0BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Terry Tetsuo Ishihara, M.D.

Physician's and Surgeon's Certificate No. G 87861

Respondent.

Case No.: 800-2020-066089

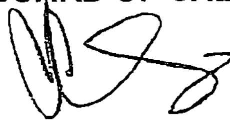
DECISION

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 April 18, 2024.

IT IS SO ORDERED: March 19, 2024.

MEDICAL BOARD OF CALIFORNIA



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

DCU32 (Rev 05-2021)

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General
CHRISTINE FRIAR WALTON
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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:	Case No. 800-2020-066089
TERRY TETSUO ISHIHARA, M.D. **Optum Healthcare** **1499 W. 1st Street** **San Pedro, CA 90732-3255**	OAH No. 2023070951
Physician's and Surgeon's Certificate No. G 87861,	**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**
Respondent.	

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 Christine Friar Walton, Deputy Attorney General.

2. Respondent Terry Tetsuo Ishihara, M.D. (Respondent) is represented in this proceeding by attorney Greg R. Bunch of Law + Brandmeyer, LLP, located at 385 E. Colorado Blvd., Suite 200, Pasadena, California 91101-1988.

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3. On October 6, 2006, the Board issued Physician's and Surgeon's Certificate No. G 87861 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-066089, and will expire on August 31, 2024, unless renewed.

JURISDICTION

4. On March 23, 2023, Accusation No. 800-2020-066089 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 March 23, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2020-066089 is attached as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-066089. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement 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; 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 and agrees that the charges and allegations in Accusation No. 800-2020-066089, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. Respondent does not contest that, at an administrative hearing, Complainant could

establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2020-066089 and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 87861 to disciplinary action.

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

CONTINGENCY

11. 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.

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. 800-2020-066089 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.

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above-entitled 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 opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 87861 issued to Respondent Terry Tetsuo Ishihara, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any Schedule II or Schedule III controlled substances as defined by the California Uniform Controlled Substances Act until Respondent has successfully satisfied both Condition No. 4 (Prescribing Practices Course) and Condition No. 6 (Clinical Competence Assessment Program) of his probation as set forth herein, and has been so notified by the Board or its designee in writing of his successful satisfaction of each of Condition No. 4 (Prescribing Practices Course) and Condition No. 6 (Clinical Competence Assessment Program).

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(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.

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, billing appropriately or both. 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.

8. 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.

9. 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.

10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $44,122.31 (Forty-four thousand one hundred twenty-two dollars and thirty-one cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

11. 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.

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

13. 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.

14. 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's 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..

15. 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. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

16. 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.

17. 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.

18. 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.

19. FUTURE ADMISSIONS CLAUSE. 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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2020-066089 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 license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Greg R. Bunch. 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: ____________________ ______________________________

TERRY TETSUO ISHIHARA, M.D.
Respondent

I have read and fully discussed with Respondent Terry Tetsuo Ishihara, 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: ____________________ ______________________________

GREG R. BUNCH
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,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

CHRISTINE FRIAR WALTON
Deputy Attorney General
Attorneys for Complainant

1 ACCEPTANCE

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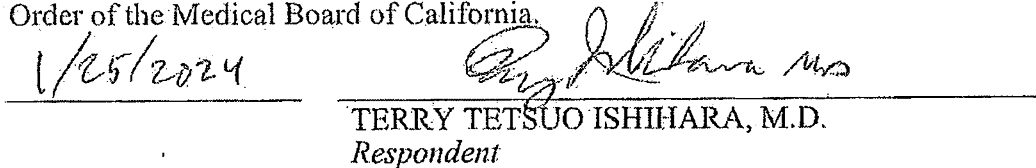

7 DATED: 1/25/2024

8 TERRY TETSUO ISHIHARA, M.D.
Respondent

9

10 I have read and fully discussed with Respondent Terry Tetsuo Ishihara, M.D. the terms a l
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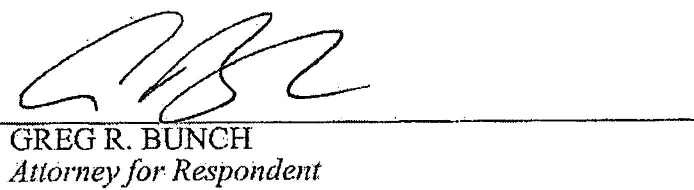

13 DATED: January 26, 2024

GREG R. BUNCH
14 *Attorney for Respondent*

15 ENDORSEMENT

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

18 DATED: January 26, 2024

Respectfully submitted,

19 ROB BONTA
Attorney General of California
20 EDWARD KIM
Supervising Deputy Attorney General

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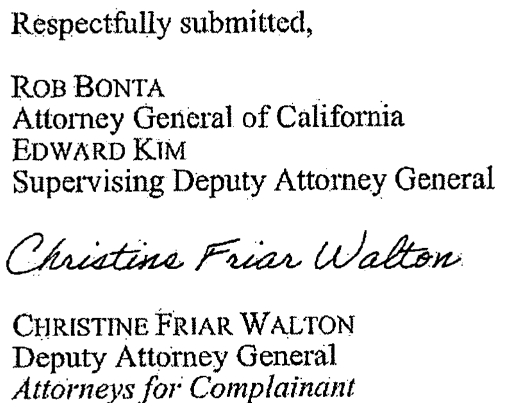

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 800-2020-066089
TERRY TETSUO ISHIHARA, M.D. **1499 W. 1st Street** **San Pedro, CA 90732-3255** **Physician's and Surgeon's Certificate No. G 87861,** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about October 6, 2006, the Board issued Physician's and Surgeon's Certificate Number G 87861 to Terry Tetsuo Ishihara, 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 August 31, 2024, 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 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the

physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

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

STATUTORY PROVISIONS

7. 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.

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.

FACTUAL ALLEGATIONS

10. Respondent is a board certified family practitioner. He currently works at Providence Medical Group-San Pedro Primary Care where he has worked since 2019. Prior thereto, he worked at HealthCare Partners in San Pedro.

Standard of Care

11. The standard of care for a primary care provider prescribing opiates is to use the lowest effective dose of controlled substances and to stay within dosing guidelines and/or restrictions. The lowest effective dose is that which controls pain, improves function and quality of life, and produces the least side effects. High dose opioids are likely to lead to abuse and also cause serious dose-related effects including cognitive impairment, motor impairment, respiratory depression, and death.

12. The standard of care calls for a primary care provider prescribing opiates is to avoid prescribing dangerous combinations of controlled substances, especially for chronic use when safer alternatives exist.

13. The standard of care for a primary care provider prescribing opiates or other controlled substances, is to ensure appropriate compliance monitoring.

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14. The standard of care for a primary care provider prescribing opiates, when considering long-term use of opioids for chronic non-cancer pain, is to perform a patient evaluation to establish a diagnosis of medical necessity.

15. The standard of care for a primary care provider prescribing opiates when considering dose escalation of opioids for non-cancer pain is to increase the dose by the smallest practical amount, review the risks and benefits of the dose change, and educate the patient regarding the risks of higher opioid doses.

16. The standard of care for a primary care provider when assessing and treating anxiety, is to follow diagnostic criteria from the Diagnostic and Statistical Manual for Mental Disorders V and to design an appropriate treatment protocol, such as prescribing selective serotonin reuptake inhibitor (SSRI) medication and referring the patient for cognitive behavioral therapy. Benzodiazepines are used for short term intervention, not long-term treatment of anxiety.

17. The standard of care for a primary care provider when considering initiating methadone therapy is to perform an individualized medical and behavioral risk evaluation.

18. The standard of care for a physician is to adequately treat patients with hypertension. Treatment goals are to obtain a target range of a blood pressure of less than 130/80.

Patient 1:[1]

19. Patient 1 was a 56-year-old male when he began treating with Respondent in 2015 for complaints of chronic pain. Respondent inherited Patient 1 from another provider who had initiated treatment with opioids. Per CURES,[2] Respondent prescribed oxycodone 15 mg #180, and Norco 325/7.5 mg #90, starting on or about January 15, 2016. Valium 10 mg #30 was prescribed by another provider. Respondent also prescribed Amilodipine, an antihypertensive medication, for Patient 1's high blood pressure.

20. Respondent noted that Patient 1 was opioid dependent and that the patient disagreed with the diagnosis. Yet, Patient 1 sought early refills of his pain medications and manifested

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[1] The patients are identified in this Accusation by number to protect their privacy

[2] CURES, the Controlled Substance Utilization Review and Evaluation System, is a database of Schedule II through Schedule V controlled substance prescriptions dispensed in California.

manipulative behavior to justify his need for oxycodone and Norco. The patient maintained that based on his reading and research, oxycodone was not addictive. Patient 1 also brought in an article to a medical visit with Respondent regarding the concomitant use of opioids and benzodiazepines because he felt the combination of the medications helped his symptoms.

21. At a visit on or about July 2, 2018, Patient 1 was seen for pain management follow up. Respondent noted that the patient had post-laminectomy syndrome and was using ice/heat and yoga. Nevertheless, Patient 1's pain persisted. Patient 1 continued to decline surgery and pain management. He reported new symptoms of arthritis of his knees. His medications were continued. Per CURES, Valium was last prescribed on or about August 31, 2017, by Respondent (Respondent appears to have commenced prescribing Valium, a benzodiazepine, for Patient 1 on or about October 13, 2016).

22. According to a message from Respondent to Patient 1 dated November 5, 2018, the patient had been treating with Physician Assistant Geogis who was slowly weaning down Patient 1's opioids. Patient 1 requested that Respondent stop the taper until February 2019.

23. On or about December 13, 2018, Patient 1 was seen for a medication refill. The patient's blood pressure on this date was 136/80. At this visit, Respondent told Patient 1 that he would have to sign a drug contract and commence random urine drug testing, which are standard for any chronic opioid user. Respondent documented a discussion with Patient 1 about opioid therapy and the need to find a careful balance. Respondent recommended a pain management specialist, since the patient had a difficult chronic pain condition, however Patient 1 refused. Patient 1 explained why he needed large amounts of opioid medication without weaning, based on his research. Patient 1 also claimed that he was not addicted to opioids, that he was offended that he was to be drug tested, and had to sign a drug contract. Patient 1 also admitted to using medicinal marijuana, but not illicit marijuana. He claimed that he was made to feel like a drug addict.

24. On or about February 24, 2020, Patient 1 presented for a routine follow up for pain management and opioid dependence. Patient 1 brought with him a "weaning request." According to the "weaning request," at that visit Patient 1 would receive oxycodone #120 and

Norco #30. In March he would receive oxycodone #90, no Norco. April he would receive oxycodone # 60, and in May oxycodone #30. Respondent noted that Patient 1 would be off opioids after May 2020. Respondent also noted that a pain management referral was recently approved for Patient 1. The patient indicated that he did not plan on finding a new primary care physician; he intended to go to the emergency room as necessary. Respondent noted that Patient 1 was angry and moderately anxious. Respondent gave Patient 1 a prescription for oxycodone #120 and Norco #30. Patient 1 reported that he no longer wanted Respondent as his primary care physician. Respondent encouraged Patient 1 to find a new primary care physician to manage his general health.

25. CURES Reports for Patient 1 for the time frames of on or about February 7, 2019 through on or about December 26, 2019 (run on February 4, 2020) and on or about June 7, 2019 through on or about April 23, 2020 (run on May 21, 2020) are located in Patient 1's chart. A pain contract was not signed by Patient 1 and no urine drug screens were conducted.

Patient 2

26. Patient 2 was a 72-year-old female when she first came under Respondent's care at Los Palos Post-Acute Care Center in San Pedro on or about September 7, 2017. Patient 2 had sustained a third-degree burn to her right leg from a hot cooking oil accident. Her family was concerned about her becoming more forgetful. In addition to her leg burn, Patient 2 had a host of co-morbidities including angina, Parkinson's Disease, Systemic Lupus Erythematosus, Rheumatoid Arthritis, polyneuropathy, Fahr's Disease (a rare neurological disorder that is characterized by abnormal calcium deposits in areas of the brain that control movement, including the basal ganglia and the cerebral cortex), osteoarthritis of the right knee, Type 2 Diabetes (complicated by diabetic polyneuropathy, diabetic cataracts, peripheral angiopathy, and diabetic chronic kidney disease), atherosclerosis of the aorta, major depressive disorder, chronic kidney disease stage 3, and chronic pain syndrome.

27. Respondent prescribed tramadol and gabapentin for Patient 2's pain and neuropathy.

28. On or about November 11, 2017, Respondent noted that the patient was having difficulty speaking and he arranged for her to be seen by a neurologist. On or about March 9,

2018, Respondent notes that Patient 2 has expressive aphasia. She was still being followed by the neurologist. Patient 2 was to be followed by a rheumatologist for her Lupus, rheumatoid arthritis, and bilateral total hip arthroplasties. She was continued on tramadol for pain. Respondent noted that Patient 2's blood pressure was elevated at 180/110 and he added clonidine for blood pressure control.

29. On or about April 11, 2018, Respondent noted that Patient 2 was diagnosed with Fahr's disease, which was the probable explanation for her speech and behavioral issues. Patient 2 was refusing to take her Atorvastatin and vitamins because she was taking too many pills. She had been treated for a urinary tract infection. Patient 2 was using a front wheeled walker or parallel bars with one to two person assist for ambulation. She also had a right heel pressure sore. She remained on tramadol and had Norco available for increased pain.

30. Approximately a month later, on or about May 7, 2018, Respondent notes that Patient 2 sustained a fall and complained of back pain. X-rays were negative [for fracture], and he prescribed Norco [for pain]. She was taken to the emergency room where she was diagnosed with shingles and an asymptomatic urinary tract infection. She was to continue on Tylenol, ibuprofen, or Norco, as needed for pain.

31. On or about June 6, 2018, Patient 2's family reported that the patient sustained a mild fall the prior week. Patient 2 complained of pain that was not controlled by Norco. She had not tried Percocet, which was prescribed for severe pain. She remained on gabapentin for neurologic pain from the shingles. Respondent ordered physical and occupational therapy for the Fahr's disease and noted that Patient 2 had an appointment with her neurologist. She was to continue with the wound care specialist for her right heel pressure sore and the right leg skin graft (from the burn wound). She was continued on Tylenol, ibuprofen, and Norco.

32. A month later, on or about July 1, 2018, Respondent notes that Patient 2 was now on Sinemet for Parkinson's Disease or Fahr's Disease. Patient 2 apparently had a pelvic pain/mass for which a CT scan had been ordered, but not yet completed. She still had shingles and was taking gabapentin and Percocet for the aggravating back contusion. Patient 2 remained with an unstageable right heel pressure sore and right leg skin graft which was treated with Tylenol

increasing to Percocet as needed for pain, and to follow up with the wound care specialist. She was to be referred to orthopedics once her skin graft healed for her Lupus/rheumatoid arthritis and bilateral hip arthroplasties. Patient 2 also complained of back pain and pelvic pain and stated that the Percocet did not provide her with sufficient relief. Respondent increased Percocet from 5 mg to 7.5 mg and continued Tylenol.

33. On or about July 8, 2018, Respondent started Patient 2 on a Fentanyl patch for her complaints of pelvic pain, which on a pelvic ultrasound was noted to be positive for a complex mass.

34. Patient 2 was admitted to Little Company of Mary Hospital for a syncopal event in her wheelchair; no fall noted. Dr. Chan notes on or about October 19, 2018, that Patient 2's syncope was due to dehydration. Dr. Chan also noted that she had on three Fentanyl patches. At discharge from the hospital on or about October 21, 2018, Dr. Chan stated that the patient has opioid dependence, but has not been in much pain in the hospital. He recommended decreasing her Fentanyl patch to 12.5 mcg and to taper her off.

35. On or about November 4, 2018, Respondent noted that Patient 2 had been hospitalized, was found to be dehydrated, but was better now. She developed cellulitis from an abdominal wound and was on antibiotics. She still had not had a CT scan of her pelvis. He continued her medications as follows: Fentanyl patch 12 mcg, Norco, Tylenol with codeine, and Tylenol.

36. On or about March 2, 2019, Respondent notes that Patient 2 complained of joint pain likely related to Lupus or rheumatoid arthritis. The Fentanyl patch was no longer going to be covered by her insurance, so he continued her on Norco and Tylenol and referred her to a Rheumatologist. On or about November 26, 2019, Patient 2 was seen by a Rheumatologist and placed on Plaquenil, an anti-rheumatic medication to treat Lupus and rheumatoid arthritis, by decreasing pain and swelling.

37. On or about December 1, 2019, Respondent increased Patient 2's dose of Fentanyl patch to 25mcg.

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38. On or about May 20, 2020, Patient 2 reported to Respondent that she discontinued her Plaquenil, Coreg (a beta blocker used to treat high blood pressure and heart failure), and Losartan an antihypertensive medication, because she wanted to limit her medications. Respondent encouraged her to resume her medications.

39. On or about August 15, 2020, Patient 2 expired from cardiopulmonary arrest secondary to Covid-19.

Patient 3

40. Patient 3 was an 80-year-old female when she began treating with Respondent on or about January 13, 2018, for osteoarthritic and chronic pain at Los Palos Post-Acute Care Center in San Pedro. Respondent initially prescribed tramadol to control Patient 3's pain. Over time, on or about August 3, 2018, he added Nucynta ER, for pain control. By October 22, 2018, Respondent changed Patient 3's pain medication to Norco 325/7.5 mg #30 every ten days, per CURES.

41. At a visit on or about July 7, 2019, Respondent reports that Patient 3 has severe degenerative joint disease of the right hip. He makes a referral to orthopedics and pain management. Respondent continues Patient 3 on Norco.

42. Patient 3 was seen a month later, on or about August 4, 2019, with right sided low back pain, hip and thigh pain and chronic abdominal tenderness. Respondent notes that the patient's abdomen is soft with mild left sided tenderness. A musculoskeletal examination was not noted.[3] The patient was noted to be in chronic pain with suboptimal control with Celebrex, baclofen, diclofenac gel, Glucosamine, Cymbalta, Tylenol, and Norco. Respondent requested an appointment with South Bay Rehab Center. Regarding her abdominal complaints, she was noted to be stable on Colase, a stool softener; Protonix, medication for acid reflux disease; and laxatives as needed.

43. At the visit on or about September 11, 2019, Respondent notes that Patient 3's pain was uncontrolled and she was on MS Contin 30 mg, three times a day, Percocet, and a lidocaine patch. Norco had been discontinued.

[3] Obvious musculoskeletal examinations were not noted on any visit in the chart.

44. Between on or about June 27, 2019 and October 22, 2019, Patient 3's received a daily dose of 60 MME.[4]

45. In a Los Palos Convalescent Hospital history and physical examination document dated on or about October 5, 2019, Respondent notes that Patient 3 has ongoing uncontrolled pain issues despite being on multiple medications. She had refused outpatient consultations, including orthopedics and pain management. She had, however, been to the emergency room "at least a couple of times." Respondent noted that for the patient's chronic pain and osteoarthritis he would continue MS Contin, lidocaine patches, Celebrex, baclofen, Cymbalta, diclofenac gel, Tylenol, and Percocet as needed, despite suboptimal pain control. A referral for palliative care was pending. Patient 3 was also noted as having depression and a history of alcoholism. A musculoskeletal examination was not conducted or if done, not documented.

46. Between on or about January 8, 2020 and March 3, 2020, Respondent notes that Patient 3's remains with chronic pain that is suboptimally controlled. The patient was not requesting Percocet. Patient 3 states she is suffering from right knee pain and stiffness on or about May 2, 2020.

47. On or about August 1, 2020, Respondent notes that the orthopedist recommends against surgery for Patient 3's complaints of chronic right hip pain. She was stable on her medications and a second opinion from an orthopedist was sought.

48. On or about September 6, 2020, Respondent was concerned with Patient 3's weight loss. He notes that the patient's pain had lessened, and he decreased her dose of MS Contin from 120 mg to 90 mg per day. However, it is also noted that the patient's chronic pain complaints are uncontrolled on multiple medications, and she is referred to orthopedics.

49. At the visit on or about December 2, 2020, Respondent notes that Patient 3 did not see the orthopedist and wants a second opinion. She states that the pain keeps her up at night. Respondent's plan was to switch the timing of her MS Contin so that Patient 3 would receive her

[4] MME stands for morphine milligram equivalent. It is a measurement that physicians use to determine how different opioids relate to each other. Using morphine as the standard, MME is a tool for doctors to compare different drugs in a simplified, unified measurement. Clinicians are encouraged to keep daily doses under 50 MME.

1 last daily dose at midnight. He also discontinued melatonin for sleep and replaced it with
2 trazodone, an antidepressant that assists with insomnia, and increased the patient's pain
3 medications. A month later, on or about January 1, 2021, Patient 3's insomnia was noted to be
4 better with trazodone and her pain was stable on her medications.

5 50. Between on or about October 28, 2019 and December 16, 2020, Patient 3 received a
6 daily dose of 60 MME.

7 51. However, a month later, on or about February 3, 2021, Respondent reports that
8 Patient 3 has pain and insomnia with cough. He again notes that Patient 3 has suboptimal pain
9 control on multiple medications. Respondent increased the dose of trazodone from 50 mg to 100
10 mg.

11 52. Between on or about March 6, 2021 and June 2, 2021, Respondent notes that Patient
12 3 has chronic pain that is uncontrolled on multiple pain medications. Patient 3 was receiving MC
13 Contin three times a day with Norco as needed. Respondent references the patient's laboratory
14 results and notes that the patient is anemic and malnourished. She is started on iron supplements
15 and a nutritional supplement. Respondent also increases her MS Contin from 30 mg to 60 mg.
16 By June 2, 2021, Respondent notes that Patient 3 is doing better since her dosage of opioids were
17 increased.

18 **Patient 4**

19 53. Patient 4 was a 65-year-old female when Respondent began treating her on or about
20 July 11, 2017, for chronic pain from spinal stenosis. Patient 4 had a history of major depressive
21 disorder and migraine headaches. She had been receiving Norco and Xanax from another
22 provider. Respondent started Patient 4 on methadone 10 mg #240 (8 tablets a day), and continued
23 the Norco 5 mg twice a day, and Xanax 2 mg three times a day. Patient 4 was also taking
24 propranolol as prophylaxis for her migraines. Respondent notes that the patient has a signed
25 narcotic contract and Narcan, an opioid antagonist that can treat an opioid overdose in an
26 emergency.

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54. Between on or about July 11, 2017 and January 8, 2018, Respondent prescribed an average of 1359 MME per day for Patient 4 and 300 tablets of Xanax 2 mg. During this time-frame Respondent prescribed 11 out of 16 prescriptions for Patient 4.

55. It appears that Patient 4 was seen primarily by Physician Assistant Georgis.

56. Between on or about January 10, 2018 and July 5, 2018, Respondent prescribed an average of 1027 MME per day for Patient 4 and 420 tablets of Xanax 2 mg. During this time-frame Respondent prescribed 10 out of 15 prescriptions for Patient 4.

57. On or about November 30, 2018, Patient 4 is seen by Respondent. He notes that the patient is a questionable historian and speaks very tangentially and rambles. She presented with an upper respiratory tract infection (URI) and complained of chronic constipation and diarrhea. Respondent advised Patient 4 that her constipation is secondary to her opioid therapy. Respondent also noted that Patient 4 had chronic pain and was opioid dependent. He treated her URI with antibiotics and cough medicine. He advised Patient 4 to continue taking methadone and Norco as needed, sparingly. Xanax was also continued, as needed, sparingly. Physical examination was significant for noting that the patient had a dull affect, fair eye contact, and rambling and tangential speech. No pain assessment was conducted or was not documented if done.

58. Between on or about July 17, 2018 and February 7, 2019, Respondent prescribed an average of 1230 MME per day for Patient 4 and 420 tablets of Xanax 2 mg. During this time-frame Respondent prescribed 13 out of 15 prescriptions for Patient 4.

59. At the visit on or about March 21, 2019, Respondent notes that Patient 4 returned for medication refills. He was continuing methadone and Norco for her chronic pain/opioid dependence. He ordered an electrocardiogram. Respondent also decreased the dose of propranolol because Patient 4 was hypotensive. The physical examination only notes that the patient is comfortable, uses a 4-wheeled walker for ambulation and has significant kyphoscoliosis.

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60. Between on or about March 11, 2019 and May 17, 2019, Respondent prescribed an average of 1079 MME per day for Patient 4 and 120 tablets of Xanax 2 mg. During this time-frame Respondent prescribed 5 out of 5 prescriptions for Patient 4.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

61. Respondent Terry Tetsuo Ishihara, M.D. is subject to disciplinary action under section 2234 subdivisions (b) of the Code in that he was grossly negligent in his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. The circumstances are as follows:

62. The facts and allegations set forth in paragraphs 10 through 60, above, are incorporated by reference and realleged as if fully set forth herein.

Patient 1

63. Respondent committed an extreme departure from the standard of care in prescribing excessive amounts of opioids to Patient 1 for an extended period of time in doses in excess of 150 MME per day in the absence of any recognizable benefit to the patient, or in failing to document a recognizable benefit to the patient.

64. Respondent committed an extreme departure from the standard of care in prescribing a combination of controlled substances including a benzodiazepine (Valium) and opioids (oxycodone and Norco) to Patient 1. These medications when used concurrently potentiate the individual medications' negative effects, such as motor impairment, cognitive impairment, and respiratory depression, which can lead to death.

65. Respondent committed an extreme departure from the standard of care in failing to adequately control Patient 1's blood pressure, placing the patient at risk for cardiovascular disease. Respondent prescribed a single low-dose first line agent for the treatment of Patient 1's hypertension. The medical records indicate that the patient's blood pressure was frequently documented to be over 160/90 (stage 2 hypertension). The recommendation for patients with stage 2 hypertension is that they be prescribed two first line agents of different classes (thiazide diuretics and/or ACE/ARB). The antihypertensive medications should be monitored and titrated to achieve the target blood pressure.

Patient 2

66. Respondent committed an extreme departure from the standard of care in failing to properly evaluate Patient 2 for chronic opioid use. There is poor evidence for the use of opioids for musculoskeletal pain and greater risk of harm. Opioids are not considered the standard of care for the management of Lupus or rheumatoid arthritis pain.

Patient 3

67. Respondent committed an extreme departure from the standard of care in failing to properly evaluate Patient 3 for chronic opioid use. There is poor evidence for the use of opioids for musculoskeletal pain and greater risk of harm, especially when using moderately high doses of opioids. Opioids are not considered the standard of care for chronic management of musculoskeletal or arthritis pain.

68. Respondent committed an extreme departure from the standard of care in failing to document any rationale for escalating Patient 3's dose of opioids. The medical records do not indicate an obvious reason to more than double Patient 3's MME between June and October 2019.

Patient 4

69. Respondent committed an extreme departure from the standard of care in prescribing excessive amounts of opioids to Patient 4 for an extended period of time in doses in excess of the daily MME guidelines. Respondent consistently prescribed between 1027 and 1359 MMD daily between on or about July 11, 2017 and May 17, 2019. Further at his interview with Board representatives, Respondent admitted that he did not know how to calculate the MME for methadone.

70. Respondent committed an extreme departure from the standard of care in failing to document any rationale for escalating Patient 4's dose of opioids. Prior to on or about July 11, 2017, Patient 4 was on approximately 10 MME. On that date, Respondent began to prescribe over 1000 MME. When transitioning patients to methadone to treat chronic pain, clinicians generally start at 2.5 mg, three times a day. The dose of methadone is gradually increased to no

more than 5 mg every 5 to 7 days. The rapid increase in MME placed Patient 4 at increased risk for negative health outcomes.

71. Respondent committed an extreme departure from the standard of care in treating Patient 4 with long-term benzodiazepines (Xanax). After Respondent diagnosed Patient 4 with general anxiety disorder, appropriate treatment of her anxiety would have been to prescribe a selective serotonin reuptake inhibitor (SSRI) medication and refer her for cognitive behavioral therapy. Benzodiazepines are used for short term intervention.

72. Respondent committed an extreme departure from the standard of care in prescribing a combination of controlled substances including a benzodiazepine (Xanax) and opioids (methadone and Norco) to Patient 4. These medications when used concurrently potentiate the individual medications' negative effects, such as motor impairment, cognitive impairment, and respiratory depression, which can lead to death.

73. Respondent committed an extreme departure from the standard of care in failing to properly evaluate Patient 4 for chronic opioid use. There is poor evidence for the use of opioids for musculoskeletal pain and greater risk of harm, especially when using chronic high doses of opioids.

74. Respondent committed an extreme departure from the standard of care in failing to stratify Patient 4's risk when initiating methadone therapy. Per CURES, prior to on or about July 11, 2017, Patient 4 had been prescribed only Norco. On or about July 11, 2017, Respondent started Patient 4 on methadone at over 1000 MME.

75. Respondent committed an extreme departure from the standard of care in failing to ensure appropriate compliance monitoring of Patient 4's prescription drug use.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

76. Respondent Terry Tetsuo Ishihara, M.D. is subject to disciplinary action under section 2234 subdivision (c) of the Code in that he was negligent in his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. The circumstances are as follows:

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77. The facts and allegations set forth in paragraphs 10 through 60, above, are incorporated by reference and realleged as if fully set forth herein.

78. The facts and allegations set forth in First Cause for Discipline, above, are incorporated by reference and realleged as if fully set forth herein.

79. Each of the alleged acts of gross negligence set forth in the First Cause for Discipline, above, are also negligent acts.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

80. Respondent Terry Tetsuo Ishihara, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records for Patient 1, Patient 2, Patient 3, and Patient 4. The circumstances are as follows:

81. The facts and allegations set forth in paragraphs 10 through 60, above, are incorporated by reference and realleged as if fully set forth herein.

82. The facts and allegations set forth in First Cause for Discipline, above, are incorporated by reference and realleged 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 or suspending Physician's and Surgeon's Certificate Number G 87861, issued to Respondent Terry Tetsuo Ishihara, M.D.;

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

3. Ordering Respondent Terry Tetsuo Ishihara, 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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4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 23 2023

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

LA2023600918