

**BEFORE 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**

Case No.: 800-2020-066089

Respondent.

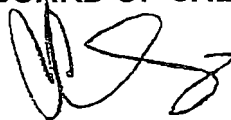
DECISION

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

This Decision shall become effective at 5:00 p.m. on April 18, 2024.

IT IS SO ORDERED: March 19, 2024.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA
Attorney General of California
2 EDWARD KIM
Supervising Deputy Attorney General
3 CHRISTINE FRIAR WALTON
Deputy Attorney General
4 State Bar No. 228421
300 South Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 269-6472
6 Facsimile: (916) 731-2117
Attorneys for Complainant
7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **TERRY TETSUO ISHIHARA, M.D.**
14 **Optum Healthcare**
15 **1499 W. 1st Street**
16 **San Pedro, CA 90732-3255**

17 **Physician's and Surgeon's Certificate**
18 **No. G 87861,**

19 Respondent.

Case No. 800-2020-066089

OAH No. 2023070951

20 **STIPULATED SETTLEMENT AND**
21 **DISCIPLINARY ORDER**

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

24 **PARTIES**

25 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
26 California (Board). He brought this action solely in his official capacity and is represented in this
27 matter by Rob Bonta, Attorney General of the State of California, by Christine Friar Walton,
28 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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1 3. On October 6, 2006, the Board issued Physician's and Surgeon's Certificate No. G
2 87861 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all
3 times relevant to the charges brought in Accusation No. 800-2020-066089, and will expire on
4 August 31, 2024, unless renewed.

5 **JURISDICTION**

6 4. On March 23, 2023, Accusation No. 800-2020-066089 was filed before the Board,
7 and is currently pending against Respondent. The Accusation and all other statutorily required
8 documents were properly served on Respondent on March 23, 2023. Respondent timely filed his
9 Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-
10 2020-066089 is attached as Exhibit A and incorporated by reference as if fully set forth herein.

11 **ADVISEMENT AND WAIVERS**

12 5. Respondent has carefully read, fully discussed with counsel, and understands the
13 charges and allegations in Accusation No. 800-2020-066089. Respondent has also carefully read,
14 fully discussed with his counsel, and understands the effects of this Stipulated Settlement and
15 Disciplinary Order.

16 6. Respondent is fully aware of his legal rights in this matter, including the right to a
17 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine
18 the witnesses against him; the right to present evidence and to testify on his own behalf; the right
19 to the issuance of subpoenas to compel the attendance of witnesses and the production of
20 documents; the right to reconsideration and court review of an adverse decision; and all other
21 rights accorded by the California Administrative Procedure Act and other applicable laws.

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

24 **CULPABILITY**

25 8. Respondent understands and agrees that the charges and allegations in Accusation
26 No. 800-2020-066089, if proven at a hearing, constitute cause for imposing discipline upon his
27 Physician's and Surgeon's Certificate.

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

1 establish a prima facie case with respect to the charges and allegations in Accusation No. 800-
2 2020-066089 and that he has thereby subjected his Physician's and Surgeon's Certificate No. G
3 87861 to disciplinary action.

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

7 CONTINGENCY

8 11. This stipulation shall be subject to approval by the Medical Board of California.
9 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
10 Board of California may communicate directly with the Board regarding this stipulation and
11 settlement, without notice to or participation by Respondent or his counsel. By signing the
12 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
13 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
14 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
15 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
16 action between the parties, and the Board shall not be disqualified from further action by having
17 considered this matter.

18 12. Respondent agrees that if he ever petitions for early termination or modification of
19 probation, or if an accusation and/or petition to revoke probation is filed against him before the
20 Board, all of the charges and allegations contained in Accusation No. 800-2020-066089 shall be
21 deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any
22 other licensing proceeding involving Respondent in the State of California.

23 13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to
24 be an integrated writing representing the complete, final and exclusive embodiment of the
25 agreement of the parties in this above-entitled matter.

26 14. The parties understand and agree that Portable Document Format (PDF) and facsimile
27 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
28 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

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

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

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

18 3. EDUCATION COURSE. Within 60 calendar days of the effective date of this
19 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
20 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
21 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
22 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
23 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
24 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
25 completion of each course, the Board or its designee may administer an examination to test
26 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
27 hours of CME of which 40 hours were in satisfaction of this condition.

28 4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective

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

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

14 Respondent shall submit a certification of successful completion to the Board or its
15 designee not later than 15 calendar days after successfully completing the course, or not later than
16 15 calendar days after the effective date of the Decision, whichever is later.

17 5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
18 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
19 advance by the Board or its designee. Respondent shall provide the approved course provider
20 with any information and documents that the approved course provider may deem pertinent.
21 Respondent shall participate in and successfully complete the classroom component of the course
22 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
23 complete any other component of the course within one (1) year of enrollment. The medical
24 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
25 Medical Education (CME) requirements for renewal of licensure.

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

1 been approved by the Board or its designee had the course been taken after the effective date of
2 this Decision.

3 Respondent shall submit a certification of successful completion to the Board or its
4 designee not later than 15 calendar days after successfully completing the course, or not later than
5 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

28 Determination as to whether Respondent successfully completed the clinical competence

1 assessment program is solely within the program's jurisdiction.

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

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

20 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
21 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
22 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
23 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role
24 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
25 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
26 signed statement for approval by the Board or its designee.

27 Within 60 calendar days of the effective date of this Decision, and continuing throughout
28 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall

1 make all records available for immediate inspection and copying on the premises by the monitor
2 at all times during business hours and shall retain the records for the entire term of probation.

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

8 The monitor(s) shall submit a quarterly written report to the Board or its designee which
9 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
10 are within the standards of practice of medicine, and whether Respondent is practicing medicine
11 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
12 that the monitor submits the quarterly written reports to the Board or its designee within 10
13 calendar days after the end of the preceding quarter.

14 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
15 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
16 name and qualifications of a replacement monitor who will be assuming that responsibility within
17 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
18 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
19 notification from the Board or its designee to cease the practice of medicine within three (3)
20 calendar days after being so notified. Respondent shall cease the practice of medicine until a
21 replacement monitor is approved and assumes monitoring responsibility.

22 In lieu of a monitor, Respondent may participate in a professional enhancement program
23 approved in advance by the Board or its designee that includes, at minimum, quarterly chart
24 review, semi-annual practice assessment, and semi-annual review of professional growth and
25 education. Respondent shall participate in the professional enhancement program at Respondent's
26 expense during the term of probation.

27 8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
28 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the

1 Chief Executive Officer at every hospital where privileges or membership are extended to
2 Respondent, at any other facility where Respondent engages in the practice of medicine,
3 including all physician and locum tenens registries or other similar agencies, and to the Chief
4 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
5 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
6 calendar days.

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

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

11 10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
12 ordered to reimburse the Board its costs of investigation and enforcement in the amount of
13 \$44,122.31 (Forty-four thousand one hundred twenty-two dollars and thirty-one cents). Costs
14 shall be payable to the Medical Board of California. Failure to pay such costs shall be considered
15 a violation of probation.

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

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

22 11. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
23 under penalty of perjury on forms provided by the Board, stating whether there has been
24 compliance with all the conditions of probation.

25 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
26 of the preceding quarter.

27 12. GENERAL PROBATION REQUIREMENTS.

28 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

1 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
2 patient care, clinical activity or teaching, or other activity as approved by the Board. If
3 Respondent resides in California and is considered to be in non-practice, Respondent shall
4 comply with all terms and conditions of probation. All time spent in an intensive training
5 program which has been approved by the Board or its designee shall not be considered non-
6 practice and does not relieve Respondent from complying with all the terms and conditions of
7 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
8 on probation with the medical licensing authority of that state or jurisdiction shall not be
9 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
10 period of non-practice.

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

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

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

18 Periods of non-practice for a Respondent residing outside of California will relieve
19 Respondent of the responsibility to comply with the probationary terms and conditions with the
20 exception of this condition and the following terms and conditions of probation: Obey All Laws;
21 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or
22 Controlled Substances; and Biological Fluid Testing..

23 15. COMPLETION OF PROBATION. Respondent shall comply with all financial
24 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
25 completion of probation. This term does not include cost recovery, which is due within 30
26 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
27 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate
28 shall be fully restored.

1 16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
2 of probation is a violation of probation. If Respondent violates probation in any respect, the
3 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
4 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
5 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
6 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
7 the matter is final.

8 17. LICENSE SURRENDER. Following the effective date of this Decision, if
9 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
10 the terms and conditions of probation, Respondent may request to surrender his or her license.
11 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
12 determining whether or not to grant the request, or to take any other action deemed appropriate
13 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
14 shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its
15 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
16 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
17 application shall be treated as a petition for reinstatement of a revoked certificate.

18 18. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
19 with probation monitoring each and every year of probation, as designated by the Board, which
20 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
21 California and delivered to the Board or its designee no later than January 31 of each calendar
22 year.

23 19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
24 a new license or certification, or petition for reinstatement of a license, by any other health care
25 licensing action agency in the State of California, all of the charges and allegations contained in
26 Accusation No. 800-2020-066089 shall be deemed to be true, correct, and admitted by
27 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
28 restrict license.

1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Greg R. Bunch. I understand the stipulation and the effect it will
4 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
5 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
6 Decision and Order of the Medical Board of California.

7 DATED: _____

8 TERRY TETSUO ISHIHARA, M.D.
9 *Respondent*

10 I have read and fully discussed with Respondent Terry Tetsuo Ishihara, M.D. the terms and
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
12 I approve its form and content.

13 DATED: _____

14 GREG R. BUNCH
15 *Attorney for Respondent*

16 ENDORSEMENT

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

19 DATED: _____

20 Respectfully submitted,

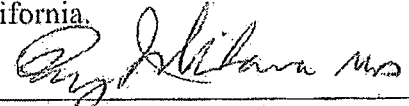
21 ROB BONTA
22 Attorney General of California
23 EDWARD KIM
24 Supervising Deputy Attorney General

25 CHRISTINE FRIAR WALTON
26 Deputy Attorney General
27 *Attorneys for Complainant*
28

1 ACCEPTANCE

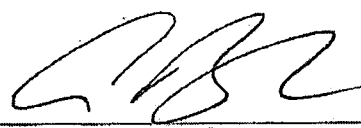
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4 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
5 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
6 Decision and Order of the Medical Board of California.

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 and
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
12 I approve its form and content.

13 DATED: January 26, 2024


14 GREG R. BUNCH
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

21 

22 CHRISTINE FRIAR WALTON
23 Deputy Attorney General
24 Attorneys for Complainant
25
26
27
28

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 State Bar No. 155307
300 South Spring Street, Suite 1702
4 Los Angeles, CA 90013
Telephone: (213) 269-6453
5 Facsimile: (916) 731-2117
E-mail: Judith.Alvarado@doj.ca.gov
6 *Attorneys for Complainant*

7
8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2020-066089

13 **TERRY TETSUO ISHIHARA, M.D.**
14 **1499 W. 1st Street**
San Pedro, CA 90732-3255

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **No. G 87861,**

Respondent.

17
18
19 **PARTIES**

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

23 2. On or about October 6, 2006, the Board issued Physician's and Surgeon's Certificate
24 Number G 87861 to Terry Tetsuo Ishihara, M.D. (Respondent). The Physician's and Surgeon's
25 Certificate was in full force and effect at all times relevant to the charges brought herein and will
26 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

1 physician and surgeon or his or her professional liability insurer to pay an amount in
2 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.

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

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

9 STATUTORY PROVISIONS

10 7. Section 2234 of the Code, states:

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

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

15 (b) Gross negligence.

16 (c) Repeated negligent acts. To be repeated, there must be two or more
17 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.

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

20 (2) When the standard of care requires a change in the diagnosis, act, or
21 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
22 licensee's conduct departs from the applicable standard of care, each departure
constitutes a separate and distinct breach of the standard of care.

23 (d) Incompetence.

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

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

27 (g) The failure by a certificate holder, in the absence of good cause, to attend
28 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.

1 8. Section 2266 of the Code states:

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

5 **COST RECOVERY**

6 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
7 administrative law judge to direct a licensee found to have committed a violation or violations of
8 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
9 enforcement of the case, with failure of the licensee to comply subjecting the license to not being
10 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
11 included in a stipulated settlement.

12 **FACTUAL ALLEGATIONS**

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

16 **Standard of Care**

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

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

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

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

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

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

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

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

17 **Patient 1:¹**

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

24 20. Respondent noted that Patient 1 was opioid dependent and that the patient disagreed
25 with the diagnosis. Yet, Patient 1 sought early refills of his pain medications and manifested
26

27 ¹ The patients are identified in this Accusation by number to protect their privacy
28 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.

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

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

12 22. According to a message from Respondent to Patient 1 dated November 5, 2018, the
13 patient had been treating with Physician Assistant Geogis who was slowly weaning down Patient
14 1's opioids. Patient 1 requested that Respondent stop the taper until February 2019.

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

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

1 Norco #30. In March he would receive oxycodone #90, no Norco. April he would receive
2 oxycodone # 60, and in May oxycodone #30. Respondent noted that Patient 1 would be off
3 opioids after May 2020. Respondent also noted that a pain management referral was recently
4 approved for Patient 1. The patient indicated that he did not plan on finding a new primary care
5 physician; he intended to go to the emergency room as necessary. Respondent noted that Patient
6 1 was angry and moderately anxious. Respondent gave Patient 1 a prescription for oxycodone
7 #120 and Norco #30. Patient 1 reported that he no longer wanted Respondent as his primary care
8 physician. Respondent encouraged Patient 1 to find a new primary care physician to manage his
9 general health.

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

14 **Patient 2**

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

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

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

1 2018, Respondent notes that Patient 2 has expressive aphasia. She was still being followed by the
2 neurologist. Patient 2 was to be followed by a rheumatologist for her Lupus, rheumatoid arthritis,
3 and bilateral total hip arthroplasties. She was continued on tramadol for pain. Respondent noted
4 that Patient 2's blood pressure was elevated at 180/110 and he added clonidine for blood pressure
5 control.

6 29. On or about April 11, 2018, Respondent noted that Patient 2 was diagnosed with
7 Fahr's disease, which was the probable explanation for her speech and behavioral issues. Patient
8 2 was refusing to take her Atorvastatin and vitamins because she was taking too many pills. She
9 had been treated for a urinary tract infection. Patient 2 was using a front wheeled walker or
10 parallel bars with one to two person assist for ambulation. She also had a right heel pressure sore.
11 She remained on tramadol and had Norco available for increased pain.

12 30. Approximately a month later, on or about May 7, 2018, Respondent notes that Patient
13 2 sustained a fall and complained of back pain. X-rays were negative [for fracture], and he
14 prescribed Norco [for pain]. She was taken to the emergency room where she was diagnosed
15 with shingles and an asymptomatic urinary tract infection. She was to continue on Tylenol,
16 ibuprofen, or Norco, as needed for pain.

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

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

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

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

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

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

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

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

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

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

7 **Patient 3**

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

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

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

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

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

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

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

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

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

19 48. On or about September 6, 2020, Respondent was concerned with Patient 3's weight
20 loss. He notes that the patient's pain had lessened, and he decreased her dose of MS Contin from
21 120 mg to 90 mg per day. However, it is also noted that the patient's chronic pain complaints are
22 uncontrolled on multiple medications, and she is referred to orthopedics.

23 49. At the visit on or about December 2, 2020, Respondent notes that Patient 3 did not
24 see the orthopedist and wants a second opinion. She states that the pain keeps her up at night.
25 Respondent's plan was to switch the timing of her MS Contin so that Patient 3 would receive her
26

27 ⁴ MME stands for morphine milligram equivalent. It is a measurement that physicians use
28 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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1 54. Between on or about July 11, 2017 and January 8, 2018, Respondent prescribed an
2 average of 1359 MME per day for Patient 4 and 300 tablets of Xanax 2 mg. During this time-
3 frame Respondent prescribed 11 out of 16 prescriptions for Patient 4.

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

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

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

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

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

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

4 **FIRST CAUSE FOR DISCIPLINE**

5 **(Gross Negligence)**

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

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

11 **Patient 1**

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

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

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

1 **Patient 2**

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

6 **Patient 3**

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

12 68. Respondent committed an extreme departure from the standard of care in failing to
13 document any rationale for escalating Patient 3's dose of opioids. The medical records do not
14 indicate an obvious reason to more than double Patient 3's MME between June and October
15 2019.

16 **Patient 4**

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

23 70. Respondent committed an extreme departure from the standard of care in failing to
24 document any rationale for escalating Patient 4's dose of opioids. Prior to on or about July 11,
25 2017, Patient 4 was on approximately 10 MME. On that date, Respondent began to prescribe
26 over 1000 MME. When transitioning patients to methadone to treat chronic pain, clinicians
27 generally start at 2.5 mg, three times a day. The dose of methadone is gradually increased to no
28

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

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

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

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

17 74. Respondent committed an extreme departure from the standard of care in failing to
18 stratify Patient 4's risk when initiating methadone therapy. Per CURES, prior to on or about July
19 11, 2017, Patient 4 had been prescribed only Norco. On or about July 11, 2017, Respondent
20 started Patient 4 on methadone at over 1000 MME.

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

23 SECOND CAUSE FOR DISCIPLINE

24 (Repeated Negligent Acts)

25 76. Respondent Terry Tetsuo Ishihara, M.D. is subject to disciplinary action under
26 section 2234 subdivision (c) of the Code in that he was negligent in his care and treatment of
27 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