

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

In the Matter of the Accusation
Against:

Francisco S. Pardo, M.D.

Physician's and Surgeon's
Certificate No. G 57474

Respondent.

Case No.: 800-2020-067064

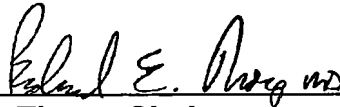
DECISION

The attached Stipulated Settlement and Disciplinary 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 May 3, 2024.

IT IS SO ORDERED: April 4, 2024.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, Chair
Panel B

1 ROB BONTA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 KEITH C. SHAW
Deputy Attorney General
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8 *Attorneys for Complainant*

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

14 In the Matter of the Accusation Against:

15 **FRANCISCO S. PARDO, M.D.**

16 **2140 Hayden Way, #A**
17 **San Diego, CA 92110**

18 **Physician's and Surgeon's Certificate No.**
19 **G 57474**

20 Respondent.

Case No. 800-2020-067064

OAH No. 2023050409

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

21
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 Keith C. Shaw, Deputy
28 Attorney General.

1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 800-2020-067064, if proven at a hearing, constitute cause for imposing discipline upon his
4 Physician's and Surgeon's Certificate.

5 10. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent gives up his right to contest that, at a hearing, Complainant
7 could establish a *prima facie* case with respect to the charges and allegations contained in the
8 Accusation.

9 11. Respondent agrees that if he ever petitions for early termination or modification of
10 probation, or if an accusation and/or petition to revoke probation is filed against him before the
11 Medical Board of California, all of the charges and allegations contained in Accusation No. 800-
12 2020-067064 shall be deemed true, correct and fully admitted by Respondent for purposes of any
13 such proceeding or any other licensing proceeding involving Respondent in the State of
14 California.

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

18 CONTINGENCY

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

1 14. The parties understand and agree that Portable Document Format (PDF) and facsimile
2 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
3 signatures thereto, shall have the same force and effect as the originals.

4 15. In consideration of the foregoing admissions and stipulations, the parties agree that
5 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
6 enter the following Disciplinary Order:

7 **DISCIPLINARY ORDER**

8 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 57474 issued
9 to Respondent Francisco S. Pardo, M.D., is revoked. However, the revocation is stayed and
10 Respondent is placed on probation for four (4) years from the effective date of the Decision on
11 the following terms and conditions:

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

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

24 2. EDUCATION COURSE. Within 60 calendar days of the effective date of this
25 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
26 for its prior approval educational program(s) or course(s) which shall not be less than 30 hours
27 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
28 correcting any areas of deficient practice or knowledge, including an emphasis on the prescribing

1 of controlled substances, and shall be Category I certified. The educational program(s) or
2 course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical
3 Education (CME) requirements for renewal of licensure. Following the completion of each
4 course, the Board or its designee may administer an examination to test Respondent's knowledge
5 of the course. Respondent shall provide proof of attendance for 55 hours of CME of which 30
6 hours were in satisfaction of this condition.

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

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

21 Respondent shall submit a certification of successful completion to the Board or its
22 designee not later than 15 calendar days after successfully completing the course, or not later than
23 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

10 Respondent shall submit a certification of successful completion to the Board or its
11 designee not later than 15 calendar days after successfully completing the course, or not later than
12 15 calendar days after the effective date of the Decision, whichever is later.

13 5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
14 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
15 meets the requirements of Title 16, California Code of Regulations section 1358.1. Respondent
16 shall participate in and successfully complete that program. Respondent shall provide any
17 information and documents that the program may deem pertinent. Respondent shall successfully
18 complete the classroom component of the program not later than six (6) months after
19 Respondent's initial enrollment, and the longitudinal component of the program not later than the
20 time specified by the program, but no later than one (1) year after attending the classroom
21 component. The professionalism program shall be at Respondent's expense and shall be in
22 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

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

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

7 If the monitor resigns or is no longer available, Respondent shall, within five (5) calendar
8 days of such resignation or unavailability, submit to the Board or its designee, for prior approval,
9 the name and qualifications of a replacement monitor who will be assuming that responsibility
10 within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within
11 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
12 notification from the Board or its designee to cease the practice of medicine within three (3)
13 calendar days after being so notified. Respondent shall cease the practice of medicine until a
14 replacement monitor is approved and assumes monitoring responsibility.

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

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

25 The program shall consist of a comprehensive assessment of Respondent's physical and
26 mental health and the six general domains of clinical competence as defined by the Accreditation
27 Council on Graduate Medical Education and American Board of Medical Specialties pertaining to
28 Respondent's current or intended area of practice. The program shall take into account data

1 obtained from the pre-assessment, self-report forms and interview, and the Decision(s),
2 Accusation(s), and any other information that the Board or its designee deems relevant. The
3 program shall require Respondent's on-site participation for a minimum of three (3) and no more
4 than five (5) days as determined by the program for the assessment and clinical education
5 evaluation. Respondent shall pay all expenses associated with the clinical competence
6 assessment program.

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

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

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

25 8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
26 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
27 Chief Executive Officer at every hospital where privileges or membership are extended to
28 Respondent, at any other facility where Respondent engages in the practice of medicine,

1 including all physician and locum tenens registries or other similar agencies, and to the Chief
2 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
3 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
4 calendar days.

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

6 9. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
7 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
8 advanced practice nurses.

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

12 11. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
13 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
14 limited to, expert review, amended accusations, legal reviews, joint investigations, and subpoena
15 enforcement, as applicable, in the amount of \$56,348.00. Costs shall be payable to the Medical
16 Board of California. Failure to pay such costs shall be considered a violation of probation.

17 Any and all requests for a payment plan shall be submitted in writing by respondent to the
18 Board.

19 12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
20 under penalty of perjury on forms provided by the Board, stating whether there has been
21 compliance with all the conditions of probation.

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

24 13. GENERAL PROBATION REQUIREMENTS.

25 Compliance with Probation Unit

26 Respondent shall comply with the Board's probation unit.

27 Address Changes

28 Respondent shall, at all times, keep the Board informed of Respondent's business and

1 residence addresses, email address (if available), and telephone number. Changes of such
2 addresses shall be immediately communicated in writing to the Board or its designee. Under no
3 circumstances shall a post office box serve as an address of record, except as allowed by Business
4 and Professions Code section 2021, subdivision (b).

5 Place of Practice

6 Respondent shall not engage in the practice of medicine in Respondent's place of residence.

7 License Renewal

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

10 Travel or Residence Outside California

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

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

17 14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
18 available in person upon request for interviews either at Respondent's place of business or at the
19 probation unit office, with or without prior notice throughout the term of probation.

20 15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
21 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
22 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
23 defined as any period of time Respondent is not practicing medicine as defined in Business and
24 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
25 patient care, clinical activity or teaching, or other activity as approved by the Board. If
26 Respondent resides in California and is considered to be in non-practice, Respondent shall
27 comply with all terms and conditions of probation. All time spent in an intensive training
28 program which has been approved by the Board or its designee shall not be considered non-

1 practice and does not relieve Respondent from complying with all the terms and conditions of
2 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
3 on probation with the medical licensing authority of that state or jurisdiction shall not be
4 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
5 period of non-practice.

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

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

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

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

18 16. COMPLETION OF PROBATION. Respondent shall comply with all financial
19 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
20 completion of probation. Upon successful completion of probation, Respondent's certificate shall
21 be fully restored.

22 17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
23 of probation is a violation of probation. If Respondent violates probation in any respect, the
24 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
25 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
26 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
27 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
28 the matter is final.

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

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

16 20. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
17 a new license or certification, or petition for reinstatement of a license, by any other health care
18 licensing action agency in the State of California, all of the charges and allegations contained in
19 Accusation No. 800-2020-067064 shall be deemed to be true, correct, and admitted by
20 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
21 restrict license.

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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Joseph La Costa, Esq. I understand the stipulation and the effect it
4 will 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
8 DATED: 02/8/24


9 FRANCISCO S. PARDO, M.D.
Respondent

10 I have read and fully discussed with Respondent Francisco S. Pardo, 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
14 DATED: 2/8/24


15 JOSEPH LA COSTA, ESQ.
Attorney for Respondent

16
17 ENDORSEMENT

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

20
21 DATED: 2/8/2024

Respectfully submitted,

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

24 

25 KEITH C. SHAW
26 Deputy Attorney General
Attorneys for Complainant

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8 *Attorneys for Complainant*

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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. 800-2020-067064

FRANCISCO S. PARDO, M.D.
2140 Hayden Way
San Diego, CA 92110

A C C U S A T I O N

**Physician's and Surgeon's Certificate
No. G 57474,**

Respondent.

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21

PARTIES

- 22 1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as
23 the Interim Executive Director of the Medical Board of California, Department of Consumer
24 Affairs (Board).
- 25 2. On or about June 16, 1986, the Medical Board issued Physician's and Surgeon's
26 Certificate No. G 57474 to Francisco S. Pardo, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
28 herein and will expire on February 29, 2024, unless renewed.

JURISDICTION

1
2 3. This Accusation is brought before the Medical Board of California, Department of
3 Consumer Affairs, under the authority of the following laws. All section references are to the
4 Business and Professions Code (Code) unless otherwise indicated.

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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1 5. Section 2234 of the Code, states:

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

5 “... .

6 “(b) Gross negligence.

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

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

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

17 “(d) Incompetence.

18 “... .”

19 6. Section 725 of the Code states:

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

27 “(b) Any person who engages in repeated acts of clearly excessive
28 prescribing or administering of drugs or treatment is guilty of a misdemeanor and

1 shall be punished by a fine of not less than one hundred dollars (\$100) nor more
2 than six hundred dollars (\$600), or by imprisonment for a term of not less than 60
3 days nor more than 180 days, or by both that fine and imprisonment.

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

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

9 7. Section 2266 of the Code states:

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

12 8. Section 2229 of the Code states that the protection of the public shall be the highest
13 priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a
14 licensee should be made when possible, Section 2229, subdivision (c), states that when
15 rehabilitation and protection are inconsistent, protection shall be paramount.

16 COST RECOVERY

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

23 PERTINENT DRUGS

24 10. **Adderall**, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a
25 central nervous system (CNS) stimulant of the amphetamine class, and is a Schedule II controlled
26 substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous
27 drug pursuant to Code section 4022. When properly prescribed and indicated, it is used for
28 attention-deficit hyperactivity disorder (ADHD) and narcolepsy. According to the Drug

1 Enforcement Administration (DEA), amphetamines, such as Adderall, are considered a drug of
2 abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their
3 onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2017),
4 at p. 50.) Adderall and other stimulants are contraindicated for patients with a history of drug
5 abuse.

6 11. **Atripla** is a fixed-dose combination medication (efavirenz, emtricitabine and
7 tenofovir) indicated in the treatment of the human-immunodeficiency-virus-1 (HIV-1) infection
8 in adults. Atripla can cause serious, life-threatening side effects, including buildup of lactic acid
9 in the blood, liver problems, severe skin rash and allergic reactions, mental health problems, and
10 new or worsening kidney problems, including kidney failure.

11 12. **Diazepam**, known by the trade name Valium, is a medicine of the benzodiazepine
12 class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous
13 drug as defined in Code section 4022 and a Schedule IV controlled substance as defined by
14 section 11057 of the Health and Safety Code. It produces CNS depression and should be used
15 with caution with other central nervous system depressant drugs. Like other benzodiazepines, it
16 can produce psychological and physical dependence. Withdrawal symptoms similar to those
17 noted with barbiturates and alcohol have been noted upon abrupt discontinuance. The DEA has
18 identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA
19 Resource Guide (2011 Edition), at p. 53.)

20 13. **Fentanyl** (Actiq, Fentora, Subsys, and Duragesic) is a powerful synthetic opioid that
21 is similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication
22 ordinarily used to treat patients with severe pain, especially after surgery. When properly
23 prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant
24 patients, severe enough to require daily, continuous, long term opioid treatment, and for which
25 alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance
26 pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug
27 pursuant to Code section 4022. The Food and Drug Administration (FDA) has issued several
28 black box warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and

1 misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal
2 syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS
3 depressants. Fentanyl comes in several forms, including as an injection, spray (Subsys),
4 intrathecal administration (an injection around the spinal canal), a transdermal patch that is placed
5 on the skin, or as a lozenge that is sucked like a cough drop (Actiq).

6 14. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of
7 hydrocodone bitartrate and acetaminophen and is a Schedule II controlled substance pursuant to
8 Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Code
9 section 4022. Schedule II controlled substances are substances that have a currently accepted
10 medical use in the United States, but also have a high potential for abuse, and the abuse of which
11 may lead to severe psychological or physical dependence. When properly prescribed and
12 indicated, hydrocodone is used for the treatment of moderate to severe pain. In addition to the
13 potential for psychological and physical dependence, there is also the risk of acute liver failure
14 which has resulted in a black box warning being issued by the FDA. The DEA has identified
15 opioids, such as hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011
16 Edition), at p. 37.)

17 15. **Hydromorphone** (Dilaudid), an opioid analgesic, is a Schedule II controlled
18 substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous
19 drug pursuant to Code section 4022. When properly prescribed and indicated, it is used for the
20 treatment of moderate to severe pain. The DEA has identified hydromorphone, such as Dilaudid,
21 as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The FDA
22 has issued black box warnings for Dilaudid which warn about, among other things, addiction,
23 abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also
24 caution about the risks associated with concomitant use of Dilaudid with benzodiazepines or other
25 CNS depressants.

26 16. **Oxycodone with acetaminophen** (Percocet), an opioid analgesic, is a Schedule II
27 controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a
28 dangerous drug pursuant to Code section 4022. When properly prescribed and indicated, it is

1 used for the management of moderate to moderately severe pain. The DEA has identified
2 oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p.
3 41.) The FDA has issued a black box warning for Percocet which warns about, among other
4 things, addiction, abuse and misuse, and the possibility of “life-threatening respiratory distress.”

5 17. **Oxycodone HCL** (OxyContin) is a Schedule II controlled substance pursuant to
6 Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code
7 section 4022. When properly prescribed and indicated, OxyContin is used for the management of
8 pain severe enough to require daily, around-the-clock, long-term opioid treatment for which
9 alternative treatment options are inadequate. The DEA has identified OxyContin as a drug of
10 abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of
11 respiratory depression and overdose is increased with the concomitant use of benzodiazepines or
12 when prescribed to patients with pre-existing respiratory depression.

13 18. **Soma** (carisoprodol) is a Schedule IV controlled substance pursuant to Health and
14 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022.
15 When properly prescribed and indicated, it is used for the treatment of acute and painful
16 musculoskeletal conditions. According to the DEA, Office of Diversion Control, “[c]arisoprodol
17 abuse has escalated in the last decade in the United States...According to Diversion Drug Trends,
18 published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals,
19 carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of
20 carisoprodol is prevalent throughout the country.

21 19. **Xanax** (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is
22 a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
23 subdivision (d), and a dangerous drug pursuant to Code section 4022. When properly prescribed
24 and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax
25 with opioids “may result in profound sedation, respiratory depression, coma, and death.” The
26 DEA has identified benzodiazepines, such as Xanax, as a drug of abuse. (Drugs of Abuse, DEA
27 Resource Guide (2017 Edition), at p. 59.)

28 ///

1 emergency team had been called a number of times, and that “coercing him into a 5150 hold” had
2 been unsuccessful. Respondent indicated that a number of pharmacies would no longer fill the
3 patient’s prescriptions, and that he was a high risk of hurting himself and had many connections
4 to “on the street opiate sources.” It was noted that if Respondent could not monitor the patient, a
5 referral to drug enforcement for diversion may be needed, and that “extra caution and strict
6 approach” must be applied.

7 25. On or about June 27, 2017, Respondent started regular prescriptions for oxymorphone
8 (30 mg daily), however, Respondent did not note that oxymorphone was being introduced.
9 Respondent did not issue Patient S any opiate prescriptions between January 2018 and September
10 2018, at which time he resumed regular prescriptions for oxycodone, Adderall, and Soma, and
11 oxymorphone the following month. On or about September 25, 2018, Respondent noted that he
12 reestablished patient care from Europe, but did not note the patient’s medical care in Europe or
13 whether opiate prescriptions were adjusted.

14 26. On or about November 15, 2018, Patient S underwent a UDS, which did not detect
15 the presence of any of the controlled substances being prescribed by Respondent, including a
16 prescription for 180 pills of oxycodone filled just one week prior. Two weeks later, Patient S
17 tested positive for heroin, methamphetamine, amphetamine, and alprazolam. Again, he tested
18 negative for his regularly prescribed medications, oxycodone and oxymorphone.

19 27. On or about December 26, 2018, Respondent discussed the positive
20 heroin/methamphetamine test with Patient S, however, the patient denied illicit drug use and
21 claimed the positive tests were the result of taking Sudafed and eating “poppy seed bagels and
22 muffins.” Respondent noted the pain contract was discussed, stating “3 strikes and you’re out.”
23 The results of the November 15, 2018, UDS were not addressed by Respondent despite Patient S
24 being at an elevated risk for opiate-related aberrant behavior, including diversion.

25 28. On or about March 26, 2019, Respondent noted that Patient S had presented to the ER
26 multiple times and had not come into the office for one month, even though the opioid contract
27 required that the patient be seen every two weeks, including conducting a UDS every two weeks.
28 On or about October 31, 2019, Respondent noted opioid dependence. On or about May 10, 2020,

1 Respondent noted that Patient S had a “potential opiate overdose” and it was unlikely that the
2 patient would ever be in complete remission of addiction. On or about December 30, 2019,
3 Patient S came to Respondent’s residence unannounced at 11:00 p.m., and told Respondent that
4 he was in unbearable pain and did not want to live that way. Respondent dismissed calling a
5 psychiatric emergency team or sending the patient to the ER, and instead “de-escalated” the
6 situation over the course of 3.5 hours.

7 29. On or about February 14, 2020, Respondent noted that Patient S had previously tested
8 positive for cocaine, and had been incarcerated for a “drug charge.” On or about December 8,
9 2020, Respondent noted another negative UDS test for prescribed medications, and highlighted
10 that Patient S had an “unacceptable high number of negative toxicology visits, requiring extra
11 monitoring”

12 30. On or about January 19, 2021, another patient of Respondent’s reported that Patient S
13 had sold two oxycodone pills for pain. Respondent noted just 10 days later that Patient S was
14 missing his bi-monthly UDS, and that a welfare check at his home was recently conducted in
15 order to confirm there was no “increased” suicide ideation. On or about February 12, 2021,
16 Respondent noted that the morphine milligram equivalents (MME) would be reduced due to
17 Patient S’s “suicide ideation with plan,” and that Patient S would be entering drug rehabilitation.
18 On or about June 7, 2021, Patient S tested positive for methamphetamine and fentanyl.
19 Respondent noted that if Patient S would remain in the practice, he would need to enter drug
20 rehabilitation.

21 31. Rather than decreasing the average MME dose for Patient S throughout the course of
22 treatment, Respondent increased the average MME each year that Patient S was under his care.
23 In 2017, the average daily MME was approximately 461. In 2018, once opiate prescriptions were
24 resumed in September, the average MME was approximately 492. In 2019, the average daily
25 MME increased to approximately 718. In 2020, the average daily MME again increased to
26 approximately 756. In approximately January 2021, the average daily MME was a staggering
27 1350. On numerous occasions, Respondent issued multiple prescriptions for oxycodone that were
28 filled on the same date. For example, in approximately March 2019, Respondent prescribed 600

1 pills of oxycodone (30 mg), while at the same time prescribing another opiate, oxymorphone, as
2 well as Soma and Adderall.

3 32. At no time did Respondent check CURES² prior to or periodically while prescribing
4 controlled substances to Patient S, even though the patient was known to be at an elevated risk for
5 aberrant drug behavior. Finally, Respondent performed invasive procedures (injections) on
6 Patient S 25 times, yet failed to document necessary elements, including signed witnessed
7 consent, pre, peri, and post-procedural events, and post-procedure instructions to the patient on 11
8 of 25 occasions, and informed consent was absent on over 50% of the procedures.

9 33. Respondent committed gross negligence in his care and treatment of Patient S which
10 included, but was not limited to, the following:

11 (a) Respondent failed to establish the presence of an appropriate CSA
12 and/or enforcement of the CSA after Patient S repeatedly failed to
13 adhere to it;

14 (b) Respondent inappropriately prescribed and continued opiates without
15 proper periodic assessments of safe opiate use and/or deescalate
16 opioid use to the lowest effective dosage;

17 (c) Respondent failed to properly review and document CURES; and

18 (d) Respondent failed to properly document invasive procedures.

19 **PATIENT H**

20 34. Respondent started treating Patient H, a then 69-year-old male, on or about February
21 27, 2018. Patient H had a history of hypertension, diabetes, chronic neck and back pain, and
22 cocaine use. Respondent issued a prescription for Percocet on or about February 23, 2018, four
23 days prior to the initial visit. While a CSA was noted at the first visit, it was not signed by the
24 patient until five months later on or about July 30, 2018. Regular prescriptions of Percocet (50
25 mg oxycodone daily) would continue, while regular prescriptions for Soma (1050 mg daily)
26

27 ² The Controlled Substance Utilization Review and Evaluation System (CURES) is a
28 platform that tracks all Schedule II – IV controlled substances dispensed to patients in California.

1 started in approximately April 2018. Respondent Patient H was under the care of Respondent
2 until approximately July 2022.

3 35. Patient H tested positive for cocaine during a routine UDS on or about September 20,
4 2018. The patient claimed that it was a false positive due to taking amoxicillin for strep throat.
5 Approximately, two months later, Patient H again tested positive for cocaine on or about
6 December 27, 2018. Less than two months later, Patient H had a third positive UDS for cocaine.

7 36. It was not until on or about March 28, 2019, that Respondent confronted Patient H
8 with the previous two positive cocaine tests, and noted, "three strikes, and you're out."
9 Respondent indicated that the patient was aware that the UDS must be negative before
10 medications would be filled again. However, prescriptions for Percocet would be filled on
11 multiple occasions before the next UDS was performed on or about June 2, 2019. On or about
12 August 29, 2019, Patient H again tested positive for cocaine. On or about September 24, 2019,
13 Respondent noted that he discussed the most recent positive cocaine test and again indicated,
14 "three strikes, and you're out." On or about October 1, 2019, Patient H tested positive for cocaine
15 once again, yet Respondent continued numerous prescriptions for controlled substances.

16 37. On or about October 1, 2019, Patient H against tested positive for cocaine. At the
17 office visit on or about October 11, 2019, Patient H denied cocaine use and Respondent discussed
18 the three strikes rule with him again (even though this would be the fifth strike). On or about
19 December 31, 2019, Respondent noted, "there will be no further second chances with respect to
20 violation of the opiate contract." On or about January 10, 2020, Patient H admitted to cocaine use
21 as he believed it helped his pain, yet Respondent continued to issue more prescriptions for
22 opiates. On or about February 13, 2020, Respondent noted a "slip up" Patient H had when he
23 used THC last month. In total, lab toxicology testing was performed on seven occasions between
24 approximately September 2018 and October 2019, and Patient H tested positive for cocaine six
25 times. Further, Respondent issued approximately 17 prescriptions for Percocet and 16
26 prescriptions for Soma following the March 2017 "three strikes" breach discussion.

27 38. On or about August 2, 2019, Respondent documented, "diabetic foot ulcer, 6/10,
28 upward trend." There lacked any notes regarding the pertinent circumstances related to the

1 diabetic foot ulcer, including whether it was worsening, vascular integrity, whether it was wet/dry
2 gangrene, or whether there existed the potential for necrotizing fasciitis³ if gas gangrene was
3 present. Similarly, there was no relevant documentation regarding the initial management,
4 treatment, referral to a specialist (podiatrist), or need for urgent or emergent care.⁴ Under
5 assessment, Respondent indicated Percocet, which is insufficient treatment for a stage 4 foot
6 ulcer. Patient H was already at risk for ischemic peripheral artery disease⁵ given his history.
7 Patient H was seen two weeks later, however, there was no mention of the left ankle foot ulcer or
8 gangrene, and no examination of the feet was conducted.

9 39. Respondent performed invasive procedures (injections) on Patient H on 21 occasions,
10 yet failed to document necessary key elements of the procedure, including informed consent,
11 signed witnessed consent, pre, peri, and post-procedural events, and post-procedure instructions,
12 on 15 of 21 occasions. On one occasion on or about July 29, 2022, Respondent documented an
13 injection was performed in the office even though it was a telemedicine visit while the patient
14 was in North Carolina.

15 40. Respondent commonly failed to document relevant circumstances regarding Patient
16 H's pain, including location, duration, alleviating, triggering, and aggravating factors, as well as
17 associated physical findings. For example, at the initial visit on or about February 27, 2018,
18 Respondent noted that the chief complaint was lumbosacral pain, 6/10 intensity, and the course
19 was stable. However, a SLR test⁶ was not conducted, nor were deep tendon reflexes or other
20 details surrounding the circumstances of the patient's pain documented. Respondent also noted
21 neck pain, but did not document the circumstances or a neck examination.

22 ³ Necrotizing fasciitis is rare bacterial infection that spreads quickly in the body and can
23 cause death.

24 ⁴ The complications associated with untreated stage 4 foot ulcer and/or gas gangrene are
25 severe, irreversible, limb and life-threatening.

26 ⁵ Peripheral artery disease is a common condition in which narrowed arteries reduce blood
27 flow to the arms or legs.

28 ⁶ The straight leg raise (SLR) test is regularly used to identify disc pathology or nerve root
irritation as it mechanically stresses the lumbosacral nerve roots.

1 41. At no time did Respondent check CURES prior to or periodically while prescribing
2 controlled substances to Patient H, even though he was known to be at an elevated risk for
3 aberrant drug behavior. While Respondent did not prescribe excessive doses of opiates to Patient
4 H, he failed to appropriately titrate the dose, consider alternative medications at the lowest
5 effective dose, or document the initial circumstances and proper examination of the patient's
6 reported pain.

7 42. Respondent committed gross negligence in his care and treatment of Patient H which
8 included, but was not limited to, the following:

- 9 (a) Respondent failed to enforcement the CSA after Patient H repeatedly
10 failed to adhere to it and Respondent acknowledged the breeches;
- 11 (b) Respondent failed to properly diagnose, treat, refer to a specialist, and
12 document the patient's diabetic foot ulcer;
- 13 (c) Respondent inappropriately initiated and continued opiates without
14 titration or considering effective alternatives;
- 15 (d) Respondent failed to properly review and document CURES;
- 16 (e) Respondent failed to properly document invasive procedures; and
- 17 (f) Respondent failed to document the relevant circumstances regarding
18 the patient's reported pain and the related physical findings.

19 **PATIENT A**

20 43. Respondent began treatment with Patient A, a then 72-year-old female, on or about
21 October 7, 2016. Patient A presented with a history of depression, anxiety, bipolar II disorder,
22 hypertension, back pain, neck pain, lumbosacral spondylosis with radiculopathy, chronic L1
23 compression fracture, chronic obstructive pulmonary disease (COPD), Ehlers-Danlos syndrome,⁷
24 diabetes mellitus,⁸ and opioid dependence. She had reportedly been prescribed controlled

25 ⁷ Ehlers-Danlos syndrome, also known as EDS or elastic skin, is group of inherited
26 disorders that mostly affect the skin, joints, and blood vessels. There lacked any laboratory data
in the patient's records to support the diagnosis of EDS.

27 ⁸ There lacked any laboratory data in the patient's records to support the diagnosis of
28 diabetes mellitus. There was no mention of "diabetic foot," which could be indicative of diabetes
mellitus.

1 substances for three decades by prior physicians. Respondent began issuing regular prescriptions
2 for hydromorphone (12 mg daily), OxyContin (120 mg daily) and Ambien (10 mg daily).

3 44. On or about July 31, 2017, September 12, 2017, November 10, 2017, and November
4 21, 2018, Patient A had the following significantly high blood pressure readings: 216/95, 211/81,
5 212/94, and 214/98, respectively. On each occasion, Respondent failed to document whether a
6 cerebrovascular or cardiovascular examination was conducted to determine whether Patient A had
7 potentially compromised organs, and whether Patient A was experiencing hypotensive emergency
8 versus hypotensive urgency.⁹ Further, on each visit, there was no documentation indicating that
9 the blood pressure was rechecked, whether anti-hypertensive medications were reinstated or
10 intensified, or whether there was prompt follow-up (other than in four weeks). On only one
11 occasion (July 31, 2017) was Patient A told by Respondent to go to the emergency room and take
12 an anti-hypertensive medication. However, there was no closely monitored follow-up
13 appointment to determine the response to the medication or a repeat blood pressure reading
14 following the medication. Lastly, Respondent failed to document the relevant circumstances
15 leading up to the elevated blood pressure readings, including food, caffeine, and/or medication
16 consumption.

17 45. On or about February 22, 2017, January 29, 2019, July 9, 2019, and August 13, 2019,
18 Patient A had the following abnormally high respiratory rate readings: 40, 29, 29, and 30,
19 respectively. Even though the patient had a tachypneic respiratory rate (rapid, shallow breathing)
20 on these visits, Respondent noted Patient A's respiratory rate was normal on the first two
21 occasions, while noting that no respiratory examination was performed on the latter two
22 occasions.

23 46. At no time did Respondent check CURES prior to or periodically while prescribing
24 controlled substances to Patient A. Additionally, Respondent performed invasive procedures
25 (injections) on Patient A on 11 occasions, yet failed to document necessary key elements of the

26 ⁹ Hypotensive urgency occurs when a blood pressure reading is 180 systolic or higher, or
27 120 diastolic or higher, but there are no signs of organ failure; whereas, a hypotensive emergency
28 occurs under the same blood pressure readings, but there are signs of life-threatening damage to
the body's organs. Clinically stable patients with hypertensive urgency can be safely sent home
with anti-hypertensive medication and a follow-up visit within 24 hours.

1 procedure, including informed consent, signed witnessed consent, pre, peri, and post-procedural
2 events, and post-procedure instructions, on 9 of 11 occasions. Additionally, there were three
3 occasions that Respondent noted the procedures were done at the patient's home, one of which
4 indicated an ultrasound was used without any associated documentation.

5 47. Patient A's last visit with Respondent occurred on or about November 24, 2021,
6 while she was hospitalized with a stroke. Patient A had been admitted to the hospital one week
7 earlier with worsened renal failure, hypotensive, anemic, bilateral hematoma, and non-occlusive
8 left thrombus. Patient A passed away on or about December 5, 2021. The cause of death was
9 unrelated to the controlled substances being prescribed.

10 48. Respondent committed gross negligence in his care and treatment of Patient A which
11 included, but was not limited to, the following:

12 (a) Respondent failed to properly review and document CURES;

13 (b) Respondent failed to appropriately assess the patient to determine
14 whether each hypotensive crisis was emergency or urgency, document
15 the relevant circumstances, and treat accordingly;

16 (c) Respondent failed to properly assess and document the symptoms,
17 physical examination, and treatment plan of the patient exhibiting
18 significantly abnormal respiratory rates; and

19 (d) Respondent failed to properly document invasive procedures.

20 **PATIENT W**

21 49. Respondent started treating Patient W, a then 58-year-old female, on or about April
22 23, 2018. Patient W had a history of hypertension, bipolar I disorder with narcissistic personality
23 disorder, chronic lower back pain, and bilateral shoulder pain. Respondent started issuing regular
24 prescriptions for hydromorphone (24 mg daily), fentanyl transdermal (100 mcg), and Xanax (2
25 mg daily) on or about April 9, 2018, two weeks prior to the first visit. Regular prescriptions for
26 Soma (1050 mg daily) started on or about January 4, 2019, while OxyContin (75 mg daily) began
27 approximately two months later. Respondent continued Patient W on the aforementioned
28 controlled substances until at least February 2023, with the exception of hydromorphone

1 (discontinued in approximately February 2020), and Soma (discontinued in approximately
2 November 2021).

3 50. Respondent maintained Patient W on high average MME doses each year that she
4 was under his care. In 2018, the average daily MME was approximately 214. In 2019, the
5 average MME increased to approximately 226. In 2020, the average daily MME was
6 approximately 212. In 2021, the average daily MME was approximately 196. Despite the patient
7 being at moderate risk for aberrant drug risk, UDS was only performed on two occasions, while
8 on two additional occasions, UDS is mentioned, but the tests are not included in the records.

9 51. On or about November 27, 2018, February 7, 2019,¹⁰ March 5, 2019, and January 20,
10 2022,¹¹ Patient W had the following significantly irregular blood pressure readings: 209/112,
11 164/134, and 187/109, respectively. On each occasion, there lacked any documentation whether a
12 cerebrovascular or cardiovascular examination was conducted to determine whether Patient W
13 had potentially compromised organs, and whether she was experiencing hypotensive emergency
14 versus hypotensive urgency. There also lacked documentation indicating that the blood pressure
15 was rechecked, nor were prompt follow-up visits scheduled within 24 hours; instead, the patient
16 was not seen until several weeks later on each occurrence. On the first two occasions, Patient W
17 reported her lumbosacral pain as 8/10 and 7/10, respectively, which may have explained the high
18 blood pressure, yet an appropriate physical examination was not performed.¹² Further, while pain
19 intensity may increase blood pressure, there was no clear correlation between the two in any visit.
20 Lastly, Respondent failed to document the relevant circumstances leading up to the elevated
21 blood pressure readings, including food, caffeine, and/or medication consumption.

22
23
24 ¹⁰ On February 7, 2019, there was no documentation when the patient had last taken her
high blood pressure medication, nor was it filled at that time.

25 ¹¹ On January 20, 2020, the reason for the visit was "hypertension," yet Respondent failed
26 to mention the significantly high blood pressure or provide a treatment plan.

27 ¹² Had the bilateral lower extremities sensory-motor deficits reflected a dissecting aortic
aneurism, this would be considered a hypertensive emergency.

28

1 52. On or about June 30, 2021, Patient W had a telemedicine visit, where her blood
2 pressure measure at 184/92. Respondent did not request that the patient come in to the office to
3 have her blood pressure rechecked, and the next visit was not until over three weeks later. The
4 reason for the telemedicine visit was a possible hand fracture, yet Respondent failed to note a
5 visual examination or treatment plan.

6 53. On or about September 4, 2018, the patient presented with possible deep vein
7 thrombosis (DVT).¹³ However, there lacked documentation regarding which extremity was
8 possibly affected, how long the patient was having symptoms, precipitating factors, or whether a
9 physical examination was conducted. Respondent was also aware that the patient was on
10 medication that increased the risk for venous thromboembolism. At the next visit nearly two
11 months later, there was no mention or follow-up regarding DVT. In a subsequent interview,
12 Respondent indicated that he was aware that DVT was serious condition but he “did not have a
13 high enough suspicion to have ordered a sonogram.”

14 54. On or about September 13, 2019, Patient W saw Respondent for possible edema
15 (excess swelling) of the hands and feet. However, Respondent did not document the symptoms, a
16 relevant physical examination, or whether edema was actually present. Respondent later
17 indicated in an interview that he was not really impressed with the edema, so did not feel the need
18 to work it up. Further, he was unsure whether it was worse in the hands or feet.¹⁴

19 55. Respondent documented on only a single occasion on or about December 20, 2018,
20 that he checked CURES, well after prescriptions for controlled substances began. Additionally,
21 Respondent performed invasive procedures (injections) on Patient W on 15 occasions, yet failed
22 to document necessary key elements of the procedure, including informed consent, pre, peri, and
23 post-procedural events, and post-procedure instructions, on 12 of 15 occasions. Additionally,
24

25 ¹³ Deep vein thrombosis occurs when a blood clot (thrombus) forms in one or more of the
26 deep veins in the body, usually in the legs. DVT can lead to potentially life-threatening
complications.

27 ¹⁴ The presence of edema on all four extremities may be a sign of many serious medical
28 conditions, including decompensated heart failure, portal hypertension, pulmonary hypertension,
hypothyroidism with myxedema, and renal failure.

1 there were three occasions that Respondent noted the procedures were done at the patient's home,
2 one of which indicated an ultrasound was used without any associated documentation.

3 56. Respondent committed gross negligence in his care and treatment of Patient W which
4 included, but was not limited to, the following:

5 (a) Respondent failed to appropriately assess the patient to determine
6 whether each hypotensive crisis was emergency or urgency, document
7 the relevant circumstances, and treat accordingly;

8 (b) Respondent failed to appropriately assess and document the patient's
9 medical concerns related to potential deep vein thrombosis;

10 (c) Respondent failed to appropriately assess and document the patient's
11 medical concerns related to potential edema; and

12 (d) Respondent failed to properly document invasive procedures.

13 **PATIENT C**

14 57. Respondent started treating Patient C, a then 52-year-old male, on or about January 4,
15 2016.¹⁵ Patient C presented with a number of comorbidities, including COPD, opioid
16 dependence, depression, anxiety, seizures, HIV, lumbosacral pain, history of bone cancer, and
17 cervicalgia. Patient C's addiction severity index was determined to be moderate to high. On or
18 about February 1, 2016, Respondent started the patient on regular prescriptions for OxyContin
19 (60-90 mg daily), and Percocet (975-1300 mg daily). In approximately January 2017,
20 Respondent began the patient on Soma (700 mg daily).

21 58. In approximately April 2017, Respondent started issuing regular prescriptions for a
22 fentanyl spray, Subsys¹⁶ (1600 mcg daily). It was noted the reason Subsys was prescribed was
23 due to a history of malignancy based on information received by a former provider, however,
24 Respondent noted he did not see confirmatory studies of malignancies. At no time after did

25 _____
26 ¹⁵ Conduct occurring more than seven (7) years from the filing date of this Accusation is
for informational purposes only and is not alleged as a basis for disciplinary action.

27 ¹⁶ Subsys is indicated primarily for breakthrough pain associated with malignancy. In
28 fact, Respondent noted in approximately June 2016 that he typically only prescribed Subsys in the
hospital setting, and for hospice patients.

1 Respondent obtain the relevant medical records to verify whether Patient C had a known
2 malignancy. Subsys would be prescribed 18 times over the next 21 months without reviewing a
3 pathology report. On or about June 1, 2018, Respondent noted that Patient C must provide
4 documented proof of the alleged cancer. Two weeks later, it was noted that Patient C completed
5 chemotherapy and radiation for a "soft tissue neoplasm." Respondent continued to prescribe
6 Subsys even though he believed that Patient C was obtaining fentanyl from the "street," and that
7 the patient could have more appropriately obtained Subsys from his oncologist. In a subsequent
8 interview, Respondent claimed that he never prescribed Subsys without a pathology report, even
9 though there was no pathology report in the records. Additionally, Respondent stated that the
10 malignancy was always in the "GI tract," even though there was no confirmatory pathology
11 report.

12 59. On or about August 21, 2018, a CSA was signed by Patient C, which was
13 approximately 30 months after regular prescriptions for opiates began. The CSA included
14 language that the patient would not use any and illicit drugs. However, between September 2018
15 and February 2019, there were approximately six separate occurrences that Patient C's UDS was
16 positive for methamphetamine. On one occasion, Patient C tested negative for two of his
17 prescribed medication, Soma and OxyContin. Respondent noted that he believed the positive
18 UDS for methamphetamine was a "false positive" on three occasions. Finally, on or about April
19 16, 2019, Respondent noted that he was giving Patient C "three chances" for positive UDS, but
20 that the patient tested positive for methamphetamine and cocaine. It was also noted that Patient C
21 was at a high risk for diversion and "we cannot allow this." No opiates were prescribed by
22 Respondent to the patient thereafter.

23 60. On approximately 12 separate occasions between March 2016 and November 2018,
24 Respondent prescribed two short acting opiates (either OxyContin, Percocet, or Subsys) at the
25 same time or within one day of each other. At no time did Respondent check CURES prior to or
26 periodically while prescribing controlled substances to Patient C, even though the patient was
27 known to be at a high risk for aberrant drug behavior, including diversion, and was using multiple
28 pharmacies. In fact, on or about December 12, 2017, Patient C was prescribed OxyContin by two

1 additional providers on the same day. Just two days later, Respondent issued the patient his
2 regular prescription for OxyContin (in addition to Subsys and Soma). Patient C used three
3 different pharmacies to fill each of the three prescription for OxyContin. On the patient's next
4 office visit on or about December 29, 2017, there was no mention by Respondent that CURES
5 was checked or that the patient was confronted. Between approximately November 13, 2017, to
6 December 14, 2017, the patient's daily MME was at least 486, not including Subsys.

7 61. On or about June 13, 2017, Respondent began issuing Patient C a prescription for
8 Atripla, a fixed-dose combination medication used for the treatment of HIV. However,
9 Respondent never verified the patient had HIV prior to or while issuing this prescription, nor
10 documented the need to prescribe this medication. Respondent, who is not an infectious disease
11 specialist, was aware that Patient C was being seen at an HIV/AIDS clinic. Additionally,
12 Respondent issued two prescriptions for Biktarvy, another prescription medicine used to treat
13 HIV-1 in approximately February and June 2020. Respondent would continue issuing numerous
14 prescriptions for Atripla until approximately July 2020, and without referring the patient back to
15 the HIV/AIDS clinic for more appropriate specialty care. In a subsequent interview, Respondent
16 stated that he started the patient on Atripla because he was concerned that the patient was
17 previously on a nephrotoxic (damaging to the kidneys) HIV medication, even though a known
18 side effect of Atripla is kidney damage and failure, and there was no lab report to suggest Patient
19 C had impaired kidney function.

20 62. Respondent's documentation regarding Patient C was inaccurate or incomplete on
21 multiple additional occasions. On or about May 16, 2016, Respondent noted a diagnosis of
22 impacted cerumen (earwax blockage) and the patient had cerumen removed. However, there was
23 no mention of the patient having symptoms associated with impacted cerumen or associated
24 examination of the ear before and after the procedure. On or about December 29, 2017,
25 Respondent noted Type 2 diabetes mellitus and diabetic foot, although a sensory exam was
26 normal. There lacked any description of the "diabetic foot," other than noting "no edema."
27 Cellulitis of the trunk was also noted, but there was no indication of a skin exam to suggest that
28 the patient had cellulitis, nor was a plan of care documented.

1 63. Finally, Respondent performed invasive interventional procedures, including
2 injections, on Patient C 16 times, yet failed to document necessary elements, including informed
3 consent, pre, peri, and post-procedural events, and post-procedure instructions to the patient on 9
4 of 16 occasions. Patient C's last visit with Respondent occurred on or about December 1, 2022.

5 64. Respondent committed gross negligence in his care and treatment of Patient C which
6 included, but was not limited to, the following:

- 7 (a) Respondent inappropriately prescribed Subsys without obtaining or
8 ordering confirmatory reports of malignancy, and/or while believing
9 the patient was receiving fentanyl from non-prescribed sources;
- 10 (b) Respondent failed to properly review and document CURES;
- 11 (c) Respondent inappropriately prescribed two-short acting opiates at
12 approximately the same time on numerous occasions, and without
13 documenting a clear reason for doing so;
- 14 (d) Respondent, a non-infectious disease specialist, inappropriately
15 prescribed and continued HIV treatment medication, without
16 verifying the patient had HIV, and while the patient was being treated
17 at an HIV/AIDS clinic;
- 18 (e) Respondent failed to properly document invasive procedures; and
- 19 (f) Respondent's documentation was inaccurate and/or incomplete on
20 numerous occasions.

21 **PATIENT G**

22 65. Respondent started treating Patient G, a then 39-year-old male, on or about June 27,
23 2016. The patient would be seen by Respondent for six years until approximately June 2022.
24 Patient G had a history of neck and lumbosacral pain. Respondent began the patient on regular
25 prescriptions for controlled substances one month prior to the first office visit, which included
26 OxyContin (120-150 mg daily), Adderall (90 mg daily), Soma (700 mg daily), and Valium (30-35
27 mg daily). On or about July 31, 2018, a CSA was signed by Patient G, over two years after the
28 initiation of opiate prescriptions.

1 66. On or about May 8, 2018, the sole toxicology test (dried blood spot) was collected for
2 Patient G, which tested positive for heroin. On or about June 12, 2018, Respondent addressed the
3 positive heroin test with the patient, who denied any illicit drug use. Respondent noted that the
4 positive heroin test was likely a “false positive” due to Patient G eating “poppy seed bagels and
5 muffins,” and the patient had “always maintained a clean toxicology record as long as he’s been
6 in this practice.”¹⁷ Respondent also noted that an onsite toxicology test was performed at that
7 visit and it was negative for heroin. However, there is no record of the onsite test and no
8 subsequent toxicology tests were performed on Patient G when he was “off” poppy seed bagels
9 and muffins. On or about September 25, 2018, Respondent noted that the “urine tox screen” was
10 appropriate with no illicit medication. However, there is no record of a UDS being performed
11 prior to this visit.

12 67. While there was evidence that Respondent had structured tapering of opiates over the
13 course of treatment, there is no record for Respondent checking CURES prior to or periodically
14 while prescribing controlled substances to Patient G. Additionally, Respondent performed
15 invasive interventional procedures, including injections, on Patient G 10 times, yet documentation
16 of the procedures were missing on four occasions, including informed consent, signed witnessed
17 consent, pre, peri, and post-procedural events, and post-procedure instructions. On half the
18 occasions when documentation was present, Respondent failed to include implied consent for the
19 invasive procedures.

20 68. Respondent committed gross negligence in his care and treatment of Patient G which
21 included, but was not limited to, the following:

- 22 (a) Respondent failed to appropriately perform toxicology testing; and
- 23 (b) Respondent failed to properly document invasive procedures.

24 ///

25 ///

26 ///

27 ¹⁷ It is unclear what Respondent is referencing by the patient has always kept a “clean
28 toxicology record” since there are no records evidencing any additional toxicology testing other
than this sole occasion in six years.

1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 69. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
4 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
5 acts in his care and treatment of Patients S, H, A, W, C and G, as more particularly alleged herein.

6 **PATIENT S**

7 70. Respondent committed repeated negligent acts in his care and treatment of Patient S
8 which included, but was not limited to, the following:

- 9 (a) Paragraphs 22 through 33, above, are hereby incorporated by reference
10 and realleged as if fully set forth herein;

11 **PATIENT H**

12 71. Respondent committed repeated negligent acts in his care and treatment of Patient H
13 which included, but was not limited to, the following:

- 14 (a) Paragraphs 34 through 42, above, are hereby incorporated by reference
15 and realleged as if fully set forth herein.

16 **PATIENT A**

17 72. Respondent committed repeated negligent acts in his care and treatment of Patient A
18 which included, but was not limited to, the following:

- 19 (a) Paragraphs 43 through 48, above, are hereby incorporated by reference
20 and realleged as if fully set forth herein; and
21 (b) Respondent failed to accurately document the patient's medical
22 conditions, including Ehlers-Danlos syndrome and diabetes mellitus.

23 **PATIENT W**

24 73. Respondent committed repeated negligent acts in his care and treatment of Patient W
25 which included, but was not limited to, the following:

- 26 (a) Paragraphs 49 through 56, above, are hereby incorporated by
27 reference and realleged as if fully set forth herein;
28 (b) Respondent failed to properly review and document CURES; and

1 (c) Respondent inappropriately prescribed and continued opiates without
2 proper periodic assessments of safe opiate use and/or deescalate
3 opioid use to the lowest effective dosage.

4 **PATIENT C**

5 74. Respondent committed repeated negligent acts in his care and treatment of Patient C
6 which included, but was not limited to, the following:

- 7 (a) Paragraphs 57 through 64, above, are hereby incorporated by
8 reference and realleged as if fully set forth herein; and
9 (b) Respondent failed to establish the presence of an appropriate CSA
10 and/or enforcement of the CSA after Patient C repeatedly failed to
11 adhere to it;

12 **PATIENT G**

13 75. Respondent committed repeated negligent acts in his care and treatment of Patient G
14 which included, but was not limited to, the following:

- 15 (a) Paragraphs 65 through 68, above, are hereby incorporated by
16 reference and realleged as if fully set forth herein; and
17 (b) Respondent failed to properly review and document CURES.

18 **THIRD CAUSE FOR DISCIPLINE**

19 **(Failure to Maintain Adequate and Accurate Records)**

20 76. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
21 defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate
22 records regarding his care and treatment of Patients S, H, A, W, C and G, as more particularly
23 alleged in paragraphs 22 through 68, above, which are hereby incorporated by reference and
24 realleged as if fully set forth herein.

25 **FOURTH CAUSE FOR DISCIPLINE**

26 **(Repeated Acts of Clearly Excessive Prescribing)**

27 77. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
28 defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive

1 prescribing of drugs or treatment to Patient S, as determined by the standard of the community of
2 physicians, as more particularly alleged in paragraphs 22 through 33, above, which are hereby
3 incorporated by reference and realleged as if fully set forth herein.

4 **FIFTH CAUSE FOR DISCIPLINE**

5 **(Lack of Knowledge)**

6 78. Respondent is further subject to disciplinary action under sections 2227 and
7 2234, as defined by section 2234, subdivision (d), of the Code, in that he has
8 demonstrated a lack of knowledge regarding his documentation, diagnosis, treatment, and
9 specialist referral pertaining to Patient H's diabetic foot ulcer, as more particularly
10 alleged in paragraphs 34 through 42, above, which are hereby incorporated by reference
11 and realleged as if fully set forth herein.

12 **PRAYER**

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

- 15 1. Revoking or suspending Physician's and Surgeon's Certificate No. G 57474, issued
16 to Francisco S. Pardo, M.D.;
- 17 2. Revoking, suspending or denying approval of Francisco S. Pardo, M.D.'s authority to
18 supervise physician assistants and advanced practice nurses;
- 19 3. Ordering Francisco S. Pardo, M.D., to pay the Board the costs of the investigation
20 and enforcement of this case, and if placed on probation, the costs of probation monitoring;
- 21 4. Taking such other and further action as deemed necessary and proper.

22
23 DATED: APR 13 2023

24 JENNA JONES FOR
25 REJI VARGHESE
26 Interim Executive Director
27 Medical Board of California
28 Department of Consumer Affairs
State of California
Complainant

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