prescribing Xanax at the same time as hydrocodone with acetaminophen. According to pharmacy records, patient B received 40 pills of 5-325 mg. hydrocodone with acetaminophen on July 9, 2013, and July 27, 2013, that were prescribed by Respondent. Patient B also received 100 pills of .5 mg. Xanax on August 8, 2013.

26. Between September 10, 2013, and January 24, 2014, Respondent prescribed or refilled 240 pills of 5-325 mg. hydrocodone with acetaminophen and 200 pills of .5 mg Xanax to patient B. The next note in the medical records is dated March 3, 2014, and states that the "patient notified she needs to have screening tests." On March 10, 2014, Respondent saw patient B in his office for a medication review. Respondent documented that patient B was receiving hydrocodone with acetaminophen, Tramadol and Xanax. Respondent documented that patient B was scheduled for gastric bypass surgery, that she was stressed, and that her husband was injured. Respondent documented a history of increased blood pressure, increased weight, anxiety, polyarthralgia, lower back pain, shoulder surgery, and knee surgery. Despite prescribing

hydrocodone with acetaminophen and Xanax for approximately 10 months, Respondent did not document performing a treatment plan, periodic review, or a pain assessment in the medical records. Respondent prescribed or refilled 40 pills of hydrocodone with acetaminophen on March 10, 2014, March 26, 2014, April 11, 2014. No other prescriptions for hydrocodone with acetaminophen were discovered after April 11, 2014. Respondent next documented a progress note on April 14, 2014, and noted that patient B was being seen for a pre-op EKG for bariatric surgery. Respondent documented that he refilled patient B's Tramadol. The prescription for hydrocodone with acetaminophen is not documented in the progress note nor that the prescription was being discontinued and the reasons for why the prescription was being discontinued.

27. On August 18, 2014, the Federal Drug Enforcement Agency reclassified Tramadol as a Schedule IV controlled substance. Respondent saw patient B. on June 19, 2015, June 30, 2015, October 27, 2015, and October 4, 2016. During that time Respondent documented that he was prescribing Tramadol and Xanax to patient B. Between August 26, 2013, and August 16, 2016, Respondent prescribed or refilled a total of 1180 5 mg. pills of Xanax and 1980 pills of 50 mg. Tramadol. In the progress notes between June 19, 2015, and October 4, 2016, Respondent did not document a pain assessment, history and physical, or a periodic review of patient B's progress on controlled substances. In the progress notes between June 19, 2015, and October 4, 2016, Respondent did not document reasons supporting the continued prescription of Xanax. On October 27, 2015, Respondent documented that patient B was complaining of leg aches but didn't document whether or not Tramadol was effective. Respondent never documented that he had previous provided informed consent to patient B for Tramadol, Xanax, and hydrocodone with acetaminophen before initiating treatment.

28. On May 2, 2017, at the subject interview with the Medical Board, Respondent stated that he still saw patient B for treatment. Respondent was asked if he developed a treatment plan for patient B's chronic pain therapy and he stated that, "I don't really." Respondent was asked if he performed periodic reviews regarding the appropriate dosage for pain therapy and he stated, "I did not document it, but I've – I believe I've talked about it with her on multiple occasions." Respondent was asked if he had provided informed consent to the patient before prescribing

medication and he stated, "no." When asked specifically if he had explained the risks and benefits of medications, he stated that he has talked to most of his patients but admitted that he "may not have documented that" in the medical record. Respondent was asked if he documented patient B's functionality on controlled substances, for example using pain scales as part of an assessment, he admitted that the information was, "(p)robably not documented, but I discuss it." Respondent acknowledged that the legibility of his handwritten medical records for patient B can be difficult to read and would be difficult for another practitioner to decipher. Respondent admitted that he didn't refer patient B to a pain management specialist or a substance abuse specialist.

29. Respondent committed gross negligence in his care and treatment of patient B as follows: (A.) by failing to properly manage patient B's chronic pain condition by providing controlled substances without performing and/or documenting a history and physical before prescribing controlled substances, without performing and/or documenting a substance abuse history, and without documenting a recognized medical condition for the use of controlled substances; (B.) by failing to properly manage patient B's chronic pain condition by providing controlled substances without documenting treatment objectives, without creating and/or documenting a treatment plan, and without performing and/or documenting any reassessment of patient B's treatment plan while on controlled substances; (C.) by failing to obtain and/or document obtaining informed consent before initiating treatment; (D.) by failing to perform and/or document performing a periodic review of the course of pain treatment of patient B; (E.) by failing to consider and/or document considering additional evaluations and consultations for patient B; and, (F.) by failing to keep accurate and complete medical records for patient B.

Patient C

30. Respondent began treating patient C on February 15, 2013. The progress note states that patient C had "warts on his feet." Respondent documented that he provided treatment for plantar warts. The next note from March 29, 2013 documented that patient C cancelled his appointment. A search of pharmacy records revealed that Respondent began prescribing Tramadol to Patient C on January 11, 2013. Respondent continued prescribing Tramadol on

multiple occasions between January 2013 and March 2013. There is no documentation regarding why Respondent began prescribing Tramadol in January 2013. Tramadol was reclassified as a Schedule IV controlled substance on August 18, 2014.

31. Between July 31, 2014, and August 19, 2016, Respondent provided 54 prescriptions and refills for Tramadol to patient C on a consistent monthly basis. In total, Respondent provided 3900 pills of 50 mg. Tramadol pills to patient C during that time. In reviewing the prescription records, Respondent's prescription quantities varied where he sometimes provided 40 pills of 50 mg. for weekly intervals and sometimes provided 100 pills of 50 mg. on monthly intervals. Respondent's next progress note for patient C was documented on April 6, 2015. The note contains abbreviations for weight, height, blood pressure, and pulse but no entries. The note does not say whether patient C cancelled. The next documented progress note with patient C is dated April 10, 2015. Respondent documented a number of vital signs and that patient C;'s warts were, "on back foot again." Despite having first prescribed Tramadol in January 2013 and on a consistent basis after August 2014, when Tramadol became a schedule controlled substance, Respondent didn't document any information related to the fact that patient C was being prescribed Tramadol in the April 10, 2015, progress note. There is no history and physical documented, no treatment plan, no pain assessment, no informed consent, no substance abuse history documented, or any documentation that explains why patient C was receiving a Tramadol prescription.

32. On May 5, 2015, Respondent documented that patient C was in the office with nausea and that he felt weak. He documented a number of vital signs and documented that patient C had been sick for three days. Respondent documented that patient C was receiving Tramadol. Respondent didn't document a pain assessment, a periodic review, or a basis that would support the continued prescribing of Tramadol to patient C.

33. On October 1, 2015, Respondent documented that patient C had a cough, suffered from shortness of breath and felt feverish. Respondent documented that patient C would be off work for two days and documented that he might have pneumonia. Respondent prescribed Levaquin, an antibiotic. Respondent documented that patient C was being prescribed Tramadol.

Respondent didn't document a pain assessment, a periodic review, or a basis that would support the continued prescribing of Tramadol to patient C.

34. On October 5, 2015, Respondent documented that patient C was still suffering from shortness of breath. Respondent documented a "tight cough", "lungs clear", and "Bronchitis." Respondent prescribed breathing treatments and documented that patient C would be off work until October 8, 2015. Respondent documented that patient C was on Levaquin but he didn't document that patient C was on Tramadol. Respondent didn't document a pain assessment, a periodic review, or a basis that would support the continued prescribing of Tramadol to patient C.

35. Respondent next documented that patient C was seen in his medical office on August 12, 2016. Respondent documented vital signs and documented that patient C was suffering from back pain and had missed two days of work. This is the first documentation in C's medical records of a pain complaint. Respondent didn't document a pain assessment, a periodic review, or a basis that would support the continued prescribing of Tramadol to patient C. Respondent documented that patient C failed to appear for his next appointment on October 24, 2016.

36. On May 2, 2017, Respondent was interviewed regarding his care and treatment of patient C. Respondent stated that patient C was a "rare visitor" to his medical office and that he had trouble getting him into his office. Respondent stated that patient C suffers from aches and pains and low back strain. Respondent admitted that he only documented respiratory illness complaints and that he didn't document patient C's use of Tramadol in some of the progress notes. Respondent admitted that he didn't perform a periodic review of patient C's Tramadol use or have patient C enter into a pain contract. Respondent admitted that he never performed a substance abuse history while prescribing Tramadol to patient C. Respondent stated he relied on his knowledge of patient C's past because patient C. lived close to him and Respondent admitted that he didn't document a substance abuse history evaluation. Respondent admitted he didn't terminate patient C's Tramadol prescriptions despite patient C making excuses to not come in to Respondent's clinic on a regular basis. Respondent admitted that he didn't document any physical examinations that supported patient C's claims that he had aches and pains. Respondent admitted that he didn't formulate a treatment plan for patient C. Respondent admitted that he

never performed urine drug testing on patient C. Respondent admitted that he never referred patient C to a specialist or sought consultation for his chronic pain issues. Respondent was unable to explain why he increased or decreased patient C's prescriptions but acknowledged that he had not provided documentation regarding the changes in the prescriptions.

37. Respondent has committed gross negligence in his care and treatment of patient C as follows: (A.) by failing to properly manage patient C's chronic pain condition by providing controlled substances without performing and/or documenting a history and physical before prescribing controlled substances, without performing and/or documenting a substance abuse history, and without documenting a recognized medical condition for the use of controlled substances; (B.) by failing to properly manage patient C's chronic pain condition by providing controlled substances without documenting treatment objectives, without creating and/or documenting a treatment plan, and without performing and/or documenting any reassessment of patient C's treatment plan while on controlled substances; (C.) by failing to obtain and/or document obtaining informed consent before initiating treatment; (D.) by failing to perform and/or document performing a periodic review of the course of pain treatment of patient C; (E.) by failing to consider and/or document considering additional evaluations and consultations for patient C; and, (F.) by failing to keep accurate and complete medical records for patient C.

Patient D

38. Respondent's first documented medical record for patient D is dated November 15, 2006. Respondent documented that he provided care for patient D on a semi-regular basis between 2008 and 2012. On June 25, 2013, Respondent documented that patient D was in his office regarding pain in her left knee for the past ten weeks. Respondent documented that patient D was seeing another physician. Respondent documented a number of vital signs, and that Patient D had a, "stable exam, exc. fullness post (L) knee." Respondent documented performing a knee injection. Respondent did not document performing a substance abuse history, or document performing a complete physical examination. While Respondent documented that patient D had left knee pain, Respondent failed to document a complete history. Respondent did not document a treatment plan, list alternative treatments, or informed consent. On July 1, 2013,

patient D received 24 pills of 7.5-200 mg. hydrocodone with ibuprofen from Respondent. There is nothing documented in patient D's record from June 25, 2013, that indicates, Respondent was preparing to start her on a controlled substance prescription.

39. Between September 3, 2013, and May 20, 2014, Respondent prescribed or refilled 35 prescriptions of 7.5-200 mg. hydrocodone with ibuprofen to patient D for a total of 1,512 pills. On November 21, 2013, Respondent increased the prescription from 24 pills every seven days to 50 pills every seven days. On April 11, 2014, Respondent adjusted the prescription from 50 pills every seven days to 100 pills every two weeks. Respondent's last prescription for hydrocodone with ibuprofen was dated May 20, 2014. Respondent next began prescribing Tramadol to patient D. Between November 24, 2014, and July 23, 2015, Respondent prescribed or refilled 19 prescriptions of 50 mg. Tramadol to patient D for a total of 880 pills. Despite prescribing controlled substances to patient D between September 3, 2013, and July 23, 2015, Respondent did not document any treatment visits in patient D's medical records during that time. Of note there is no documentation regarding a pain assessment, a periodic review of controlled substance treatment, any evidence of informed consent, or a basis that supported why patient D was receiving controlled substances.

40. Respondent next documented a treatment visit with patient D on July 30, 2015. Respondent documented vital signs and that patient D had left knee pain that required an injection and documented providing a knee injection. Respondent documented that patient D was receiving Tramadol. Respondent did not document performing a pain assessment, performing a periodic review, and whether or not he was seeking outside consultation regarding patient D's pain issues. On August 3, 2015, Respondent documented that he saw patient D for strep throat and prescribed antibiotics. Respondent did not document any information related to patient D's controlled substance prescriptions.

41. On August 18, 2015, Respondent documented the next treatment visit with patient D. Respondent documented vital signs and that, "both feet→ sore hurts on top & bottom of heels. Sore feet." Respondent documented that patient D was on Tramadol. Respondent then documented, "insists Percocet." Respondent did not document performing a pain assessment or

conduct a periodic review of patient D's pain treatment. On August 18, 2015, Respondent prescribed 60 pills of 10-325 mg. hydrocodone with acetaminophen. On August 26, 2015, Respondent prescribed 100 pills of 50 mg. Tramadol. On September 4, 2015, Respondent prescribed 100 pills of 7.5-200 mg. hydrocodone with acetaminophen. On September 10, 2015, Respondent prescribed 100 pills of 50 mg. Tramadol. Between September 26, 2015, and August 22, 2016, Respondent prescribed or refilled 13 prescriptions of 100 pills of 50 mg. Tramadol for a total of 1300 pills and prescribed or refilled 15 prescriptions of 7.5-325 mg. hydrocodone with ibuprofen for a total of 1052 pills. The 15 prescriptions of 7.5-325 mg. hydrocodone with ibuprofen continually varied in either 50 pill, 60 pill, or 100 pill amounts.

42. On October 15, 2015, Respondent documented that patient D cancelled her appointment. Respondent documented that on October 20, 2015, patient D was suffering from "bilateral foot pain." Respondent documented that the pain was getting worse over the last three months. Respondent documented that patient D was applying ice at night, and heat in the form of hot water but the alternative remedies provided, "no help." Respondent documented next to the word arches, "no help". Respondent documented that patient D had continual "sharp pains and dull ache." Respondent documented that she was going to have x-rays taken of her feet by a different physician. Respondent documented that patient D was receiving Tramadol and Norco. Respondent didn't document a pain assessment or a periodic review of the controlled substances that patient D was receiving. Respondent didn't document providing informed consent despite prescribing two short acting controlled substances at the same time.

43. The next progress note documented in patient D's medical chart is from March 11, 2016. The note was drafted by a mid-level practitioner who was working under Respondent's supervision. The note is detailed in comparison to the notes drafted by Respondent.

44. The next progress note in patient D's medical file is documented on September 6, 2016. Respondent documented vital signs and documented that patient D had flu symptoms. Respondent also documented that patient D was scheduled for surgery with another physician. Respondent documented that patient D was receiving Tramadol and hydrocodone with

acetaminophen. Respondent didn't document a pain assessment or a periodic review of the controlled substances that patient D was receiving.

45. On May 2, 2017, Respondent was interviewed regarding the treatment that he provided to patient D. Respondent admitted that he did not have a pain contract with patient D. Respondent admitted that he didn't document performing a periodic review of patient D's pain management treatment. Respondent admitted that he didn't perform and document performing a substance abuse history before prescribing controlled substances.[7] Respondent admitted that he didn't document trying to lower patient D's controlled substance prescriptions. Respondent admitted that he didn't receive any consultation on patient D's chronic pain issues in 2014 or 2015 from outside specialists. Respondent stated that he had assessed patient D's pain at each visit but admitted that he didn't document that pain assessment. Respondent admitted that he didn't perform urine drug testing on patient D.

46. Respondent committed gross negligence in his care and treatment of patient D as follows: (A.) by failing to properly manage patient D's chronic pain condition by providing controlled substances without performing and/or documenting a history and physical before prescribing controlled substances, without performing and/or documenting a substance abuse history, and without documenting a recognized medical condition for the use of controlled substances; (B.) by failing to properly manage patient D's chronic pain condition by providing controlled substances without documenting treatment objectives, without creating and/or documenting a treatment plan, and without performing and/or documenting any reassessment of patient D's treatment plan while on controlled substances; (C.) by failing to obtain and/or document obtaining informed consent before initiating treatment; (D.) by failing to perform and/or document performing a periodic review of the course of pain treatment of patient D; (E.) by failing to consider and/or document considering additional evaluations and consultations for patient D; and, (F.) by failing to keep accurate and complete medical records for patient D.

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[7] At the interview, Respondent admitted that Patient D had later been diagnosed with a previously unknown alcohol problem on or about March 2017.

Patient E.

47. On June 15, 2001[8], patient E began treatment with Respondent's medical practice. At the time, patient E was seen by a mid-level practitioner under Respondent's supervision. According to the medical records, Patient E was not being prescribed any controlled substances in 2001. Respondent or Respondent's mid-level practitioner saw patient E on a consistent basis through 2004. On April 27, 2004, Respondent documented that patient E received a controlled substance prescription that included 40 pills of 10-325 mg. hydrocodone with acetaminophen for carpal tunnel syndrome. Respondent also documented that patient E was receiving Ambien, a sedative that is prescribed for restlessness. Respondent documented the next visit on March 21, 2006, and documented that patient E was receiving temazepam, "from a friend." Respondent also documented that patient E was experiencing knee pain and Respondent documented a history that included "having a ligament removed in high school" and having a "tumor removed last year." Finally, Respondent documented that patient E experienced, "bone on bone" pain and needs a knee replacement. Finally, in the March 21, 2006, note, Respondent documented that patient E, "needs meds for pain." Following that treatment visit, Respondent would continually prescribe Norco to patient E for the next 11 years. Respondent or Respondent's mid-level practitioner continued seeing patient E on a consistent basis through 2008. On March 11, 2008, Respondent documented that he began prescribing Soma to patient E. Respondent would continually prescribe Soma for the next nine years. There is no documentation contained in the records from 2001 to 2008, regarding the creation of a treatment plan, documentation of a pain assessment and documentation of informed consent before the addition of new controlled substances. There is no documentation in the medical records of a complete history and physical being performed before the initiation of opioid therapy.

48. On January 13, 2009, Respondent documented that patient E was suffering from pain under his ribs. Respondent began prescribing temazepam to patient E. Respondent would continually prescribe temazepam for the next eight years. On July 9, 2010, Respondent

[8] As noted above, mention of events that occurred before the statute of limitations are mentioned for historical reference only.

documented that patient E was suffering from ear pain. Respondent documented that he prescribed lorazepam. Respondent would document prescribing lorazepam for the next seven years. Respondent continued to see patient E on a regular basis through 2017 in his practice. On April 15, 2012, Respondent documented in a hospital discharge summary that patient E had been on "Percocet and Valium for a long time, taking significant amounts." Respondent continued to prescribe to patient E through 2017.

49. According to pharmacy records, between September 9, 2013, and September 19, 2015, on a consistent monthly basis, Respondent prescribed at least 100 pills of 2 mg. alprazolam, 30 pills of 30 mg. temazepam, 100 tablets of 350 mg. carisoprodol, 180 pills of 10-325 mg. oxycodone with acetaminophen and 180 pills of 10-325 pills of hydrocodone with acetaminophen to patient E.[9] During that two-year period of time, Respondent prescribed a total of 2480 pills of 2 mg. alprazolam, 720 pills of 30 mg. temazepam, 2470 tablets of 350 mg. carisoprodol, 4510 pills of 10-325 mg. oxycodone with acetaminophen, and 5020 pills of 10-325 mg. hydrocodone with acetaminophen.[10] For example, on February 19, 2015, Respondent prescribed 100 pills of 2 mg. alprazolam and 90 pills of 350 mg. carisoprodol. On February 20, 2015, Respondent prescribed 30 pills of 30 mg. temazepam, 180 pills of 10-325 mg. hydrocodone with acetaminophen, and 180 pills of oxycodone with acetaminophen. On March 19, 2015, Respondent prescribed 100 pills of 350 mg. carisoprodol, 180 pills of 10-325 mg. oxycodone with acetaminophen, and 30 pills of 30 mg. temazepam to patient E. On March 20, 2015, Respondent prescribed 180 pills of 10-325 mg. hydrocodone with acetaminophen, and 120 pills of 2 mg. alprazolam.

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[9] On a number of occasions Respondent prescribed 200 pills of 10-325 mg. oxycodone with acetaminophen and 200 pills of 10-325 mg. hydrocodone with acetaminophen to patient E. On June 22, 2015, Respondent received a letter from patient E's insurance warning Respondent that his prescriptions (400 pills per month containing 325 mg. of acetaminophen) were placing patient E above the daily recommended dose of 4 grams' acetaminophen which could lead to liver toxicity. Respondent also prescribed 120 pills of 2 mg. alprazolam on one occasion during that time period.

[10] In total, 15200 pills. Over a 740 day period, as prescribed, patient E would have averaged 20 pills a day.

50. Between September 9, 2013, and September 19, 2015, Respondent documented that patient E had treatment appointments on February 14, 2014, September 12, 2014, February 6, 2015, June 23, 2015, and September 15, 2015. Respondent documented that patient E cancelled appointments on April 18, 2014, and January 30, 2015. On February 4, 2014, Respondent documented that patient E was being seen for follow-up regarding possible seizures. Respondent documented that patient E was taking 13 Norco and Percocet pills per day and that he, "must cut down." Respondent noted that "if he can't cut down must ▲ ("cut") meds to ↓ ("lower") APAP ("acetaminophen")." Respondent documented that patient E was dealing with "pain med overuse." At the time, Respondent was prescribing a total of 400 pills of opiate medications per month, in particular 200 pills of Percocet and 200 pills of Norco, that each contained 325 mg. of acetaminophen.[11] Respondent continued to prescribe or refill 400 pills of opiates through April 2014. Respondent didn't document a pain assessment or perform a periodic review to determine if patient E continued to require controlled substances. Respondent didn't document that he was stopping patient E's acetaminophen intake.

51. On September 12, 2014, Respondent saw patient E in the clinic for "medication review". Respondent noted that patient E had a hernia, was depressed, and had chronic pain. Respondent noted that patient E's brother had died from "M.I." Respondent documented that patient E's "knee looked good" and that patient E refused any "med. Work-up." During the interview with the Board, Respondent stated that med was short for "medical." Respondent also clarified that "knee looked good" meant that the knee was stable, yet still badly deformed. Respondent wrote, "chronic" under analysis and documented "take 10 or less Percocet/Norco" under plan. Respondent documented that he was prescribing temazepam, alprazolam, Norco, Percocet, and Soma to patient E. Respondent did not document performing a substance abuse history, document performing a pain assessment, or perform a periodic review on patient E's progress. There is no documentation regarding whether patient E was provided a detailed informed consent, in particular to the dangers of respiratory depression, despite Respondent

[11] 400 pills multiplied by 325 mg. = 130000 mg. / 30 days in a month = 4333 grams.

prescribing two short acting opiates, two benzodiazepines and carisoprodol at the same time. Respondent also continued to prescribe twelve pills of Percocet and Norco per month. On February 6, 2015, Respondent saw patient E in clinic for a complaint of high blood pressure. Respondent documented that he warned patient E of his high acetaminophen intake. Respondent noted that he was still prescribing temazepam, alprazolam, Norco, Percocet, and Soma to patient E. Respondent did not perform a substance abuse history, document a pain assessment, or perform a periodic review. Respondent did not note whether patient E was now taking less than ten pills of Percocet and Norco per month. According to the pharmacy records, Respondent was still prescribing at least twelve pills of Percocet and Norco each month.

52. On June 23, 2015, Respondent documented seeing patient E in the clinic for "med review - needs refills." Respondent documented that patient E was taking Soma, temazepam, alprazolam, lorazepam, Norco, and Percocet. Respondent documented patient E was, "staying under the line." Respondent documented that patient E's "knee had given out, hx of bone tumor resection, stressful home life." Respondent also documented that patient E had "chronic (knee) pain, chronic anxiety." Respondent did not perform a substance abuse history, document a pain assessment, or perform a periodic review of patient E's treatment plan. Respondent did not note whether patient E was taking less than ten pills of Percocet and Norco per month, only documenting that patient E was "staying under the line" next to the medication list. There is no documentation in the progress notes from February 6, 2015, and June 23, 2015, regarding outside consultation and referral to specialists.

53. On May 2, 2017, Respondent was interviewed by the Medical Board of California. Respondent admitted that Soma should only be prescribed short term use and acknowledged that he thought, "it may potentiate other drugs." Respondent admitted that Xanax is indicated for short term use and that patients become agitated when they don't receive a dose if they have become habituated. Respondent acknowledged that habituating and agitation may indicate addiction. Respondent admitted that he didn't document that he instructed patient E to take less Xanax. Respondent admitted he didn't personally limit the Xanax prescriptions to patient E, just that he "was hopeful and (Respondent) was asking him to" limit his intake. Respondent admitted

that Xanax, temazepam, and Soma when combined with opiates can potentially cause respiratory depression. Respondent admitted that he prescribed both Norco and Percocet to patient E at the same time because the patient asked for it. Respondent described it as, "self-medicating" and acknowledged that it was dangerous to prescribe in that way because it could lead to overdose.

54. Respondent stated that he performed a periodic assessment of patient E's pain level but that he didn't document it. Respondent admitted that he didn't perform urine drug testing on patient E to verify that patient E was taking his prescribed medications and not using other substances. Respondent acknowledged that patient E in 2010 had admitted in the past to having an 18 can a day beer habit and admitted to past use of marijuana, cocaine and methamphetamine. Respondent stated that he was concerned at every visit regarding patient E's past substance abuse history but admitted that he didn't document those concerns. Respondent stated he performed a physical examination on June 23, 2015, but admitted he didn't document it. Respondent admitted that he didn't document a pain scale in patient E's records. Respondent admitted that he didn't refer patient E for a psychiatric consultation despite prescribing Xanax for anxiety. Respondent admitted that he didn't order x-rays in 2013, 2014, 2015, and 2016, to support continued opiate prescribing. Respondent stated that he performed informed consent by warning patient E about the dangers of overuse of opiates, benzodiazepines, and Soma but admitted that he "did not document it generally."

55. Respondent committed gross negligence in his care and treatment of patient E as follows: (A.) by failing to properly manage patient E's chronic pain condition by providing controlled substances without performing and/or documenting a history and physical before prescribing controlled substances, without performing and/or documenting a substance abuse history, and without documenting a recognized medical condition for the use of controlled substances; (B.) without performing and/or documenting a reassessment of patient E's treatment plan while on controlled substances; (C.) by failing to obtain and/or document obtaining informed consent before initiating treatment; (D.) by failing to perform and/or document performing a periodic review of the course of pain treatment of patient E; (E.) by failing to consider and/or

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document considering additional evaluations and consultations for patient E; and, (F.) by failing to keep accurate and complete medical records for patient E.

Patient F

56. According to pharmacy records, on November 19, 2014, Respondent began treating patient F when he prescribed 150 pills of 10-325 mg. hydrocodone with acetaminophen and 60 pills of 30 mg. morphine sulfate to her. In reviewing the Respondent's medical records for patient F, Respondent documented that she rescheduled her appointment on November 6, 2014, and failed to show up for her medical appointments on December 4, 2014, and December 11, 2014. Based on a review of the medical records, it does not appear that Respondent had seen patient F for an initial consultation before prescribing opiates on November 19, 2014.

57. On December 16, 2014, Respondent documented that patient F was seen in his clinic. Respondent documented a number of vital signs and noted that she was currently taking Lyrica, a medication used to treat neuropathic pain, Norco, and Morphine E.R. Respondent documented that patient F was present in clinic for a "med renewal, depression." Respondent documented that patient F had a "hx (history) of spine surgery, low back pain rad (radiating) to legs + neuropathic pain." Respondent documented that patient F's right knee was, "torn but no surgery." Respondent then wrote down that patient F, had "chronic low back, neuropathy, depression." Respondent didn't document a substance abuse history, an initial history, an initial physical, a pain assessment or document a treatment plan. Respondent didn't document informed consent before initiating opiate therapy. On December 16, 2014, Respondent prescribed 150 pills of 10-325 mg. hydrocodone with acetaminophen and 60 pills of 30 mg. morphine sulfate to patient F. Respondent continued refilling the hydrocodone with acetaminophen and morphine sulfate prescriptions on a monthly basis until April 2015.

58. On April 3, 2015, Respondent documented that patient F was present for refills. Respondent did not document any of patient F's vital signs. Respondent only noted the following, "changed MS → dilaudid 2 mg." On April 3, 2015, patient F received a prescription for 150 pills of 10-325 mg. hydrocodone with acetaminophen and 120 pills of 2 mg. hydromorphone hcl. Respondent didn't document a pain assessment, didn't document a change

in patient F's treatment plan, and provided no documentation explaining why he was changing patient F's prescription to two short-acting opioid medications. On April 10, 2015, Respondent documented a progress note in patient F's file. Respondent documented a number of vital signs and that the "pain medication not working, pain 9/10 to back, knee." Respondent documented that he was discontinuing Dilaudud and restarting patient F on morphine sulfate ER. Respondent documented that patient F was feeling tired and that she wanted "to try Nuvigil." On April 11, 2015, Respondent prescribed 30 pills of 250 mg. Nuvigil to patient F. Despite Respondent discontinuing Dilaudid on April 10, 2015, patient F received a prescription for 150 pills of 10-325 mg. hydrocodone with acetaminophen and 120 pills of 2 mg. hydromorphone hcl on May 1, 2015, from Respondent. On May 8, 2015, Respondent prescribed 60 pills of 30 mg. morphine sulfate to patient F. While Respondent documented a pain assessment on April 10, 2015, he failed to document a treatment plan, informed consent for Nuvigil, and explain why Dilaudid had first been prescribed on April 3, 2015.

59. On June 19, 2015, Respondent saw patient F in his clinic. Respondent documented her vital signs and that patient F was taking Norco and Morphine for back pain, and Nuvigil to "help keep her awake while driving." Respondent documented that they were waiting on "PA" ("prior authorization") on Nuvigil. Respondent documented that patient F had, "swelling in both legs, right knee popping, see EMR for note." Respondent did not provide a corresponding electronic medical record note dated June 19, 2015, to the Medical Board when the Medical Board requested certified records. Respondent did not document a pain assessment, did not perform urine drug testing, and did not perform a periodic review of patient F's pain therapy. Respondent next saw patient F in his clinic on July 28, 2015. Respondent documented vital signs and that patient F had back and knee pain and needs, "medication and disability-considering." Respondent did not document a pain assessment, did not perform urine drug testing, and did not perform a periodic review of patient F's pain therapy. Respondent didn't document that he was preparing to make any changes in patient F's treatment plan. At the time of the visit on

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July 28, 2015, patient F was receiving 2 pills of 30 mg. morphine sulfate and 6 pills of hydrocodone with acetaminophen per day for a total Morphine Equivalent Dose ("MED")[12] of 120.

60. On July 31, 2015, Respondent prescribed 180 pills of 10 mg. methadone to patient F and on August 14, 2015, prescribed 180 pills of 10-325 mg. hydrocodone with acetaminophen to patient F. These prescriptions, taken over a month, would divide into 6 pills of 10 mg. methadone and 6 pills of hydrocodone with acetaminophen per date for a total MED of 660. Respondent did not document why he was changing patient F's prescriptions from morphine sulfate to methadone in the progress note dated July 28, 2015. Respondent next documented a visit by patient F in his clinic on September 22, 2015. Respondent increased patient F's methadone prescription to 240 pills of 10 mg. per month and kept her hydrocodone with acetaminophen prescription at 180 pills per month for an MED of 900. Respondent documented that patient F was complaining of knee and back pain and that she wanted to discuss increasing methadone. Respondent documented a medical history that included patient F's prior surgeries and a goal that they, "fix pain & decrease meds." Respondent documented that the methadone prescription was being increased to 240 pills per month from 180 pills per month. Respondent documented that patient F should "try to ↓ Norco" at the bottom of the note. Respondent did not document informed consent for the prescription of methadone, a full history and physical, or an updated treatment plan that included the prescription of methadone. Respondent continued to prescribe 240 pills of 10 mg. methadone and 180 pills of 10-325 mg. hydrocodone with acetaminophen to patient F on a monthly basis until August 2016.

61. On May 2, 2017, Respondent was interviewed by the Medical Board of California. Respondent admitted that he didn't perform and document a substance abuse history for patient F, prior to initiating long term opioid therapy. Respondent admitted that he didn't document performing a periodic review of patient F chronic pain therapy in the medical records but did see

[12] http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm An MED is a numerical standard against which most opioids can be compared by converting them into a morphine equivalent and then comparing them in an apples-to-apples comparison.

her in clinic on a frequent basis. Respondent admitted that he didn't provide or document informed consent. Respondent stated he probably didn't have a pain contract with patient F. Respondent admitted he didn't perform urinalysis of patient F in 2015. Respondent admitted that in late 2015 or early 2016, he believed that patient F was addicted to her opiate therapy but didn't document those concerns in the medical records.

62. Respondent committed gross negligence in his care and treatment of patient F as follows: (A.) by failing to properly manage patient F's chronic pain condition by providing controlled substances without performing and/or documenting a history and physical before prescribing controlled substances, without performing and/or documenting a substance abuse history, and without documenting a recognized medical condition for the use of controlled substances before initiating controlled substances; (B.) by failing to obtain and/or document obtaining informed consent before initiating treatment; (C.) by failing to perform and/or document performing a periodic review of the course of pain treatment of patient F; (D.) by failing to consider and/or document considering additional evaluations and consultations for patient F; and, (F.) by failing to keep accurate and complete medical records for patient F.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

63. Respondent Thomas Alan Bowhay, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts during the care of patients A, B, C, D, E, and F by failing to properly prescribe controlled substances. The circumstances are as follows:

64. Complainant realleges paragraphs 19 through 62, and those paragraphs are incorporated by reference as if fully set forth therein.

65. Respondent's license is subject to disciplinary action because he committed the following repeated negligent acts during the care of patients A, B, C, D, E and F:

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Patient A

a.) As more fully described in paragraphs 20 through 23, Respondent failed to complete and/or document a history and physical examination before the initiation of treatment with controlled substances;

b.) As more fully described in paragraphs 20 through 23, Respondent failed to create and/or document a treatment plan and objectives before the initiation of treatment with controlled substances;

c.) As more fully described in paragraphs 20 through 23, Respondent failed to provide and/or document providing informed consent before the initiation of treatment with controlled substances;

d.) As more fully described in paragraphs 20 through 23, Respondent failed to perform and/or document performing a periodic review of patient A's progress while receiving chronic pain therapy;

e.) As more fully described in paragraphs 20 through 23, Respondent failed to refer and/or document referring patient A for additional evaluations and consultations while patient A was receiving chronic pain therapy;

f.) As more fully described in paragraphs 20 through 23, Respondent's failed to document complete medical records that would support the prescribing of controlled substances to patient A;

g.) As more fully described in paragraphs 20 through 23, Respondent repeatedly prescribed controlled substances to patient A despite patient A having a close family relationship with Respondent;

Patient B

h.) As more fully described in paragraphs 24 through 29, Respondent failed to complete and/or document a history and physical examination before the initiation of treatment with controlled substances;

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i.) As more fully described in paragraphs 24 through 29, Respondent failed to create and/or document a treatment plan and objectives before the initiation of treatment with controlled substances;

j.) As more fully described in paragraphs 24 through 29, Respondent failed to provide and/or document providing informed consent before the initiation of treatment with controlled substances;

k.) As more fully described in paragraphs 24 through 29, Respondent failed to perform and/or document performing a periodic review of patient B's progress while receiving chronic pain therapy;

l.) As more fully described in paragraphs 24 through 29, Respondent failed to refer and/or document referring patient B for additional evaluations and consultations while patient B was receiving chronic pain therapy;

m.) As more fully described in paragraphs 24 through 29, Respondent's failed to document complete medical records that would support the prescribing of controlled substances to patient B;

n.) As more fully described in paragraphs 24 through 29, Respondent prescribed opioids and benzodiazepines at the same time without providing and/or document providing an additional detailed informed consent regarding the potential dangers of taking opioids and benzodiazepines at the same time;

Patient C

o.) As more fully described in paragraphs 30 through 37, Respondent failed to complete and/or document a history and physical examination before the initiation of treatment with controlled substances;

p.) As more fully described in paragraphs 30 through 37, Respondent failed to create and/or document a treatment plan and objectives before the initiation of treatment with controlled substances;

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q.) As more fully described in paragraphs 30 through 37, Respondent failed to provide and/or document providing informed consent before the initiation of treatment with controlled substances;

r.) As more fully described in paragraphs 30 through 37, Respondent failed to perform and/or document performing a periodic review of patient C's progress while receiving chronic pain therapy;

s.) As more fully described in paragraphs 30 through 37, Respondent failed to refer and/or document referring patient C for additional evaluations and consultations while patient C was receiving chronic pain therapy;

t.) As more fully described in paragraphs 30 through 37, Respondent failed to document complete medical records that would support the prescribing of controlled substances to patient C;

Patient D

u.) As more fully described in paragraphs 38 through 46, Respondent failed to complete and/or document a history and physical examination before the initiation of treatment with controlled substances, represents a departure from the standard of care;

v.) As more fully described in paragraphs 38 through 46, Respondent failed to create and/or document a treatment plan and objectives before the initiation of treatment with controlled substances;

w.) As more fully described in paragraphs 38 through 46, Respondent failed to provide and/or document providing informed consent before the initiation of treatment with controlled substances;

x.) As more fully described in paragraphs 38 through 46, Respondent failed to perform and/or document performing a periodic review of patient D's progress while receiving chronic pain therapy;

y.) As more fully described in paragraphs 38 through 46, Respondent failed to refer and/or document referring patient D for additional evaluations and consultations while patient D was receiving chronic pain therapy;

z.) As more fully described in paragraphs 38 through 46, Respondent failed to document complete medical records that would support the prescribing of controlled substances to patient D;

aa.) As more fully described in paragraphs 38 through 46, Respondent improperly prescribed two short acting narcotic pain medications, Tramadol and hydrocodone, at the same time on multiple occasions;

Patient E

bb. As more fully described in paragraphs 47 through 55, Respondent failed to complete and/or document a history and physical examination before the initiation of treatment with controlled substances;

cc.) As more fully described in paragraphs 47 through 55, Respondent failed to create and/or document a treatment plan and objectives before the initiation of treatment with controlled substances;

dd.) As more fully described in paragraphs 47 through 55, Respondent failed to provide and/or document providing informed consent before the initiation of treatment with controlled substances;

ee.) As more fully described in paragraphs 47 through 55, Respondent failed to perform and/or document performing a periodic review of patient E's progress while receiving chronic pain therapy;

ff.) As more fully described in paragraphs 47 through 55, Respondent failed to refer and/or document referring patient E. for additional evaluations and consultations while patient E was receiving chronic pain therapy;

gg.) As more fully described in paragraphs 47 through 55, Respondent failed to document complete medical records that would support the prescribing of controlled substances to patient E;

hh.) As more fully described in paragraphs 47 through 55, Respondent improperly prescribed two short-acting narcotic pain medications, oxycodone and hydrocodone, at the same time on multiple occasions;

ii.) As more fully described in paragraphs 47 through 55, Respondent prescribed opioids and benzodiazepines at the same time without providing and/or document providing an additional detailed informed consent regarding the potential dangers of taking opioids and benzodiazepines at the same time;

jj.) As more fully described in paragraphs 47 through 55, Respondent prescribed 400 pills of 10-325 mg. Norco and Percocet per month which allowed for the ingestion of more than 4000 mg. of acetaminophen per day;

Patient F

kk.) As more fully described in paragraphs 56 through 62, Respondent failed to complete and/or document a history and physical examination before the initiation of treatment with controlled substances;

ll.) As more fully described in paragraphs 56 through 62, Respondent failed to create and/or document a treatment plan and objectives before the initiation of treatment with controlled substances;

mm.) As more fully described in paragraphs 56 through 62, Respondent failed to provide and/or document providing informed consent before the initiation of treatment with controlled substances;

nn.) As more fully described in paragraphs 56 through 62, Respondent failed to perform and/or document performing a periodic review of patient F's progress while receiving chronic pain therapy;

oo.) As more fully described in paragraphs 56 through 62, Respondent failed to refer and/or document referring patient F for additional evaluations and consultations while patient F was receiving chronic pain therapy;

pp.) As more fully described in paragraphs 56 through 62, Respondent failed to document complete medical records that would support the prescribing of controlled substances to patient F;

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qq.) As more fully described in paragraphs 56 through 62, Respondent improperly prescribed two short-acting narcotic pain medications, hydromorphone and hydrocodone, at the same time on multiple occasions;

rr.) As more fully described in paragraphs 56 through 62, Respondent improperly titrated methadone by prescribing a 60 mg. dose to a patient who was receiving 60 mg. of Morphine Sulfate ER.

THIRD CAUSE FOR DISCIPLINE

(Inaccurate and Inadequate Medical Records)

66. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records relating to the provision of services to his patients. The circumstances are as follows:

67. Complainant realleges paragraphs 19 through 62, and those paragraphs are incorporated by reference as if fully set forth herein.

68. As more fully described above, Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients.

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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 A 45383, issued to Thomas Alan Bowhay, M.D.;

2. Revoking, suspending or denying approval of Thomas Alan Bowhay, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Thomas Alan Bowhay, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: November 28, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2017305830
33106271.rtf

Exhibit B

Accusation and Petition to Revoke

800-2021-083070

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

In the Matter of the Accusation & Petition to Revoke Probation Against: **THOMAS ALAN BOWHAY, M.D.** **820 East Highway 88** **Jackson, CA 95642** Physician's and Surgeon's Certificate No. A 45383 Respondent.	Case No. 800-2021-083070 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. William Prasifka ("Complainant") brings this Accusation and Petition to Revoke Probation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about October 17, 1988, the Board issued Physician's and Surgeon's Certificate Number A 45383 to Thomas Alan Bowhay, M.D. ("Respondent").

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That certificate was in effect at all times relevant to the charges brought herein and will expire on February 28, 2024, unless renewed.

3. In a prior disciplinary action entitled *In the Matter of the Accusation Against: Thomas Alan Bowhay, M.D.*, Case No. 800-2015-018370, the Board, issued a Decision, effective July 20, 2018, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five (5) years with certain terms and conditions. As part of the settlement agreement in Case No. 800-2015-018370, Respondent agreed there was a factual basis[1] to establish that Respondent engaged in gross negligence, repeated negligent acts, and medical record keeping violations during the prescription of controlled substances to six patients. Patient F in the prior disciplinary matter is the same person as Patient 3[2] alleged in this Accusation and Petition to Revoke Probation. Respondent's license remains on probation. A copy of that Decision and Order is attached as Exhibit A and is incorporated by reference.

JURISDICTION

4. This Accusation and Petition to Revoke Probation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2227 of the Code provides in pertinent part, 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.

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[1] Pursuant to paragraph 12, page 3 of the Decision and Order, upon the filing of a new Accusation, Respondent agrees that all the charges and allegations in Accusation No. 800-2015-018730, shall be deemed true, correct, and fully admitted by Respondent for the purposes of any such proceeding.

[2] The three patients are identified by number ("1, 2, and 3") in order to protect patient privacy. All patients will be fully identified in discovery if not already identified during the investigative process.

STATUTORY PROVISIONS

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

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

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

(b) Gross negligence.

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

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

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

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7. Section 2266 of the Code states, in pertinent part:

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. Business and Professions Code section 125.3[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.

[3] Effective January 1, 2022. As Amended by 2021 Cal.Legis.Serv.Ch. 649 (S.B. 806) (WEST), the Board will be seeking costs of investigation and enforcement incurred after January 1, 2022, to comply with the legislature's intent that investigative and enforcement costs be imposed in Medical Board matters.

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

9. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high

doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for the extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

10. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[4] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

11. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Modafinil/Armodafinil – Generic name for the drugs Provigil and Nuvigil. Modafinil is a novel stimulant used for the treatment of narcolepsy and to reduce extreme sleepiness. Modafinil is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (f), and Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Phentermine – Generic name for the drugs Lomaira and Adipex-P. Phentermine is an amphetamine-like stimulant used to suppress appetite and promotes weight loss when used for a

[4] Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

short period. Phentermine is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (f), and Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and as a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone has a fast onset of analgesic effect but a long elimination half-life, which at higher doses can place a patient at risk of overdose and death. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Pregabalin – Generic name for the drug Lyrica. Pregabalin is a nerve pain medication used to treat nerve and muscle pain, including fibromyalgia. Pregabalin is a Schedule V controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.15. It is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

Patient 1

16. Respondent is a primary care physician primarily based in Jackson, California. Respondent began seeing Patient 1 in his medical practice after Patient 1's prior physician closed his medical practice. Patient 1 was already on controlled substances when Patient 1 began going to Respondent's practice. The Board reviewed medical records for Patient 1 between February 2018 and March 2021. Patient 1 had joined Respondent's practice prior to 2018. Patient 1 signed an opiate/pain management agreement with Respondent's medical practice on December 22, 2017, January 24, 2020, and July 3, 2020. Respondent's medical records for Patient 1 between February 2018 and August 2019 were handwritten and often illegible. After August 2019, Respondent used typed medical records to document Patient 1's care and treatment. Respondent documented that Patient 1 required chronic pain management to treat chronic low back pain, left leg pain, and left knee pain. Respondent documented that Patient 1 had degenerative arthritis of

the hip and knee, worsened by past motor vehicle accidents with vertebral compression fractures. Respondent documented that Patient 1 was prescribed diazepam to treat Patient 1's generalized anxiety disorder. Finally, Respondent documented that Patient 1 was prescribed modafinil to give him more energy and keep him awake during the daytime.

17. In February 2018, Respondent was prescribing 30 tablets of 200 mg modafinil, 150 tablets of 30 mg oxycodone HCL, 150 tablets of 10/325 mg hydrocodone with acetaminophen, and 60 tablets of 10 mg diazepam to Patient 1 on a monthly basis. As prescribed, Patient 1 was receiving a morphine equivalent dose[5] (MED) of 275, in combination with benzodiazepines. Respondent documented at Patient 1's February 2018 visit that Respondent wanted to start tapering down Patient 1's high narcotic dosage. However, at the April 2018 visit, Respondent documented that Patient 1 complained of palpitations when out of medication, that Patient 1 works at a quarry, and that Patient 1 needed an increase in his medications to 180 tablets of 30 mg oxycodone and 180 tablets of 10/325 mg hydrocodone with acetaminophen per month. Respondent did not document performing a musculoskeletal examination or a review of Patient 1's pain condition in the April 2018 note. Based on Patient 1's request, Respondent prescribed a monthly prescription of 180 tablets of 30 mg oxycodone, 180 tablets of 10/325 mg hydrocodone with acetaminophen, 60 tablets of 10 mg diazepam, and 30 tablets of 200 mg modafinil to Patient 1. As prescribed, Patient 1 was receiving a MED of 330.

18. By the end of 2018, Respondent discontinued Patient 1's hydrocodone with acetaminophen prescription and increased his oxycodone prescription to 210 tablets of 30 mg oxycodone hcl per month.[6] Respondent also increased Patient 1 to 30 mg of diazepam per day, while keeping him on 200 mg of modafinil per day. Respondent roughly continued Patient 1's prescriptions at the level set at the end of 2018 through early March 2020 and tried minimal tapering a few times without success. On May 25, 2019, Patient 1 received 220 tablets of 30 mg

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[5] Morphine Equivalent Dosing (MED) or Morphine Milligram Equivalents (MME) is an apples-to-apples comparison of different opioids to a reach a simple numeric measurement that allows for an accurate medication review. As noted in the 2016 CDC opiate guidelines, clinicians should avoid a dosage greater than 90 MME per day. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

[6] MED of 315.

oxycodone HCL. On June 14, 2019, Patient 1 received 220 tablets of 30 mg oxycodone HCL. Respondent saw Patient on May 7, 2019, and he documented that Patient 1 had been off medications for 7 to 10 days and experienced withdrawals. Respondent next saw Patient 1 on July 9, 2019, and failed to document why Patient 1 received an early refill of oxycodone on June 14, 2019. Between February 2018 and March 2021, Respondent failed to use urine toxicology testing to assess Patient 1 for possible diversion. Respondent did review CURES[7] once in 2017, twice in 2018, and once in 2019.

19. In January 2020, Respondent documented that he referred Patient 1 for an orthopedic consultation for possible surgery. In May 2020, Respondent documented that he informed Patient 1 that they needed to taper medications and by that time, Patient 1 was receiving 130 tablets of 30 mg oxycodone HCL per month[8]. However, by August 2020, Respondent documented that Patient 1 was again receiving 180 tablets of 10/325 hydrocodone with acetaminophen and 210 tablets of 30 mg oxycodone per month[9] in combination with 30 mg of diazepam per day and 200 mg of modafinil per day. By March 2021, Respondent had tapered Patient 1 down to 120 tablets of 30 mg oxycodone HCL and 120 tablets of hydrocodone with acetaminophen[10] per month in combination with 30 mg of diazepam per day.

20. Between February 2018 and March 2021, Respondent failed to document providing Patient 1 any non-opiate pain management options for Patient 1's chronic pain. Respondent failed to document trying prescriptions of multiple NSAID[11] medications, or any adjuvant medication such as anti-seizure medications, tricyclics, and topical therapies. Respondent failed to documented adding an SSRI[12] to Patient 1's treatment plan to help with Patient 1's chronic pain management and anxiety. Respondent failed to refer Patient 1 to a weight loss program despite Patient 1 being morbidly obese and failed to use physical therapy as a treatment modality.

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[7] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice which tracks the dispensing of all Scheduled controlled substances.

[8] MED of 195.

[9] MED of 375.

[10] MED of 220.

[11] Non-steroidal anti-inflammatory drug.

[12] Selective Serotonon reuptake inhibitor.

21. Between February 2018 and March 2021, Respondent failed to document performing a risk stratification of Patient 1's risk of opioid addiction and dependency despite Patient 1 being young, male, and having a history of generalized anxiety. Between February 2018 and March 2021, Respondent failed to document whether he considered referring Patient 1 for mental health treatment and cognitive behavioral therapy. Between February 2018 and March 2021, Respondent failed to document whether he performed a periodic review to determine if Patient 1 was developing tolerance and opioid-induced hyperalgesia syndrome. Despite Patient 1's attempted tapering of his narcotics in February 2018, Respondent failed to force Patient 1 to continue with tapering and instead increased Patient 1's opioid prescriptions. Between February 2018 and March 2021, Respondent often prescribed two short-acting opiate medications rather than transitioning Patient 1 to a long-acting and short-acting opiate to minimize addiction risks. Between February 2018 and March 2021, Respondent failed to document whether he ever determined if Patient 1's daytime somnolence and fatigue were a result of his excessively high opiate dosage. Respondent failed to document treating Patient 1's sleep apnea, failed to document developing a controlled substance treatment program that reduced sedative effects, and Respondent failed to prescribe naloxone to Patient 1.

22. Between February 2018 and March 2021, Respondent failed to document a pain intensity scale for Patient 1 at clinic visits. Respondent failed to document whether Patient 1 was experiencing side effects, or a lack thereof. Respondent rarely assessed Patient 1's functionality on controlled substances and failed to describe if Patient 1 had any aberrant behaviors or affects. Between February 2018 and March 2021, Respondent failed to document any updated detailed physical examinations for Patient 1; in the handwritten records, they were non-existent whereas in the typed records they were copied and pasted. In three years, Respondent failed to document a detailed knee joint examination of Patient 1, including range of motion, ligament examination, and palpation for fluids.

23. Between February 2018 and March 2021, Respondent failed to properly prescribe benzodiazepines to Patient 1 by using diazepam as a first-line treatment. In July 2019, Respondent documented he was prescribing diazepam to Patient 1 for generalized anxiety.

Respondent also stated to the Board he was prescribing diazepam to Patient 1 to treat muscle spasms. However, between February 2018 and March 2021, Respondent failed to try other medications like SSRI, SNRI, or tricylic medications that would have posed less of a risk of addiction and abuse than a benzodiazepine such as diazepam to Patient 1. As noted above, Respondent failed to refer Patient 1 to mental health treatment. In addition, on August 13, 2019, Respondent prescribed phentermine to Patient 1 for weight loss but failed to document whether this medication could adversely affect Patient 1's general anxiety disorder. Between February 2018 and March 2021, Respondent failed to adequately document whether he evaluated the cause, severity, and functional limitations of Patient 1's anxiety disorder.

24. Between February 2018 and March 2021, as noted above, Respondent repeatedly prescribed both opiates and benzodiazepines to Patient 1. Respondent failed to document whether Patient 1 was at an elevated risk of respiratory depression due to these prescriptions. Respondent failed to attempt to taper Patient 1's diazepam prescription despite Patient 1 being on high dose opioids, which placed him at a greater risk of respiratory depression. As noted above, Respondent failed to prescribe naloxone despite Patient 1 being prescribed high-dose opioids in combination with benzodiazepines. Finally, Respondent failed to document whether he analyzed whether Patient 1's sleep apnea placed him at a greater risk of death while on both opiates and benzodiazepines.

Patient 2

25. Respondent began providing medical care to Patient 2 prior to 2017. The Board reviewed Patient 2's medical records from February 2018 to April 2020. In April 2017, Respondent was prescribing 50 mg of methadone per day to Patient 2 for chronic back pain. A 2018 clinic note made brief reference to a 2011 MRI[13] report, which indicated that Patient 2 had herniated spine disc disease. In August 2017, Respondent increased Patient 2's methadone prescription to 80 mg[14] per day. Respondent stated that the dose was increased to help Patient 2

[13] Magnetic Resonance Imaging (MRI) is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of organs and tissues in the human body.

[14] MED of 960. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

with functionality as she worked in a restaurant. The Respondent continued Patient 2 on this dose of methadone through 2018. Respondent's medical records for Patient 2 contain minimal documentation related to physical examinations or opiate medication management. In November 2018, Respondent began to taper Patient 2's methadone dose. By October 2019, Respondent was prescribing 40 mg of methadone per day to Patient 2.

26. Between February 2018 and April 2020, Respondent failed to document whether any urine toxicology was performed on Patient 2. Between February 2018 and April 2020, Respondent failed to document any updated informed consents or pain management agreements related to Patient 2's care. Respondent did document consulting with CURES on July 2018, May 2019, and June 2019. Between February 2018 and April 2020, Respondent failed to document any referrals for consultations with medical specialists, in particular a surgical spine evaluation or pain management specialist, in Patient 2's medical chart. Respondent failed to document any records related to radiological testing or the performance of EKG[15] testing on Patient 2 despite Patient 2 receiving long-term methadone treatment.

27. Between February 2018 and April 2020, Respondent failed to try any non-opiate management of Patient 2's chronic back pain aside from ibuprofen. Respondent failed to document whether he considered anti-seizure medications, tricyclic medications, muscle relaxants, or topical creams. Between February 2018 and April 2020, Respondent failed to document whether he referred Patient 2 to adjuvant therapies such as physical therapy or chiropractic adjustments. Between February 2018 and April 2020, Respondent failed to document whether he performed an opioid risk assessment for Patient 2. Between February 2018 and April 2020, Respondent failed to document whether he prescribed naloxone to Patient 2 despite prescribing high-dose opioids.

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[15] An Electocardiogram (ECG or EKG) records the electrical signal from a patient's heart to assist in the diagnosis of heart conditions. An EKG can be used to determine the QT Interval which is the time from the beginning of the QRS complex, representing ventricular depolarization, to the end of the T wave, resulting from ventricular repolarization. Methadone can result in prolonged QT intervals that can be observed on an EKG. Prolonged QT intervals can place a patient at risk of a fatal cardiac arrhythmia.

28. Between February 2018 and April 2020, Respondent failed to document Patient 2's pain intensity scales, any apparent side effects, Patient 2's functionality, whether Patient 2 was engaging in aberrant behaviors, and Patient 2's affect at appointments. Between February 2018 and April 2020, Respondent failed to document any significant abnormal physical examination findings, which would have justified continued high-dose opioid prescribing to Patient 2. The Respondent's handwritten notes failed to include examination findings and Respondent's electronic typed notes appeared to be copied and pasted from visit to visit.

Patient 3

29. Patient 3 began receiving treatment from Respondent in November 2014. Respondent's care and treatment of Patient 3[16] between November 19, 2014, and August 2016 was previously litigated in Decision and Order in MBC Case No. 800-2015-018730, and that Decision and Order as noted above, is incorporated into this Accusation and Petition to Revoke Probation. In this matter, the Board reviewed Patient 3's patient records from July 2016 to March 2021. Patient 3 has a past medical history of gastric bypass surgery, spinal fusion surgery, chronic osteoarthritis, chronic lymphedema, and depression. Respondent documented that Patient 3 requires chronic pain management to treat chronic low back pain and knee pain caused by osteoarthritis and a spinal lumbar fusion. Patient's chronic pain syndrome was complicated by necrotizing fasciitis of her legs requiring surgery. Respondent documented multiple x-ray, MRI, and CT[17] scan evaluations in Patient 3's medical records. Respondent documented in Patient 3's medical records that Patient 3 was referred for orthopedic surgical evaluations, pain management specialists, and physical therapists. Respondent documented that Patient 3 had arthroscopic knee surgery in 2018 and that she was recommended to undergo total knee replacement surgery in May 2020 if she could lose weight to prevent postoperative complications.

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[16] Patient 3 was identified as Patient F in Case No. 800-2015-018730.

[17] A Computed tomography (CT) scan is a useful diagnostic tool for detecting diseases and injuries. It use a series of X-rays and a computer to create a 3D image of soft tissues and bones.

30. In April 2017, Respondent was prescribing 70 mg of methadone plus 50 mg of hydrocodone with acetaminophen to Patient 3.[18] Respondent was also prescribing phentermine, Lyrica, and Armodafinil to Patient 3 at that time. In July 2017, Respondent prescribed 90 mg of morphine sulfate and 50 mg of hydrocodone with acetaminophen and discontinued methadone.[19] However, in August 2017, Respondent put Patient 3 back on methadone. Unexpectedly, Respondent asserted that Patient 3 did not have additional withdrawal symptoms as a result of her switch to the morphine prescription, aside from her pain was not well controlled. In late 2017, Respondent began to taper Patient 3's methadone prescription.

31. By March 2018, Patient 3 received a prescription for 30 mg of methadone per day.[20] Patient 3 didn't even fill a methadone prescription in February or April 2018. On April 24, 2018, a phone message was documented in Patient 3's medical records that Patient 3 had been out of her medications for a couple of weeks. On May 1, 2018, a phone message was documented in Patient 3's medical record that stated she needed Respondent to call her on her medications. On February 22, 2018, Respondent documented a progress note that Patient 3 complained about inadequate pain control most days and that she was hunched over with a bad gait. However, Respondent did not document any other withdrawal symptoms. On April 30, 2019, Respondent documented a progress note that Patient 3 had been out of medications "for weeks" and that he was tapering her medications for probable tolerance. On May 29, 2018, Respondent documented a progress note that Patient 3 was continuing to taper down her methadone prescription. Respondent documented in the progress note a urine toxicology screen that was negative for methadone and hydrocodone. Respondent stated to the Board that no action was taken regarding this negative urine drug screen. Respondent did not document whether Patient 3 was suffering from any withdrawal symptoms in the May 2018 progress note. Respondent prescribed 100

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[18] MED of 890. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

[19] MED of 140.

[20] MED of 240.

tablets of 10/325 mg hydrocodone with acetaminophen and 120 tablets of 10 mg methadone to Patient 3 at the May 2018 visit.[21]

32. Following the May 29, 2018 visit, Respondent rapidly increased Patient 3's controlled substance prescriptions. By October 2018, Respondent was prescribing 60 mg methadone per day and 60 mg hydrocodone with acetaminophen per day to Patient 3.[22] By December 2018, Respondent was prescribing 80 mg methadone per day and 60 mg hydrocodone with acetaminophen per day to Patient 3.[23] Respondent continued Patient 3's prescriptions until April 2019. On April 18, 2019, Respondent prescribed 160 mg Oxycontin ER per day and 40 mg hydrocodone with acetaminophen to Patient 3 and discontinued methadone.[24] On April 30, 2019, Respondent documented that Patient 3 reported the Oxycontin was not helping and Respondent put Patient 3 back on methadone. Respondent did not document whether Patient 3 was suffering from any other withdrawal symptoms despite the huge disparity in MED between methadone and Oxycontin. By September 2019, Respondent was prescribing 80 mg methadone per day and 40 mg hydrocodone with acetaminophen per day to Patient 3.[25] In early 2020, Respondent prescribed 70 mg of methadone per day and 50 mg hydrocodone with acetaminophen per day to Patient 3. By June 2020, Respondent prescribed 60 mg of methadone per day and 60 mg of hydrocodone with acetaminophen per day to Patient 3. In March 2021, a pain management specialist evaluated Patient 3 and recommended that she be tapered off hydrocodone. A urine drug screen performed by the pain management specialist was consistent with Patient 3's prescriptions.

33. Between July 2016 to March 2021, Respondent failed to document whether he referred Patient 3 for a mental health consultation with a mental health professional. Between July 2016 and March 2021, Respondent documented only a few urine toxicology tests, and none in 2019 or 2020. Respondent also did not document any significant withdrawal symptoms in 2017 and 2019, despite prescribing opiates that had significantly lower MED amounts than the

[21] MED of 350.
[22] MED of 660.
[23] MED of 1020.
[24] MED of 280.
[25] MED of 1000.

methadone Patient 3 had previously been prescribed in the medical records. Respondent confirmed to the Board that Patient 3 did not have significant withdrawal symptoms when he attempted to prescribe morphine and OxyContin ER. Between July 2016 and March 2021, despite strong evidence that Patient 3's methadone prescriptions were not helping her and were consistent with opioid induced hyperalgesia syndrome, Respondent failed to impose and stick to a tapering plan. Instead, Respondent returned Patient 3 to higher dosages of methadone merely upon Patient 3's request.

34. Between July 2016 to March 2021, Respondent failed to document appropriate monitoring of Patient 3's progress on controlled substances. Respondent's documentation of Patient 3's medication was often very limited, the notes lacked physician examination findings, and Respondent failed to adequately document Patient 3's progress on controlled substance therapy, including her pain levels and functionality. Even after December 2019, when Respondent's progress notes were converted to a typed format, the progress notes appeared to be copied and pasted from visit to visit and still lacked significant justification for on-going prescribing.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

35. Respondent's license is subject to disciplinary action under section 2234, subdivision (b) of the Code in that Respondent engaged in gross negligence during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

36. Complainant realleges paragraphs 16 through 34, and those paragraphs are incorporated by reference as if fully set forth herein.

37. Respondent committed the following acts of gross negligence during the care and treatment of Patients 1, 2, and 3, separately and collectively, in the following ways:

a.) By improperly monitoring Patient 1's chronic pain condition between February 2018 and March 2021, by repeatedly prescribing a high dose of two short-acting opiates in combination with benzodiazepines to Patient 1 without documenting whether he performed an

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opioid risk stratification, without prescribing naloxone, and without documenting adequate physical examinations of Patient 1;

b.) By improperly managing Patient 1's generalized anxiety condition between February 2018 and March 2021 by repeatedly prescribing benzodiazepines to Patient 1 without documenting a full evaluation of Patient 1's anxiety condition and Patient 1's functional limitations, without documenting the use of safer alternative medications, and prescribing medications that could increase Patient 1's anxiety, specifically phentermine;

c.) By failing to properly evaluate whether Patient 2's chronic back pain between February 2018 and April 2020, could be managed with non-opioid pain medications including, trying non-opioid medications, referring Patient 2 to physical therapy, referring Patient 2 to medical specialists, and following up with additional radiological evaluations of Patient 2's condition;

d.) By failing to properly monitor Patient 2 between February 2018 and April 2020, while Patient 2 was on a high dose methadone prescription, including not performing an opioid risk assessment, failing to perform urine drug testing; failing to perform EKG testing, failing to prescribe naloxone, and failing to keep medical records that documented physical examinations and assessments of Patient 2's functionality; and

e.) By failing to properly monitor Patient 3's chronic pain management treatment between July 2016 to March 2021 while Patient 3 was on a high dose methadone prescription including not performing an opioid risk assessment, failing to recognize diversion behaviors based on an inconsistent urine drug test and lack of withdrawal symptoms, failing to perform urine drug screening in 2019 and 2020, by failing to ensure successful methadone tapering, and by failing to keep medical records that documented physical examinations and assessments of Patient 3's functionality.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

38. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

39. Complainant realleges paragraphs 16 through 37, and those paragraphs are incorporated by reference as if fully set forth herein.

40. Respondent committed the following negligent acts during the care and treatment of Patients 1, 2, and 3:

a.) By failing between February 2018 and March 2021 to prescribe non-opiate medications such as NSAIDs or adjuvant medications such as anti-seizure medications, tricyclics, topical therapies, and SSRI medications to Patient 1 as an alternative to opioid therapy;

b.) By failing between February 2018 and March 2021 to refer Patient 1 to physical therapy and/or a comprehensive weight loss program to manage Patient 1's chronic back pains;

c.) By failing between February 2018 and March 2021 to document performing an objective opioid risk stratification for Patient 1;

d.) By failing between February 2018 and March 2021 to mandate periodic urine toxicology of Patient 1 despite prescribing high quantities of controlled substances to Patient 1;

e.) By failing between February 2018 and March 2021 to recognize hyperalgesia syndrome in Patient 1, and repeatedly failing to engage in meaningful tapering of Patient 1's narcotic prescriptions;

f.) By repeatedly prescribing two short acting opiates to Patient 1 that Patient 1 took concurrently between February 2018 and March 2021;

g.) By failing to prescribe naloxone between February 2018 and March 2021 to Patient 1 despite prescribing high dose opiates in combination with benzodiazepines to Patient 1 who had a history of sleep apnea;

h.) By failing to document adequate physical examinations of Patient 1 and Patient 1's current functionality while being prescribed controlled substances between February 2018 and March 2021;

i.) By failing to document a full evaluation of Patient 1's anxiety condition and functional limitations between February 2018 and March 2021;

j.) By repeatedly prescribing diazepam to Patient 1 as a long-term treatment for Patient 1's anxiety between February 2018 and March 2021;

k.) By prescribing phentermine to Patient 1 for weight loss without documenting whether there was a risk of impacting Patient 1's anxiety condition;

l.) By prescribing high-dose opiates in combination with benzodiazepines that Patient 1 took concurrently between February 2018 and March 2021;

m.) By failing to prescribe non-opiate medications to Patient 2 and/or refer Patient 2 to physical therapy between February 2018 and April 2020 as an alternative to opioid therapy;

n.) By failing to make referrals for a surgical spine evaluation and pain management evaluation for Patient 2 between February 2018 and April 2020;

o.) By failing to document any radiological evaluation of Patient 2's lower back pain between February 2018 and April 2020;

p.) By failing to perform an opioid risk assessment of Patient 2 between February 2018 and April 2020;

q.) By failing to perform periodic urine drug testing on Patient 2 between February 2018 and April 2020;

r.) By failing to regularly perform EKG testing on Patient 2 and monitoring Patient 2's QT intervals between February 2018 and April 2020;

s.) By failing to recognize that Patient 2 was likely suffering from opioid hyperalgesia syndrome and drug tolerance between February 2018 and April 2020;

t.) By failing between February 2018 and April 2020 to prescribe naloxone to Patient 2 despite repeatedly prescribing methadone;

u.) By failing between February 2018 and April 2020 to provide medical documentation of Patient 2 that included adequate physical examinations and functional assessment;

v.) By failing to document between February 2018 and April 2020 whether Respondent provided informed consent or entered a written pain agreement with Patient 2 that outlined the dangers of methadone prescribing.

w.) By failing between July 2016 to March 2021 to refer Patient 3 for a mental health consultation with a mental health professional;

x.) By failing between July 2016 to March 2021 to perform an opioid risk stratification assessment for Patient 3;

y.) By failing to recognize possible diversion behaviors from Patient 3 due to an inconsistent urine drug screen and the absence of withdrawal symptoms between July 2016 to March 2021;

z.) By failing to perform urine drug screening in 2019 and 2020 on Patient 3;

aa.) By failing between July 2016 to March 2021 to recognize that Patient 3 had induced hyperalgesia syndrome and engage in successful tapering of Patient 3's methadone;

bb.) By prescribing between July 2016 to March 2021 an excessive opioid dosage, at times over a 1000 MED, to Patient 3;

cc.) By failing between July 2016 to March 2021 to provide medical documentation for Patient 3 that included adequate physical examinations and an assessment of Patient 3's functionality; and,

dd.) By failing to document between July 2016 to March 2021 whether Respondent provided informed consent or had a written pain agreement with Patient 3 that outlined the dangers of methadone prescribing.

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THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

41. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he kept inadequate and inaccurate medical records during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

42. Complainant realleges paragraphs 16 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

CAUSE TO REVOKE PROBATION

(New Violation of the Law)

43. At all times after the effective date of Respondent's probation, Condition Number 8, of the Decision and Order in MBC Case No. 800-2015-018370 stated:

> 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 probation, payments, and other orders.
>
> Condition Number 14, provides in pertinent part that upon the filing of an Accusation or Petition to Revoke 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.

44. Respondent's probation is subject to revocation because he failed to comply with Probation Condition Number 8 referenced above. The facts and circumstances regarding this violation are as follows:

A. Complainant realleges paragraphs 16 through 42, and those paragraphs are incorporated by reference as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

45. As noted above, to determine the degree of discipline, if any, to be imposed on Respondent, Complainant realleges the allegations in paragraph 3, and those allegations are fully incorporated therein. That Decision is now final and is incorporated by reference as if fully set forth.

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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 the probation that was granted by the Medical Board of California in Case No. 800-2015-018370 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. A 45383 issued to Respondent Thomas Alan Bowhay, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate No. A 45383, issued to Respondent Thomas Alan Bowhay, M.D.;

3. Revoking, suspending or denying approval of Respondent Thomas Alan Bowhay, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code, and advance practice nurses;

4. Ordering Respondent Thomas Alan Bowhay, M.D. to pay the Medical Board of California the reasonable costs of the investigation and enforcement of this case pursuant to Bus. & Prof. Code 125.3[26], and, if placed on probation, the costs of probation monitoring;

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

DATED: DEC 27 2021

Reji Varghese
Deputy Director

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

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[26] Costs of the investigation and enforcement of this case after January 1, 2022.

Exhibit C

Accusation and Petition to Revoke

800-2021-080989

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **THOMAS ALAN BOWHAY, M.D.** **820 East Highway 88** **Jackson, CA 95642-2040** Physician's Surgeon's Certificate No. A 45383, Respondent.	Case No. 800-2021-080989 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

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 October 17, 1988, the Medical Board issued Physician's Surgeon's Certificate Number A 45383 to Thomas Alan Bowhay, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2024, unless renewed.

3. In a prior disciplinary action entitled *In the Matter of the Accusation Against: Thomas Alan Bowhay, M.D.*, Case No. 800-2015-018370, the Board issued a Decision, effective July 20, 2018, revoking Respondent's Physician's and Surgeon's Certificate. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five (5) years with certain terms and conditions. Respondent's license remains on probation.

4. On or about December 27, 2021, in a disciplinary action entitled *In the Matter of the Accusation Against: Thomas Alan Bowhay, M.D.*, MBC Case No. 800-2021-083070, the Board filed an Accusation and Petition to Revoke Probation against Respondent's Physician's and Surgeon's Certificate. That Accusation matter is still pending before the Board and Respondent has requested a hearing.

JURISDICTION

5. 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.

6. Section 2227 of the Code provides, in pertinent part, 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.

7. Section 2234 of the Code, provides, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> ...
>
> (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.

...

COST RECOVERY

8. Section 125.3 of the Code states:

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

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

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

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

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

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

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

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

costs.

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

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

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

DEFINITIONS

9. Tramadol – Generic name for the drug Ultram. Tramadol is a novel opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11056, subdivision (c).

10. Duloxetine – Generic name for the drug Cymbalta. Duloxetine is a serotonin-norepinephrine reuptake inhibitor that is used to treat major depressive disorder, generalized anxiety disorder, fibromyalgia, neuropathic pain, and central sensitization. Duloxetine in combination with tramadol can increase the risk of a serious condition called serotonin syndrome. It is a dangerous drug pursuant to Business and Professions Code section 4022.

11. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

FACTUAL ALLEGATIONS

12. On or about May 6, 2021, Patient 1 presented at Respondent's medical office in Jackson, California. Respondent, a family practice trained physician, provides primary care and

urgent care services at his medical office. Patient 1 had a prior medical history of chronic lower back pain, anxiety, asthma, diverticulitis, kidney stones, and reflux disease. Patient 1 has a family history of prior alcoholism, and a past history of smoking. Respondent documented that Patient 1 was not currently using alcohol, but failed to document whether or not Patient 1 had a prior substance abuse history with alcohol and/or drugs. Respondent's lower back pain had been previously treated with physical therapy, at least four steroid epidural injections, and spinal surgery. Patient 1 presented at Respondent's clinic for a medication refill with a complaint of lower back pain and left knee pain. Patient 1 was noted as taking 10/325 mg Norco, two to three times a day, fish oil, various supplements including CBD, and Kratom, an herb with opium-like properties and stimulant effects. Respondent documented an exam, which showed low back tenderness and decreased range of motion. Respondent obtained a signed medical release from Patient 1 for his prior medical records and prescribed 60 tablets of 10/325 mg Norco to Patient 1.

13. Respondent took over Patient 1's primary care following the May 6, 2021, urgent care visit. Respondent next saw Patient 1 on May 21, 2021, and documented that Patient 1 was now taking three tablets of 10/325 mg Norco per day, had lower back pain, and nausea. Respondent prescribed 90 tablets of 10/325 mg Norco to Patient 1. On June 7, 2021, Respondent provided a prescription by phone to Patient 1 for 30 tablets of 10/325 mg Norco. Respondent next saw Patient 1 on June 25, 2021, and provided a refill of 90 tablets of 10/325 mg Norco.

14. Respondent next saw Patient 1 on July 22, 2021 for a chief complaint of digestive problems associated with taking Norco. Respondent documented that Patient 1 stated laxatives were not helping, that he had lower right side pain, was depressed, tired, had no motivation, was on edge, had negative thoughts and was frustrated. Respondent also documented that Patient 1 was now consuming marijuana oral edibles. Respondent documented an examination, which indicated that Patient 1 had mild distress, agitation, a depressed affect, was anxious, and had right lower quadrant tenderness, as well as the prior complaints of lower back tenderness and reduced range of motion of the lower back. Respondent documented an assessment that included depression, obstipation, mood swings, and lower back pain.

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15. At the July 22, 2021, visit, Respondent prescribed 30 tablets of 30 mg Cymbalta to Patient 1 to treat depression and pain. Respondent prescribed 40 tablets of 50 mg tramadol to Patient 1 to be taken as needed for pain. Finally, Respondent prescribed 30 tablets of .2 mg Symproic, a peripherally-acting Mu-opioid receptor antagonist agent used to treat opioid-induced constipation. According to Patient 1, he notified Respondent that he had previously had an adverse reaction to Cymbalta and that it had caused him to suffer psychosis. Respondent failed to provide Patient 1 with informed consent regarding Patient 1 taking Cymbalta at the same time as tramadol. Respondent also failed to document in Patient 1's medical records that there is a risk that the medications in combination may cause a serious interaction, including serotonin syndrome. Respondent failed to document whether he discussed with Patient 1 that Cymbalta and tramadol can also interact adversely with marijuana, supplements, and Kratom. Finally, Respondent prescribed Cymbalta to Patient 1 despite knowing that Patient 1 had experienced adverse reactions to the medication in the past. Patient 1's wife picked up Patient 1's medications at the local pharmacy, and the pharmacist notified her that Cymbalta may interact with tramadol. Having learned of this information from his wife, Patient 1 contacted Respondent's medical office on July 23, 2021, to discuss the possible risk of interactions.

16. Respondent briefly spoke with Patient 1 on July 23, 2021, over the phone, and Patient 1 asked Respondent about the possible interactions of the two medications and his continued concerns about taking Cymbalta despite a past negative personal history of taking the medication. Respondent asked Patient 1 to give him some time to look into the issue and that Respondent would call Patient 1 back. On July 26, 2021, having not heard from Respondent, Patient 1 contacted the medical office. Respondent did not respond. On July 27, 2021, Patient 1 called Respondent's office again and stated that tramadol was not working and requested Norco. Respondent documented that he was referring Patient 1 to pain management and that he was discharging Patient 1 from his practice because Patient 1 had exhibited threatening and abusive behavior. On July 29, 2021, Respondent discharged Patient 1 from his practice.

17. Despite taking over Patient 1's primary care, on or between May 6, 2021, and July 22, 2021, Respondent failed to obtain a comprehensive history of Patient 1. Respondent failed to

address Patient 1's family history of alcoholism, or to adequately address Patient 1's May 6, 2021, complaints of numbness, weakness, depression, fatigue, obstipation, abdominal pain, or changes in appetite. On August 23, 2022, during an interview with the Board, Respondent confirmed that he was unaware of Patient 1's own past history of alcoholism, having never performed a comprehensive substance abuse history of Patient 1 during treatment. Respondent failed to address Patient's complaint of right lower quadrant abdominal pain, which could have been indicative of kidney stones or appendicitis. Finally, Respondent failed to document whether he counseled Patient 1 about possible concerns between the multiple supplements and herbal remedies that Patient 1 reported taking and the risk of possible harm when taken in combination with opiates and Cymbalta.

CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts during the care and treatment of Patient 1. The circumstances are set forth in paragraphs 12 through 17, and those paragraphs are incorporated by reference as if fully set forth herein.

19. Respondent committed repeated negligent acts in the following ways:

A. By failing to recognize and/or documenting that he failed to recognize and discuss the possible serious interactions of co-prescribing Cymbalta and tramadol to Patient 1; and,

B. By failing to treat Patient 1's multiple co-morbidities including failing to adequately manage expected complications of constipation and depression, failing to perform a detailed substance abuse history, and overlooking various symptoms such as right lower quadrant abdominal pain.

CAUSE TO REVOKE PROBATION

(New Violation of the Law)

20. At all times after the effective date of Respondent's probation, Condition Number 8, of the Decision and Order in MBC No. 800-2015-018730 stated:

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 probation, payments, and other orders.

Condition Number 14, provides in pertinent part that upon the filing of an Accusation or Petition to Revoke 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.

21. Respondent's probation is subject to revocation because he failed to comply with Probation Condition Number 8 referenced above. The circumstances are as forth in paragraphs 12 through 17, and those paragraphs are incorporated by reference as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

22. As noted above, to determine the degree of discipline, if any, to be imposed on Respondent, the allegations in paragraph 3 are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking the probation that was granted by the Medical Board of California in Case No. 800-2015-018370 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. A 45383 issued to Respondent Thomas Alan Bowhay, M.D.;

2. Revoking or suspending Physician's Surgeon's Certificate Number A 45383, issued to Thomas Alan Bowhay, M.D.;

3. Revoking, suspending or denying approval of Thomas Alan Bowhay, M.D.'s authority to supervise physician's assistants, and advance practice nurses;

4. Ordering Thomas Alan Bowhay, 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,

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

DATED: DEC 23 2022

REJI VARGHESE
Deputy Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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