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

In the Matter of the Accusation Against: Cynthia A. Point, M.D. Physician's and Surgeon's Certificate No. G 58321 Respondent.	Case No. 800-2019-060460

DECISION

The attached Stipulated Surrender of License and 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 February 6, 2024.

IT IS SO ORDERED January 30, 2024.

MEDICAL BOARD OF CALIFORNIA

Jeuna Jones For
Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
MACHAELA M. MINGARDI
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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: **CYNTHIA A POINT, M.D.** 833 France Ave. San Francisco, CA 94112-3541 Physician's and Surgeon's Certificate No. G 58321 Respondent.	Case No. 800-2019-060460 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. 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 Machaela M. Mingardi, Supervising Deputy Attorney General.

2. Cynthia A Point, M.D. (Respondent) is represented in this proceeding by her attorney, Cyrus Tabari, 990 Fifth Ave., San Rafael, CA 94901.

3. On or about August 18, 1986, the Board issued Physician's and Surgeon's Certificate No. G 58321 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-060460 and expired on October 31, 2023.

JURISDICTION

4. Accusation No. 800-2019-060460 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 June 20, 2022. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2019-060460 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-060460. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her 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 admits the truth of each and every charge and allegation in Accusation No. 800-2019-060460, agrees that cause exists for discipline and hereby surrenders her Physician's and Surgeon's Certificate No. G 58321 for the Board's formal acceptance.

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

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CONTINGENCY

10. 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."

11. 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 her Physician's and Surgeon's Certificate No. G 58321 without further notice to, or opportunity to be heard by, Respondent.

12. 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 her 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.

13. 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

14. 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.

15. 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.

16. 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 and Surgeon's Certificate No. G 58321, issued to Respondent Cynthia A. Point, M.D., is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2019-060460 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $19,820 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-060460 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

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

DATED: 12/13/23

CYNTHIA A. POINT, M.D.
Respondent

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

DATED: 12/18/23

CYRUS A. TABARI
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California

MACHAELA M. MINGARDI
Supervising Deputy Attorney General
Attorneys for Complainant

ACCEPTANCE

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

DATED: _____

CYNTHIA A. POINT, M.D.
Respondent

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

DATED: _____

CYRUS A. TABARI
Attorney for Respondent

ENDORSEMENT

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

DATED: 1/10/2024

Respectfully submitted,

ROB BONTA
Attorney General of California

MACHAELA M. MINGARDI
Supervising Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2019-060460

ROB BONTA
Attorney General of California
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Supervising 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: **Cynthia A. Point, M.D.** **833 France Ave.** **San Francisco, CA 94112-3541** **Physician's and Surgeon's Certificate No. G 58321,** Respondent.	Case No. 800-2019-060460 **ACCUSATION**

PARTIES

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

2. On or about August 18, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number G 58321 to Cynthia A. Point, 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 October 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have 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, in pertinent part, 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.

6. Section 2242 (a) states in relevant part:

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

7. 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."

8. Section 2266 of the Code states:

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

COST RECOVERY

9. 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.

RESPONDENT'S PRACTICE

10. Respondent practices as a primary care physician in San Francisco, California. She is board certified in internal medicine. At all relevant times, Respondent operated a solo family and internal medicine practice.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence/Medical Recordkeeping Violations)

Patient 1 [1]

11. Respondent treated Patient 1 from 2017 to 2021. Patient 1 was a sixty-seven-year-old female with a history of chronic low back pain and neck pain. Patient 1 also had scoliosis and osteoporosis of her spine. Additionally, Patient 1 suffered from chronic major depression and generalized anxiety and hypertension.

12. Patient 1 had been taking high dose narcotics medications for many years prescribed by her orthopedic spine surgeons. In early 2017, Respondent decided to continue prescribing the same opiate dosage of oxycodone[2] 40 mg daily with hydrocodone[3] 100 mg daily (total MEDD[4] of 160 mg). Respondent continued prescribing the hydrocodone for the next four years.

13. Before prescribing opioids, Respondent did not perform an objective risk stratification of the patient's opiate addiction potential. Because the patient had a history of major depression, anxiety, and tobacco/alcohol use, the patient's risk of opiate dependency and addiction was increased.

14. Respondent also prescribed Alprazolam[5] (2 mg daily) to Patient 1 to manage the patient's anxiety disorder. In April 2018, Respondent increased the patient's Alprazolam to 3 mg daily because the patient was complaining of increased anxiety due to increasing family stressors. Respondent, however, did not document a detailed evaluation of the patient's anxiety. For example, Respondent did not document a detailed review of the patient's anxiety symptoms with their functional limitations or whether the patient's anxiety was primarily psychological in nature or secondary to withdrawal anxiety.

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

[2] Oxycodone is an opioid pain medication and controlled substance.

[3] Hydrocodone is an opioid pain medication and controlled substance.

[4] MEDD is the morphine equivalent daily dose.

[5] Alprazolam is a benzodiazepine and controlled substance.

15. Respondent did not maintain detailed documentation of Patient 1's pain intensity, adverse side effects, functional improvement, and personal affects. These details help a physician to decide whether a patient should continue long term opiate therapy or have their medications tapered. Respondent also did not document the necessary physical examinations for Patient 1 to justify long term opiate therapy.

16. Respondent failed to timely recognize Patient 1's opiate dependency and hyperalgesia syndrome (paradoxical increase in the pain perception caused by opiates). Given the patient's age (over 65 years of age), the dangers of long term opiate usage were amplified due to the increased risk of falls, accidental bone fractures, cognitive impairment, traffic accidents, and respiratory compromise associated with older age.

17. Despite multiple recommendations of opiate reduction documented in the medical records, Respondent did not start to meaningfully taper the patient's hydrocodone until September 2018. The Controlled Substance Utilization Review and Evaluation System (CURES)[6] data showed some modest success as the Respondent was able to wean down the patient's hydrocodone dosage to 60 mg daily with oxycodone 40 mg daily for MEDD total of 120 mg by July 2019. However, due to the patient's reported increasing back and neck pains in late 2019, Respondent increased the hydrocodone dosage back to 80 mg daily with oxycodone 40 mg daily (MEDD of 140 mg daily).

18. In early 2020, Patient 1 suffered a fall, which resulted in a pelvic fracture. Respondent continued the patient on hydrocodone 80 mg daily with oxycodone 40 mg daily throughout the entire year of 2020. Because of the increased risks of accidental overdose due to this high dosage of opioids, Respondent should have prescribed naloxone antidote[7] to the patient.

19. During the four years that Respondent prescribed long term opioids to Patient 1, Respondent did not obtain any urine toxicology testing from the patient to monitor for diversion

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[6] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances.

[7] Naloxone antidote is a medication used to counteract an opioid overdose.

behaviors. Respondent did not maintain a signed pain care agreement with informed consent for Patient 1 and Respondent did not document routine CURES queries even though Respondent stated in her Board interview that she routinely consulted the CURES database.

20. Respondent did not prescribe non-addictive pharmacotherapy or recommend other non-opioid treatments/interventions in order to reduce Patient 1's dependency on long term opiate therapy.

21. In January 2021, Patient 1 sought treatment for her opiate dependency and addiction. Patient 1 was started on buprenorphine therapy by an addiction specialty physician.

22. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 1, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2266 of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence, and failed to maintain accurate and adequate medical records, including but not limited to the following:

A. Respondent failed to prescribe non-addictive pharmacotherapy to Patient 1;

B. Respondent failed to consider and recommend acupuncture therapy and chiropractic manipulation to Patient 1 to help reduce the patient's narcotic dependency;

C. Respondent failed to perform an objective risk stratification before prescribing long term opioids to Patient 1;

D. Respondent failed to obtain routine urine drug testing for Patient 1 and run CURES queries to monitor the patient's opioid use;

E. Respondent failed to maintain a signed pain care agreement with informed consent from Patient 1. Respondent did not document that she explained the potential risks of opiate use to Patient 1 and ways to minimize the risks of aberrant behaviors;

F. Respondent failed to timely recognize the patient's opiate tolerance and opioid-induced hyperalgesia syndrome;

G. Respondent's decision to continue prescribing opiate therapy to an elderly geriatric patient despite the inherent physical and cognitive risks associated with this patient population;

H. Respondent failed to prescribe naloxone therapy to the patient in the event that the patient needed to counteract a possible opioid and/or opioid and benzodiazepine combination overdose;

I. Respondent maintained inadequate medical record documentation regarding her opiate monitoring of Patient 1;

J. Respondent's concurrent long term prescribing of benzodiazepine therapy and opiate therapy put the patient at an increased risk of harm;

K. Respondent's failure to recognize the patient's benzodiazepine dependency, and failure to taper the patient's medications, and prescribe a safer non-benzodiazepine medication; and

L. Respondent failed to document a detailed evaluation of the patient's anxiety in the medical records.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence/Medical Recordkeeping Violations)

Patient 2

23. Respondent treated Patient 2 from 2018 to 2021. Patient 2 was a sixty-year-old female with obesity, persistent asthma, obstructive sleep apnea, bipolar disorder, and a past history of amphetamine abuse.

24. Patient 2's previous physician had been prescribing an opiate regimen of time-released morphine[8] with short acting morphine for many years for management of her chronic low back pain, sciatica, and fibromyalgia. Patient 2's opiate regimen consisted of MS Contin[9] 60 mg daily with short acting morphine 30-40 mg daily for MEDD total of 90-100 mg daily.

25. Respondent prescribed the morphine regimen to Patient 2 without an independent and thorough symptom assessment and physical examination during the initial visits. Respondent did not perform an objective risk stratification before prescribing long term opioids to Patient 2 even

[8] Morphine is an opioid pain medication and controlled substance.

[9] MS Contin is an opioid pain medication and controlled substance.

though Patient 2 was at an increased risk of opiate addiction given her history of methamphetamine and tobacco usage.

26. Respondent did not document physical examinations for Patient 2 during the initial four office visits. In October 2018, Respondent documented a physician examination of Patient 2. Respondent noted that Patient 2's examination was completely normal with no musculoskeletal limitations.

27. Between June 2018 and October 2018, Respondent prescribed high dosage morphine therapy to Patient 1 without any physical examinations to confirm the patient's pain complaints.

28. In October 2019, Respondent documented a normal physical examination of Patient 2. These examination findings are inconsistent with the patient's chronic pain syndrome requiring high dosage morphine. After the October 2019 physical examination, Respondent did not document any further physical exams in the year 2019, despite monthly refills of narcotics.

29. During the period of time that Respondent prescribed opioids to Patient 2, Respondent did not conduct proper opiate monitoring of the patient such as a detailed review of symptoms, or review of, for example, the 5 A's of pain management: analgesia effects, adverse side effects, activities of daily living, aberrancy, and personal affect.

30. During the COVID pandemic, the patient continued to receive monthly narcotic prescriptions from Respondent via telephone visits and phone messages from 2020 to 2021.

31. During the three years that Respondent provided chronic pain management, Respondent did not obtain further imaging evaluations for Patient 2. Patient 2 was not evaluated by a pain management specialist, surgical specialist, or rheumatology specialist to evaluate her chronic fibromyalgia syndrome. Respondent did not refer or recommend physical therapy or chiropractic treatment to Patient 2.

32. Respondent did not recommend to Patient 2 that she obtain mental health consultations, despite the patient being prescribed multiple psychotropic medications, including an antipsychotic prescribed to Patient 2 for her bipolar illness. Respondent did not recommend cognitive behavioral therapy to the patient.

33. During the course of treatment, Respondent did not obtain any urine toxicology testing from the patient despite Patient 2's prior history of drug abuse. Respondent did not document any CURES query reports. Respondent did not maintain a signed pain care agreement with informed consent for Patient 2.

34. Respondent did not prescribe naloxone antidote therapy to Patient 2 despite the patient's elevated risk for overdose due to her persistent asthma and sleep apnea.

35. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 2, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2266 of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence and failed to maintain accurate and adequate medical records, including but not limited to the following:

A. Respondent failed to perform an independent and adequate evaluation of the patient's chronic pain syndrome before prescribing opioids;

B. Respondent failed to perform an objective risk stratification before prescribing long term opioids to Patient 2;

C. Respondent failed to implement a multi-disciplinary management of the patient's chronic pain syndrome;

D. Respondent's failed to obtain routine urine drug testing and CURES queries to monitor the patient's opioid use;

E. Respondent failed to maintain a signed pain care agreement with informed consent from Patient 2. Respondent did not document that she explained the potential risks of opiate use to the patient and how to minimize the risks of aberrant behaviors;

F. Respondent did not prescribe naloxone antidote therapy to Patient 2;

G. Respondent failed to obtain and/or document musculoskeletal examinations for Patient 2 that detailed the functional benefits of opioids;

H. Respondent failed to prescribe safer and non-addictive pharmacotherapy; and

I. Respondent failed to offer cognitive behavioral therapy to the patient.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence/Medical Recordkeeping Violations)

Patient 3

36. Respondent treated Patient 3 from early 2018 to early 2021. Patient 3 was a seventy-year-old female with a history of depression, Parkinson's disease, obesity, alcohol/marijuana usage, and prior tobacco addiction.

37. In 2017, Respondent began prescribing high doses of oxycodone to Patient 3 for management of the patient's chronic low back pain, knee pain, and shoulder pain. Respondent prescribed a daily oxycodone dosage of 320 mg daily (MEDD of 480 mg). Respondent continued prescribing this dosage until early 2019. Subsequently, Respondent reduced the oxycodone dosage to 300 mg daily (MEDD of 450 mg).

38. Prior to prescribing high dose opioids, Respondent failed to properly risk stratify the patient's opioid addiction risk. The patient's depression, alcoholism (daily alcohol usage), marijuana usage, and past tobacco usage increased her risks of addiction to opiates.

39. During the three years that Respondent prescribed opioids to Patient 3, the patient had no pain management consultations.

40. During the entire 2020 year, there were no physical office visits or telemedicine visits even though Respondent was prescribing high dosage oxycodone. Respondent conducted minimal examinations and symptoms review. Respondent often noted that the patient's spine examinations were normal. These physical findings are inconsistent with a patient who suffered from persistent and chronic musculoskeletal pains requiring high dosage oxycodone therapy.

41. Respondent did not conduct proper opiate monitoring of Patient 3 such as a detailed review of symptoms, for example, the 5 A's of pain management: analgesia effects, adverse side effects, activities of daily living, aberrancy, and personal affect

42. Respondent did not recommend physical therapy or acupuncture to the patient. Respondent did not obtain additional radiological imaging.

43. During the several years that Respondent prescribed opioids to Patient 3, Respondent

did not obtain urine toxicology testing for Patient 3 or document CURES queries in the records.

44. Respondent did not maintain a signed pain agreement with informed consent from her patient. Respondent had a duty to warn the patient of the dangers of long term opiate therapy and to reduce the patient's risks of opiate addiction. This duty was even more relevant and important as Respondent was prescribing excessively high MEDD.

45. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 3, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2266 of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence, and/or failed to maintain accurate and adequate medical records, including but not limited to the following:

A. Respondent's failed to perform an objective risk stratification before prescribing long term opioids to Patient 3;

B. Respondent's decision to prescribe long term oxycodone therapy to an elderly patient with Parkinson's disease who was subject to increased risks of cognitive impairment and mechanical falls;

C. Respondent failed to obtain routine urine drug testing and CURES queries to monitor the patient's opioid use;

D. Respondent authorized automatic refills of monthly oxycodone throughout 2020 without any assessment of the patient via office visits or telemedicine visits;

E. Respondent failed to consider and recommend non-opioid pharmacotherapy to the patient;

F. Respondent failed to recommend physical therapy or acupuncture therapy or cognitive behavior therapy to the patient;

G. Respondent failed to engage the patient actively in weight loss measures for back pain management;

H. Respondent failed to timely recognize the patient's opiate tolerance and opioid-induced hyperalgesia syndrome;

I. Respondent failed to maintain a signed pain care agreement with informed consent

from Patient 3; and

J. Respondent maintained inadequate and incomplete medical records regarding opioid monitoring of Patient 3.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence/Excessive Prescribing/Prescribing Without Medical Indication/Recordkeeping Violations)

Patient 4

46. Respondent treated Patient 4 from 2004 to 2021. Patient 4 was a female, sixty–six years old, who suffered from peripheral neuropathy and required chronic pain management. Patient 4 also had chronic low back pain and foot/ankle osteoarthritis.

47. In early 2019, Respondent prescribed fentanyl[10] 200 mcg/hour with methadone[11] 100 mg daily (MEDD of 1680 mg) to Patient 4. Respondent did not perform an opioid risk assessment of the patient's addiction potential, despite the patient's marijuana use. Respondent did not perform regular urine toxicology testing to monitor the patient for diversion behaviors and potential usage of other illicit drugs. Respondent did not document any CURES queries for the patient even though Patient 4's general risk of accidental over dosage was higher than those of younger population due to her comorbidities (liver cirrhosis) and marijuana usage, and increased risk of falls, traffic accidents, and cognitive impairment.

48. In June 2019, Respondent reduced Patient 4's fentanyl dosage to 150 mcg/hour.

49. In December 2019, Respondent reduced Patient 4's fentanyl dosage down to 125 mcg/hour with daily methadone 80 mg for MEDD of 1260 mg. Respondent continued prescribing this dosage for the next nine months until late 2020 when Respondent further reduced the patient's MEDD to 1200 mg daily (Fentanyl 100 mcg/hour with 80 mg methadone daily).

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[10] Fentanyl is a strong opioid medication and is indicated only for treatment of chronic pain that cannot be managed by lesser means and requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation, and should be used with extreme caution in conjunction with other CNS depressants.

[11] Methadone hydrochloride is a controlled substance and an opioid.

50. During the three years of pain management, Respondent evaluated Patient 4 every 3 to 4 months for narcotic refills. Respondent did not document any detailed notes regarding functional benefits, adverse reactions, analgesic effects, and affect in the progress notes. Respondent did note detailed examinations of Patient 4's feet but the back and spinal examinations were mostly copied and pasted as "normal."

51. Due to the COVID pandemic in 2020, Patient 4 did not have any clinical office visits with Respondent that year, and Respondent approved Patient 3's narcotic refills based on brief phone discussions with the patient (no formal telemedicine visits).

52. During 2018 through 2021, in addition to the long term Fentanyl and methadone, Respondent was also prescribing lorazepam (benzodiazepine) at 2 to 4 mg daily. It is not clear why the patient needed this controlled substance medication as there was no indication documented in the chart.

53. Respondent did not recommend cognitive behavior therapy or acupuncture therapy to reduce the patient's opiate needs.

54. Respondent did not maintain a signed pain agreement with informed consent from her patient. Respondent had a duty to warn the patient of the dangers of long term opiate therapy and to reduce the patient's risks of opiate addiction.

55. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 4, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2242(a) and/or 725 and/or 2266 of the Code in that Respondent committed gross negligence and/or repeated negligent acts and/or demonstrated incompetence, and/or excessively prescribed and/or failed to maintain accurate and adequate medical records, including but not limited to the following:

A. Respondent prescribed an extremely high opiate dosage to a patient that was over 65 years of age and to a patient that had a history of cirrhosis;

B. Respondent did not perform an opioid risk assessment of the patient's opioid addiction potential, especially given the patient's marijuana use;

C. Respondent failed to conduct urine toxicology testing and routine CURES queries for Patient 4;

D. Respondent's failed to timely recognize the patient's opiate tolerance and dependency and did not refer her to an addiction specialist;

E. Respondent prescribed two long acting opiates, which increased the risk of toxicity to the patient due to the adverse combination of medications;

F. Respondent's failed to consider and recommend non-opioid pharmacotherapy to the patient and failed to recommend cognitive behavior therapy or acupuncture therapy to reduce the patient's opiate usage;

G. Respondent prescribed long term benzodiazepine lorazepam to Patient 4 without a clear medical indication and documentation; Respondent did not fully evaluate the patient's anxiety disorder;

H. Respondent's concurrent long term prescribing of benzodiazepine therapy and opiate therapy. Because of the dangerously high MEDD of at least 1200 mg in this patient, the risk of accidental overdose was significant;

I. Respondent failed to recognize the patient's benzodiazepine dependency, didn't taper the patient's medication, and failed to prescribe a safer non-benzodiazepine medication;

J. Respondent's maintained inadequate and incomplete medical records regarding her opioid monitoring of Patient 4; and

K. Respondent did not maintain a signed pain agreement with informed consent from her patient.

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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 G 58321, issued to Cynthia A. Point, M.D.;

2. Revoking, suspending or denying approval of Cynthia A. Point, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Cynthia A. Point, 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: JUN 20 2022

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

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