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

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **FRANCISCO S. PARDO, M.D.** **2140 Hayden Way, #A** **San Diego, CA 92110** **Physician's and Surgeon's Certificate No. G 57474** Respondent.	Case No. 800-2020-067064 OAH No. 2023050409 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Keith C. Shaw, Deputy Attorney General.

2. Respondent Francisco S. Pardo, M.D. (Respondent) is represented in this proceeding by attorney Joseph La Costa, Esq., whose address is: 1855 First Avenue, Suite 103, San Diego, CA 92101.

3. On or about June 16, 1986, the Board issued Physician's and Surgeon's Certificate No. G 57474 to Francisco S. Pardo, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-067064, and will expire on February 28, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-067064 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 13, 2023. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2020-067064 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-067064. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

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

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

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

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

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

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

Place of Practice

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

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.

14. 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.

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

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

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

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

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

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

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

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

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

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

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

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ACCEPTANCE

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

DATED: 02/8/24

FRANCISCO S. PARDO, M.D.
Respondent

I have read and fully discussed with Respondent Francisco S. Pardo, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2/8/24

JOSEPH LA COSTA, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 2/8/2024

Respectfully submitted,

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

Keith Shaw

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **FRANCISCO S. PARDO, M.D.** **2140 Hayden Way** **San Diego, CA 92110** **Physician's and Surgeon's Certificate No. G 57474,** Respondent.	Case No. 800-2020-067064 **ACCUSATION**

PARTIES

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

2. On or about June 16, 1986, the Medical Board issued Physician's and Surgeon's Certificate No. G 57474 to Francisco S. Pardo, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2024, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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5. Section 2234 of the Code, states:

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

". . .

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

". . . ."

6. Section 725 of the Code states:

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

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

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

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

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

7. Section 2266 of the Code states:

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

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

COST RECOVERY

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

PERTINENT DRUGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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20. **Zolpidem**, known by the trade name Ambien, is a Schedule IV controlled substance, and a sedative primarily used to treat insomnia. It is a dangerous drug as defined in Code section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is a CNS depressant and should be used cautiously in combination with other central nervous system depressants. It is an addictive substance and users should avoid alcohol as serious interactions may occur.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients S, H, A, W, C and G, as more particularly alleged hereinafter:

PATIENT S

22. Respondent began treating Patient S,[1] a then 42-year-old male, on or about March 3, 2017. Patient S presented with a number of comorbidities, including ADHD (attention deficit/hyperactivity disorder), hypotension, lower back pain, hip pain, wrist pain, migraines, depression, bipolar II disorder, and cocaine abuse. Patient S's last visit with Respondent occurred on or about July 7, 2022.

23. At the first visit, Respondent noted that a controlled substance agreement (CSA) was signed, however, absent from the patient records were key elements of the CSA, such as adherence to scheduled appointments, not to use illicit drugs, submit to urine drug screenings (UDS), the benefits, risks and alternatives of the medication(s), adherence to a single pharmacy, and that the agreement was understood and voluntary.

24. Respondent started Patient S on regular prescriptions for oxycodone (150 mg daily) and Soma (1050 mg daily). The following month, Respondent began regular prescriptions for Adderall (60 mg daily). On or about June 20, 2017, Respondent noted that the psychiatric

[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

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

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

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

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

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

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

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

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

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

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

32. At no time did Respondent check CURES[2] prior to or periodically while prescribing controlled substances to Patient S, even though the patient was known to be at an elevated risk for aberrant drug behavior. Finally, Respondent performed invasive procedures (injections) on Patient S 25 times, yet failed to document necessary elements, including signed witnessed consent, pre, peri, and post-procedural events, and post-procedure instructions to the patient on 11 of 25 occasions, and informed consent was absent on over 50% of the procedures.

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

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

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

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

(d) Respondent failed to properly document invasive procedures.

PATIENT H

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

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

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

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

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

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

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

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

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

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

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

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

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

[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.

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

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

(a) Respondent failed to enforcement the CSA after Patient H repeatedly failed to adhere to it and Respondent acknowledged the breeches;

(b) Respondent failed to properly diagnose, treat, refer to a specialist, and document the patient's diabetic foot ulcer;

(c) Respondent inappropriately initiated and continued opiates without titration or considering effective alternatives;

(d) Respondent failed to properly review and document CURES;

(e) Respondent failed to properly document invasive procedures; and

(f) Respondent failed to document the relevant circumstances regarding the patient's reported pain and the related physical findings.

PATIENT A

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

[7] Ehlers-Danlos syndrome, also known as EDS or elastic skin, is group of inherited 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.

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

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

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

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

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

[9] Hypotensive urgency occurs when a blood pressure reading is 180 systolic or higher, or 120 diastolic or higher, but there are no signs of organ failure; whereas, a hypotensive emergency 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.

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

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

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

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

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

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

(d) Respondent failed to properly document invasive procedures.

PATIENT W

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

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

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

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

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[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.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Respondent failed to properly document invasive procedures.

PATIENT C

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

58. In approximately April 2017, Respondent started issuing regular prescriptions for a fentanyl spray, Subsys[16] (1600 mcg daily). It was noted the reason Subsys was prescribed was due to a history of malignancy based on information received by a former provider, however, Respondent noted he did not see confirmatory studies of malignancies. At no time after did

[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.

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

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

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

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

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

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

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

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

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

(a) Respondent inappropriately prescribed Subsys without obtaining or ordering confirmatory reports of malignancy, and/or while believing the patient was receiving fentayl from non-prescribed sources;

(b) Respondent failed to properly review and document CURES;

(c) Respondent inappropriately prescribed two-short acting opiates at approximately the same time on numerous occasions, and without documenting a clear reason for doing so;

(d) Respondent, a non-infectious disease specialist, inappropriately prescribed and continued HIV treatment medication, without verifying the patient had HIV, and while the patient was being treated at an HIV/AIDS clinic;

(e) Respondent failed to properly document invasive procedures; and

(f) Respondent's documentation was inaccurate and/or incomplete on numerous occasions.

PATIENT G

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

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

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

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

(a) Respondent failed to appropriately perform toxicology testing; and

(b) Respondent failed to properly document invasive procedures.

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

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

PATIENT S

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

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

PATIENT H

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

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

PATIENT A

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

(a) Paragraphs 43 through 48, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to accurately document the patient's medical conditions, including Ehlers-Danlos syndrome and diabetes mellitus.

PATIENT W

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

(a) Paragraphs 49 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to properly review and document CURES; and

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

PATIENT C

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

(a) Paragraphs 57 through 64, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to establish the presence of an appropriate CSA and/or enforcement of the CSA after Patient C repeatedly failed to adhere to it;

PATIENT G

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

(a) Paragraphs 65 through 68, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to properly review and document CURES.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

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

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

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

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

FIFTH CAUSE FOR DISCIPLINE

(Lack of Knowledge)

78. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated a lack of knowledge regarding his documentation, diagnosis, treatment, and specialist referral pertaining to Patient H's diabetic foot ulcer, as more particularly alleged in paragraphs 34 through 42, above, which are hereby 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 No. G 57474, issued to Francisco S. Pardo, M.D.;

2. Revoking, suspending or denying approval of Francisco S. Pardo, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Francisco S. Pardo, 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;

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

DATED: APR 13 2023

JENNA JONES FOR
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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