ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
TAN N. TRAN
Deputy Attorney General
State Bar No. 197775
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6535
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **ROBERT D. SIEW, M.D.** **10 Congress Street, Suite 155** **Pasadena, CA 91105-3027** **Physician's and Surgeon's Certificate No. A 45333,** Respondent.	Case No. 800-2021-080190 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Reji Varghese (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 September 19, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number A 45333 to Robert D. Siew, 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 December 31, 2025, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

STATUTORY PROVISIONS

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

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

7. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

8. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

9. Section 2266 of the Code states:

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

10. Section 725 of the Code states:

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

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

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

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

11. Health and Safety Code § 11165.4 states:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, first time means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

COST RECOVERY

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

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – 6 Patients)

13. Respondent, Robert Siew, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code, for the commission of acts or omissions involving gross negligence in the care and treatment of Patients 1, 2, 3, 4, 5, and 6.[1] The circumstances are as follows:

Patient 1

14. Patient 1 (or "patient") is an 86-year-old male, who treated with Respondent from approximately November 2020 through March 2022. Per Respondent, the patient was a chronic pain patient from out-of- state who was taking oxycodone (Percocet) (an opiate painkiller and dangerous drug pursuant to Code section 4022) "six times a day." Respondent admitted that he never contacted the patient's prior physician, and that he merely trusted the patient and his son's reporting. Patient 1 had various ailments including chronic pain, chronic knee pain, low back pain, allergic rhinitis (irritation in nose), hypertension, hypercholesterolemia (high cholesterol), atrial fibrillation (irregular heartbeat), and TAVR (transcatheter aortic valve replacement) bioprosthetic.

15. From February 8, 2021 through March 2, 2022 there were twelve prescriptions of oxycodone prescribed to Patient 1 (mostly at 90 MME).[2] Prior to Respondent prescribing oxycodone for this patient on February 8, 2021, Patient 1 had hydrocodone (Norco) (another opiate painkiller and dangerous drug pursuant to Code section 4022) and diazepam (Valium, a benzodiazepine used for anxiety and dangerous drug pursuant to Code section 4022) prescribed by another physician, but there was no documentation of any records from other physicians, nor evidence that such was requested by Respondent.

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

[2] MME (morphine milligram equivalent) or MMED (morphine milligram equivalent per day) are values that represent the potency of an opioid dose relative to morphine. Patients taking 50 or greater MME daily are more at risk for problems related to opioid use. Very high dosages are 90 or greater MME a day. Other than the one-time dose reduction (60 MME) on May 2021, there was no dose reduction of the twelve prescriptions for oxycodone filled between February 2021 and March 2022.

16. Despite prescribing controlled substances on a continuous basis to this patient, Respondent did not have a written opiate contract (i.e., to convey to the patient the potential side effects and precautions in the use of opiates and opiates with benzodiazepines and other drugs) with the patient, as Respondent indicated that it was "not necessary." Besides oxycodone, the patient was also on other medications such as carbamazepine[3] (Tegretol, an anticonvulsant and dangerous drug pursuant to Code section 4022, used to treat seizures, nerve pain, and bipolar disorder) and mirtazapine (Remeron, an antidepressant and dangerous drug pursuant to Code section 4022), but there was no documentation that Respondent performed toxicology screens on the patient, nor was there any documentation that Respondent utilized any other opioid risk/screening tools (e.g., inquiry into the patient's family/personal history, psychological conditions, etc.) in order to assess the patient's risk for opioid abuse/misuse, despite the patient taking large amounts of narcotics and other medications on a daily basis.

17. Also, there was no evidence that Respondent documented the patient's specific activities for which the pain medications allowed him to pursue, the level of analgesia, and whether there was any aberrant behavior (i.e., potential for diversion). For example, on multiple visits there was no mention in the chief complaint or review of systems or examination of the nature and quality of the pain for which the opiates were prescribed, nor the duration, location, intensity, relieving factors, or any other pain descriptions. There was no documentation indicating the estimated numerical perceived intensity or severity of pain, and no documentation indicating the patient's response to the prescribed opiates. There were no narratives documenting the history of present illness.

18. Moreover, pharmacologic and non-pharmacologic alternatives to opiates were not documented, and other than the last documented visit on March 2, 2022, there was no mention of referring the patient to specialists to address the patient's pain. Many of the available notes contain misspellings, and/or inaccurate, or not credible, or not reasonably documented

[3] Respondent stated during a Board interview that another doctor or neurologist may have prescribed carbamazepine to the patient, but Respondent "might have refilled it..." and "didn't question [the prescription]." Respondent also claims that he did check CURES for this patient, but not on a monthly basis, although the patient was receiving a new prescription on a monthly basis.

information, and there was no evidence that Respondent adequately reconciled the results of tests ordered (e.g., some tests showed significant abnormalities) and conveyed the results to Patient 1 in terms which he could understand.

19. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 1 which represent extreme departures from the standard of care.

20. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

Patient 2

21. Patient 2 (or "patient"), a 70 year-old female, treated with Respondent from approximately November 2013 through April 2022. The patient had various ailments including Diabetes mellitus type 2, hypertension, obesity, generalized anxiety disorder, osteoarthritis of the knee, multiple back surgeries, and anemia (low red blood cell count). During this time period, Respondent prescribed to Patient 2 both opioids (e.g., oxycodone (Percocet), and hydrocodone (Norco), which are both opiate painkillers and Schedule II drugs) and benzodiazepines (e.g., alprazolam, (Xanax) which is used for anxiety relief and is a dangerous drug pursuant to Code section 4022) in a chronic and continuous manner. During the period Respondent was the primary physician for Patient 2, other doctors, at times, were also prescribing the same medications. [4]

22. While the oxycodone was initiated by another physician in August 2016, Respondent continued the prescribing of monthly opioids in January 2017. While Respondent transitioned the patient from the more potent oxycodone to hydrocodone by November 2017, the MMED on the hydrocodone slowly escalated over the years (from 2017 through 2021).[5] By January 2017,

[4] Effective October 2018, it became mandatory for doctors to check the CURES (Controlled Substance Utilization Review and Evaluation System, a drug monitoring database for Schedule II through V controlled substances dispensed in California), database prior to prescribing controlled substances, but there was no documentation that Respondent checked CURES during 2021 or 2022. Respondent claims that he could not access/check CURES for a few months during the COVID pandemic due to "computer" issues.

[5] There were dose reductions starting around March 2022, but this reduction occurred shortly after Respondent was notified of the complaint and Board investigation.

Respondent's prescribing pattern reflected chronic, continuous use of opiates, in a patient with no documented objective evidence of the need to prescribe opiates continuously and chronically.

23. Chronic and continuous prescribing of the benzodiazepines (e.g., alprazolam) by Respondent started in December 2014[6] and continued to at least September 2021. Although the patient was prescribed alprazolam for many years, there was no documentation that Respondent considered referring the patient to a psychologist or psychiatrist, nor was there any documentation that Respondent offered the patient less dangerous drugs such as SSRIs (Selective Serotonin Reuptake Inhibitor, e.g., Zoloft) and SNRIS (Serotonin and Norepinephrine Reuptake Inhibitors, e.g., Cymbalta) as initial pharmacotherapy.

24. Notwithstanding, the chronic and continuous prescribing of both opioids and benzodiazepines by the Respondent to Patient 2, Respondent admitted that he did not begin checking CURES for this patient until "around 2020 or 2021," despite the patient having multiple providers/prescribers and using multiple pharmacies. Respondent also admitted never doing any drug testing for the patient, because according to Respondent, "...There's no reason to..." Also, there was no controlled substance agreement (CSA) in the available records, and no evidence that Respondent utilized toxicology screens for this patient. Nor was there any documentation that Respondent utilized any other opioid risk/screening tools (e.g., inquiry into the patient's family/personal history, psychological conditions, etc.) in order to assess the patient's risk for opioid abuse/misuse. Also, there was no documentation that Respondent adequately assessed the patient's pain (e.g., intensity/severity of pain) and the patient's response to the prescribed opiates. Many of the available notes contain misspellings, and/or inaccurate, or not credible, or not reasonably documented information, as the documentation did not always correlate with the exam findings.

25. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 2 which represent extreme departures from the standard of care.

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[6] Acts and omissions occurring prior to 2017 are listed herein for historical purposes.

26. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

Patient 3

27. Patient 3 (or "patient"), a 73 year-old female, treated with Respondent from approximately April 2013 through February 2022. The patient had various ailments including breast cancer, chronic pain syndrome, depression, posttraumatic stress disorder (PTSD), hypertension, diabetes, and other conditions. From approximately July 2015 through March 2022, the patient was prescribed over 200 prescriptions of multiple medications, including both opioids (e.g., oxycodone (Percocet), and Fentanyl, which are both opiate painkillers and Schedule II drugs) and benzodiazepines (e.g., diazepam), as well as zolpidem (Ambien) a hypnotic and dangerous drug pursuant to Code section 4022).[7]

28. Overall, there were no tapered and sustained reduction of the opioid doses, as the average MMED of the prescriptions steadily increased from January 2016 to March 2022. There was also no documentation indicating the estimated numerical perceived intensity or severity of pain, and no documentation indicating the patient's response to the prescribed opiates. Although the patient was diagnosed with depression and PTSD and prescribed benzodiazepines for many years, there was no documentation that Respondent consulted with psychologists or psychiatrists. Specifically, diazepam was initially prescribed around May 2016. Respondent increased the dosage of diazepam beginning November 2018 through February 2022, with the diazepam becoming a monthly medication. The available records indicate that Respondent also prescribed zolpidem to Patient 3 on or about December 2015 through May 2018, but there was no associated note/documentation for the indication therefore. This constituted an extreme departure from the standard of care as it relates to the prescribing of controlled substances, including both opioids and benzodiazepines, which can cause dangerous interactions.

[7] Respondent admitted in a Board interview that the patient had been receiving an "outrageous" amount of narcotics for many years, and that Respondent referred the patient to pain management after he was notified of the Board investigation. It also appeared that Fentanyl and oxycodone may have been recommended by other doctors (e.g., pain specialist/psychiatrist), but there was no reasoning documented by the Respondent to increase the dose of the oxycodone at visits after the patient was seen by the psychiatrist.

29. Despite the long-term (i.e., more than 90 days) prescribing of both opioids and benzodiazepines to Patient 3, there was no controlled substance agreement (CSA) in the available records, and no evidence that Respondent utilized toxicology screens or did any drug testing for this patient. Nor was there any documentation that Respondent utilized any other opioid risk/screening tools (e.g., inquiry into the patient's family/personal history, psychological conditions, etc.), or that he considered Patient 3's diagnoses of depression and PTSD. CURES reports are not found in Patient 3's chart that would indicate that Respondent checked CURES prior to prescribing controlled substances for Patient 3. Many of the available notes contain misspellings, and/or inaccurate, or not credible, or not reasonably documented information, as the documentation did not always correlate with the exam findings.

30. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 3 which represent extreme departures from the standard of care.

31. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

Patient 4

32. Patient 4 (or "patient"), was an 88 year-old female, who treated with Respondent from approximately April 2009 through October 2019. This patient had various conditions including cancer, vascular disease, total knee and hip replacements, COPD (chronic obstructive pulmonary disease), hypertension, and other maladies. The patient died in January 2020 with metastatic lung cancer.

33. From January 2015 through November 2019, Respondent prescribed various controlled substances to the patient including both opioids (e.g., hydrocodone, and Fentanyl), as well as benzodiazepines (e.g., alprazolam/Xanax and lorazepam/Ativan (a dangerous drug pursuant to Code section 4022)).[8] There were also multiple prescribers of controlled substances to this patient during the time period from 2015 through 2019, when Respondent was the primary physician. Specifically, while Respondent was treating the patient, there were at least 14 different

[8] Respondent claims that he tried to reduce the dose of narcotics "every time [he] saw [the patient]..." but just kept the doses the same because the patient stated she was in pain.

doctors who also prescribed narcotics to Patient 4. The patient also filled the prescriptions at seven different pharmacies. Respondent admitted that he was not aware of this.

34. Notwithstanding the long-term (i.e., more than 90 days) prescribing of both opioids and benzodiazepines to Patient 4, there was no controlled substance agreement (CSA) in the available records, and no evidence that Respondent utilized toxicology screens or did any drug testing[9] for this patient. Nor was there any documentation that Respondent utilized any other opioid risk/screening tools (e.g., inquiry into the patient's family/personal history, psychological conditions, etc.), despite the patient consuming alcohol (although limited), and having tobacco dependence. Also, there were no CURES reports to indicate that Respondent checked CURES prior to prescribing controlled substances for Patient 4, as Respondent indicated that he did not think CURES was mandatory (in 2018 or 2019), and that he was not aware that there were multiple prescribers of narcotics to this patient.[10]

35. Respondent also departed from the standard of care in his assessment of the patient's pain, as there was no documentation indicating the estimated numerical perceived intensity or severity of pain, and no documentation indicating the patient's response to the prescribed opiates, in order to determine whether pharmacologic intervention(s) were effective in controlling her pain. Many of the available notes contain misspellings, and/or inaccurate, or not credible, or not reasonably documented information, as the documentation did not always correlate with the exam findings.

36. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 4 which represent extreme departures from the standard of care.

37. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

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[9] Respondent admitted in a Board interview that he never did any drug testing on this patient because, since he "...gave her the "narcotics, and opiates, and benzos"..., Respondent knew it was positive.

[10] Respondent also stated in a Board interview that this patient died [in January 2020] before CURES was "invented..." and that the patient may have been "manipulating" him since she was also receiving the same narcotics (e.g., hydrocodone) from other prescribers, without Respondent being aware of same.

Patient 5

38. Patient 5 (or "patient"), was an 87 year-old female, who treated with Respondent from approximately May 2015 through July 2018. This patient had various conditions including TAVR (bioprosthetic valve) for severe AS (aortic stenosis), atrial fibrillation, chronic diastolic heart failure, coronary artery disease, cancer, hypertension, obesity, chronic venous insufficiency, and other maladies. The patient died in May 2020 at age 87 of inanition (state of malnutrition).

39. From May 2015 through September 2019,[11] Respondent prescribed various controlled substances to the patient including Tramadol (an opioid/painkiller and dangerous drug pursuant to Code section 4022) and hydrocodone. There were also two other prescribers of controlled substances to this patient during the time period from 2015 through 2019, when Respondent was the primary physician.

40. Notwithstanding the long-term (i.e. more than 90 days) prescribing of opioids to the patient, there was no controlled substance agreement (CSA) in the available records (e.g., to explain to the patient that she should notify the doctor of any other prescribers of controlled substances, etc.), and no evidence that Respondent utilized toxicology screens or did any drug testing for this patient. Nor was there any documentation that Respondent utilized any other opioid risk/screening tools (e.g., inquiry into the patient's family/personal history, psychological conditions, etc.), despite the patient having a prior tobacco dependence and "occasional" alcohol consumption. There were no CURES reports in the patient's chart to indicate that Respondent checked CURES prior to prescribing controlled substances to Patient 5.[12]

41. Respondent also departed from the standard of care in his assessment of Patient 5's pain, as there was no adequate expansion/description of the pain (e.g., location, quantifiable intensity, quality, duration, etc.). Many of the available notes contained misspellings, and/or

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[11] There were ten prescriptions of controlled substances (Tramadol and hydrocodone) filled and sold under Respondent's name after October 2018, with the last prescription filled and sold on September 20, 2019, which was more than a year after the last documented visit of July 18, 2018. There were no office notes available after July 18, 2018.

[12] Patient 5 had received prescriptions for controlled substances from other prescribers in 2015 and from September through November 2018, after checking CURES became mandatory. However, the Respondent did not appear to have any knowledge of the patient having multiple prescribers while she was under Respondent's primary care.

inaccurate, or not credible, or not reasonably documented information, as the documentation did not always correlate with the exam findings, and there was no evidence that Respondent adequately reconciled the results of tests ordered, and had to repeat the labs to determine whether some of the results/conditions had changed.

42. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 5 which represent extreme departures from the standard of care.

43. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

Patient 6

44. Patient 6 (or "patient"), is an 82 year-old female, who treated with Respondent from approximately November 2006 through October 2020. This patient had various conditions including right nephrectomy (kidney removal) in 2007, depression, anxiety, degenerative joint disease, insomnia, pain, and other maladies. Per prescription records, from November 2014 through March 2021, multiple controlled substances were prescribed to this patient including opiates (e.g., hydrocodone and Tramadol), as well as benzodiazepines (e.g., alprazolam/Xanax and clonazepam/Klonopin, a benzodiazepine and dangerous drug pursuant to Code section 4022, used to treat seizures, panic disorder, and anxiety).[13]

45. Notwithstanding the long-term (i.e. more than 90 days) prescribing of opioids and benzodiazepines to Patient 6, there was no controlled substance agreement (CSA) in the available records and no toxicology screens/labs, despite the patient having multiple labs collected over the years. Nor was there any documentation that Respondent utilized any other opioid risk/screening tools (e.g., inquiry into the patient's family/personal history, psychological conditions, etc.), despite the patient having depression (e.g., on Zoloft (antidepressant) and buspirone (anti-anxiety medication)), and also likely having alcohol dependence. There were no CURES reports in the patient's chart to indicate that Respondent checked CURES prior to prescribing controlled

[13] Specifically, although alprazolam was not prescribed on a chronic and continuous manner for most of the years, clonazepam was prescribed on a chronic and continuous manner from most of 2014 through the end of 2019. Again, acts before 2017 are discussed for historical purposes.

substances for Patient 6, as Respondent even admitted that he did not check CURES for this patient in 2020, after it became mandatory by law to do so. Many of the available notes were inaccurate, or not credible, or did not reasonably document information, did not document in more detail, and/or accurately document the patient's symptoms. Nor did Respondent's progress notes for Patient 6 have adequate subjective narratives to describe the patient's reason for the visit or her chief complaint.

46. Overall, Respondent committed the acts and/or omissions, described above, in his care and treatment of Patient 6 which represent extreme departures from the standard of care.

47. The above acts or omissions constitute gross negligence under the Code, and therefore subject Respondent's medical license to discipline.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – 6 Patients)

48. Respondent, Robert Siew, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code for the commission of acts or omissions involving negligence in the care and treatment of Patients 1, 2, 3, 4, 5, and 6, above.

49. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth.

50. Each of the alleged acts of gross negligence set forth in the First Cause for Discipline, above, is also a negligent act.

51. Respondent also committed simple departures from the standard of care with respect to Patients 2, 3, and 4, as it relates to the prescribing of opiates with periodic assessments of safe opiate use, assessments of the ongoing need for safe opiate use, and negotiating a collaborative partnership to de-escalate opiates to the least effective dose.

52. Respondent also committed a simple departure in his care and treatment of Patient 5, as there was no evidence that Respondent documented the patient's activities for which the pain medications allowed her to pursue, the level of analgesia achieved, whether there was any aberrant behavior, and the patient's affect while on the opiates.

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53. The above acts or omissions constitute repeated negligence under the Code, and therefore subject Respondent's medical license to discipline.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing – 4 Patients)

54. Respondent, Robert Siew, M.D. is subject to disciplinary action under section 725 of the Code in that Respondent excessively prescribed dangerous drugs to Patients 1, 2, 3, and 4, above.

55. Paragraphs 14 through 37, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

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

56. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent, Robert Siew, M.D. is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1, 2, 3, 4, 5, and 6, above.

FIFTH CAUSE FOR DISCIPLINE

(Violation of Drug Statute; CURES – 5 Patients)

57. Respondent, Robert Siew, M.D. is subject to disciplinary action under section 2238 of the Code and section 11165.4 of the Health and Safety Code, in that he failed to consult the CURES database to review the patients' controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patients for the first time and at least once every four months thereafter while the controlled substances remained part of the treatment of the patient. The circumstances are as follows:

58. The allegations of the First through Fourth Causes for Discipline, with respect to Patients 2, 3, 4, 5, and 6, paragraphs 21-56, inclusive, are incorporated herein 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 or suspending Physician's and Surgeon's Certificate Number A 45333, issued to Respondent Robert D. Siew, M.D.;

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

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

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

DATED: JAN 25 2024

Jenna Jones for
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant