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

In the Matter of the Second Amended Accusation Against: David Keith Rosing, M.D. Physician's and Surgeon's Certificate No. A 89674 Respondent.	Case No.: 800-2020-067516

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 17, 2024.

IT IS SO ORDERED: April 18, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

ROB BONTA
Attorney General of California
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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 Second Amended Accusation Against: **DAVID KEITH ROSING, M.D.** **1441 Avocado Avenue** **Newport Beach, CA 92660** **Physician's and Surgeon's Certificate No. A 89674,** Respondent.	Case No. 800-2020-067516 OAH No. 2023100308 **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 LeAnna E. Shields, Deputy Attorney General.

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2. Respondent David Keith Rosing, M.D. (Respondent) is represented in this proceeding by attorney Craig B. Garner, Esq., whose address is: 475 Washington Blvd., Marina del Rey, CA 90292.

3. On or about December 22, 2004, the Board issued Physician's and Surgeon's Certificate No. A 89674 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in the Second Amended Accusation No. 800-2020-067516, and will expire on August 31, 2024, unless renewed.

JURISDICTION

4. On May 10, 2021, Accusation No. 800-2020-067516 was filed before the Board and properly served on Respondent along with all other statutorily required documents. On January 19, 2022, the First Amended Accusation No. 800-2020-067516 was filed before the Board and properly served on Respondent. On September 21, 2023, the Second Amended Accusation No. 800-2020-067516 was filed before the Board, properly served on Respondent, and is currently pending against Respondent. Respondent timely filed his Notice of Defense. A true and correct copy of the Second Amended Accusation No. 800-2020-067516 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in the Second Amended Accusation No. 800-2020-067516. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

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

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation contained in the Second Amended Accusation No. 800-2020-067516.

9. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. A 89674 is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

11. This Stipulated Settlement and Disciplinary Order shall be subject to approval of the Board. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the

exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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 Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 89674 issued to Respondent DAVID KEITH ROSING, M.D., is hereby revoked. However, the revocation is stayed and Respondent is placed on probation for ten (10) years on the following terms and conditions:

1. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for 180 days beginning the sixteenth (16th) day after the effective date of this decision.

2. CONTROLLED SUBSTANCES - TOTAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

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Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

3. CONTROLLED SUBSTANCES - SURRENDER OF DEA PERMIT. Respondent is prohibited from practicing medicine until Respondent provides documentary proof to the Board or its designee that Respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, Respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

4. CONTROLLED SUBSTANCES - ABSTAIN FROM USE. Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not

apply to medications lawfully prescribed to Respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, Respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If Respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. Respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide Respondent with a hearing within 30 days of the request, unless Respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, requests for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

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5. ALCOHOL - ABSTAIN FROM USE. Respondent shall abstain completely from the use of products or beverages containing alcohol.

If Respondent has a confirmed positive biological fluid test for alcohol, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. Respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide Respondent with a hearing within 30 days of the request, unless Respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issues its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, requests for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

6. BIOLOGICAL FLUID TESTING. Respondent shall immediately submit to biological fluid testing, at Respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Prior to practicing medicine, Respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or

service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and Respondent.

If Respondent fails to cooperate in a random biological fluid testing program within the specified time frame, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. Respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide Respondent with a hearing within 30 days of the request, unless Respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, requests for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

7. COMMUNITY SERVICE - FREE SERVICES. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval a community service plan in which Respondent shall, within the first 2 years of probation, provide 200 hours of free services (e.g., medical or nonmedical) to a community or

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non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service, Respondent shall provide a true copy of the Decision to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where Respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

8. 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 80 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 105 hours of CME of which 80 hours were in satisfaction of this condition.

9. 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.

10. 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.

11. 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 (CCR) 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.

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.

12. PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate Respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on Respondent's performance in and evaluations

from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, Respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not Respondent successfully completed the program.

A professional boundaries 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 not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

13. 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.

Respondent shall not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

Within 60 days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include 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, or until the Board or its designee determines that further participation is no longer necessary.

14. PSYCHIATRIC EVALUATION. Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not

be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that Respondent is mentally fit to practice medicine safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

15. PSYCHOTHERAPY. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, Respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist with any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require Respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, Respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

16. MEDICAL EVALUATION AND TREATMENT. Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, Respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician with any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment, Respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of Respondent's choice. Upon approval of the treating physician, Respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment that the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that Respondent is medically fit to practice safely.

17. 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, 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 medical practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices

are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

18. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

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If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

19. PATIENT DISCLOSURE. Before a patient's first visit following the effective date of this order and while Respondent is on probation, Respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes Respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on Respondent by the Board, the Board's telephone number, and an explanation of how the patient can find further information on Respondent's probation on Respondent's profile page on the Board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct treatment relationship with the patient.

20. 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.

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

22. 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.

23. 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, investigation(s), and subpoena enforcement, as applicable, in the amount of $30,400. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

24. 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.

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25. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

26. 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.

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27. 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.

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

29. 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.

30. 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 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.

31. 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.

32. 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 the Second Amended Accusation No. 800-2020-067516 shall be deemed to be true, correct, and fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Craig B. Garner, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 89674. 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: 02/12/2024

DAVID KEITH ROSING, M.D.
Respondent

I have read and fully discussed with Respondent David Keith Rosing, 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: 02/12/2024

CRAIG B. GARNER, ESQ.
Attorney for Respondent

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ENDORSEMENT

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

DATED: February 12, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

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84347277

Exhibit A

Second Amended Accusation No. 800-2020-067516

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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 Second Amended Accusation Against: **DAVID KEITH ROSING, M.D.** **3857 Birch Street, No. 5027** **Newport Beach, CA 92660-2616** **Physician's and Surgeon's Certificate No. A 89674,** Respondent.	Case No. 800-2020-067516 **SECOND AMENDED ACCUSATION** [Cal. Gov. Code, § 11507.]

Complainant alleges:

PARTIES

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

2. On or about December 22, 2004, the Medical Board issued Physician's and Surgeon's Certificate No. A 89674 to David Keith Rosing, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2024, unless renewed.

3. On or about October 22, 2020, an order was issued in the case entitled *People of the State of California v. David K. Rosing*, Superior Court of California, Riverside County, Case No. SWF2007307, prohibiting Respondent from prescribing any and all controlled substances as defined in the California Controlled Substances Act under Schedules II, III, IV, and V, until the conclusion of the criminal proceeding.

JURISDICTION

4. This Second Amended Accusation, which supersedes the First Amended Accusation No. 800-2020-067516 filed on January 19, 2022, in the above-entitled matter, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2227 of the Code states, in pertinent part:

> (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.
>
> ...

6. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

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

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

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

...

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

...

7. Section 2236 of the Code states, in pertinent part:

(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter [Chapter 5, the Medical Practice Act]. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

...

(c) The clerk of the court in which a licensee is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the board. The division may inquire into the circumstances surrounding the commission of a crime in order to fix the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

8. California Code of Regulations, title 16, section 1360, states, in pertinent part:

(a) For the purposes of denial, suspension or revocation of a license, certificate or permit pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license, certificate or permit under the Medical Practice Act if to a substantial degree it evidences present or potential

unfitness of a person holding a license, certificate or permit to perform the functions authorized by the license, certificate or permit in a manner consistent with the public health, safety or welfare. Such crimes or acts shall include but not be limited to the following: Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of the Medical Practice Act.

...

9. Section 725 of the Code states, in pertinent part:

(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.

...

10. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

11. Section 2241 of the Code states, in pertinent part:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

...

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

12. Section 2242 of the Code states, in pertinent part:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

...

13. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

14.. Section 2262 of the Code states, in pertinent part:

Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

...

15. 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.

16. Section 11153 of the Health and Safety Code states, in pertinent part:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of

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professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

...

17. Section 11154 of the Health and Safety Code states, in pertinent part:

(a) Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division.

...

18. Section 11156 of the Health and Safety Code states:

(a) Except as provided in Section 2241 of the Business and Professions Code, no person shall prescribe for, or administer, or dispense a controlled substance to, an addict, or to any person representing himself or herself as such, except as permitted by this division.

(b) (1) For purposes of this section, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section.

19. Section 11157 of the Health and Safety Code states: No person shall issue a prescription that is false or fictitious in any respect.

20. Section 11173 of the Health and Safety Code states, in pertinent part:

...

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.

...

21. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member

in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

22. Section 2228.1 of the Code states, in pertinent part:

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:
>
> (1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:
>
> ...
>
> (D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.
>
> (2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.
>
> (b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.
>
> (d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.
>
> (1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

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(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

COST RECOVERY

23. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may 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.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

DEFINITIONS

24. **Controlled Substance Utilization Review and Evaluation System** (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) CURES is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California. California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) The history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

25. **Morphine Equivalent Dose** (MED), also commonly referred to as Morphine Milligram Equivalent (MME), is a calculation used to equate different opioids into one standard value, based on morphine and its potency, referred to as MED. MED calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations. In general, the standard of practice is to limit a patient's daily opioid dose to less than 50 MED in most patients receiving opioid treatment for chronic pain, and to exceed 90 MED in only the most unusual circumstances.

26. **Opioids** (e.g., oxycodone, hydrocodone, and fentanyl) are Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (c), and are dangerous drugs pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, they are generally used for pain management. All opioids carry a Black Box Warning that states, in part, "assess opioid abuse or addiction risk prior to prescribing; monitor all patients for misuse, abuse, and addiction." The combination of opioids with benzodiazepines is among the most common causes of death due to prescription drug overdose. The Black Box Warning for opioids states, "Concomitant opioid use with benzodiazepines... may result in profound sedation, respiratory depression, coma, and death; reserve concomitant use for patients with inadequate alternative treatment options; limit to minimum required dosage and duration."

27. **Benzodiazepines** (e.g., alprazolam) are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and are dangerous drugs pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, they are used for the management of anxiety disorders or for the short-term relief of anxiety.

28. **Alprazolam** (brand name Xanax) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is a short-acting benzodiazepine. When properly prescribed and indicated, it is commonly used to relieve anxiety.

29. **Amphetamine salt combo** (brand name Adderall) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of attention-deficit hyperactivity disorder and narcolepsy. Adderall carries a Black Box Warning indicating that it has high abuse potential.

30. **Fentanyl** (brand name Duragesic) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl is a potent synthetic opioid drug. When properly prescribed and indicated, it is used for the treatment of pain relief. It is approximately

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100 times more potent than morphine. In general, 1 mcg per hour of fentanyl is approximately equivalent to 2.4 morphine milligram equivalent in a 24-hour period.

31. **Hydromorphone** (brand name Dilaudid) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication commonly used to treat moderate to severe pain.

32. **Ileum** is the third part of the small intestine, between the jejunum and the cecum, which empties into the colon, large intestine.

33. **Levothyroxine** (brand name Levothroid or Synthroid) is a thyroid medication commonly used to treat hypothyroidism, underactive thyroid, by replacing hormones normally produced to regulate energy and metabolism. It is a dangerous drug pursuant to Business and Professions Code section 4022.

34. **Morphine** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

35. **Opium** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

36. **Oxycodone** (brand name OxyContin or Roxicodone) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication commonly used to treat moderate to severe pain. The Drug Enforcement Administration (DEA) has identified opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

37. **Oxycodone-acetaminophen** (brand name Percocet) is the drug combination of oxycodone (2.5 mg, 5 mg, 7.5 mg, or 10 mg) and acetaminophen (325 mg). Oxycodone is an opioid and is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code

section 4022. When properly prescribed and indicated, it is commonly used to treat moderate to moderately severe pain. The Federal Drug Administration (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."

38. **Promethazine-codeine** (brand name Phenergan-codeine) is a drug combination containing codeine which is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is commonly used to treat cold or allergy symptoms. Codeine is an opioid medication commonly used to treat pain.

39. **Zolpidem tartrate** (brand name Ambien) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Ambien is a benzodiazepine analog and sedative hypnotic. When properly prescribed and indicated, it is commonly used to treat insomnia.

FACTUAL ALLEGATIONS

Medical Care of Patient A[1]

40. On or about August 8, 2010,[2] Patient A, a then 44-year-old female, was admitted at the Kaiser Permanente Medical Center (KP) as a transfer from a local emergency department for severe abdominal pain with frequent vomiting. According to medical records, Patient A had an extensive surgical history with approximately seventeen (17) prior surgeries, including, but not

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[1] For patient privacy purposes, patients' true names are not used in the instant Accusation to maintain patient confidentiality. The patients' identities are known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery and in accordance with Government Code section 11507.6.

[2] Any medical care or treatment rendered by Respondent more than seven (7) years prior to the filing of the original Accusation filed on May 10, 2021, is described for informational purposes only and not alleged as a basis for disciplinary action.

limited to, cholecystectomy,[3] gastric bypass, partial colectomy[4] with ileostomy,[5] ileostomy revision, ventral hernia repair with mesh, and removal of mesh after subsequent infection. Patient A was admitted and Respondent provided a surgical consultation.

41. From in or around August 2010 through in or around July 2012, Patient A presented to the KP emergency department and KP clinics on a near monthly basis with complaints of pain and regular requests for refills of her medications. Patient A was hospitalized on numerous occasions for complaints of abdominal pain, vomiting, nausea and constipation.

42. From in or around August 2010 through in or around July 2012, Respondent continued to be involved in the care and treatment of Patient A for several medical conditions, including, but not limited to, intestinal dysfunction, adynamic bowel, and ileus.[6]

43. On or about August 8, 2010, according to records, Respondent determined Patient A suffered from small bowel obstruction and that Patient A had a functional obstruction due to chronic opioid use. Respondent noted surgical procedures were unlikely to resolve Patient A's medical issues, and prescribed Patient A pain medications.

44. On or about March 24, 2011, records indicate Respondent performed several surgical procedures on Patient A, including, but not limited to, an exploratory laparotomy, ileostomy, resection of the small intestine, and lysis of adhesions.[7]

45. On or about May 6, 2011, Respondent noted Patient A's active medication list included prescriptions for, among other things, hydromorphone liquid (12 mL, four times per day), morphine (5-10 mL, every six hours), Phenergan-codeine (5 mL, six times per day),

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[3] Cholecystectomy is a surgical procedure involving the removal of the gallbladder.

[4] Partial colectomy is a surgical procedure in which a portion of the colon, large intestine, is removed.

[5] Ileostomy is a surgical procedure in which a piece of the ileum is diverted to an artificial opening in the abdominal wall.

[6] Ileus is a condition of paralysis of motion in the small intestine such that food or drink is not passed through the bowel.

[7] Lysis of adhesions is a procedure to remove scar tissue that forms within the body in effort to restore normal function and reduce pain.

Ambien (20 mg per day), fentanyl (100 mcg per hour, new patch every 72 hours), oxycodone (5 mg, four tablets every four hours), and hydromorphone (4 mg, three tablets every six hours as needed).

46. On or about May 18, 2011, Patient A presented to the emergency department with complaints of weakness and lightheadedness. According to records, Patient A reported experiencing multiple falls resulting in multiple blows to the head without loss of consciousness. Records also indicate Patient A reported lost pain medications.

47. On or about June 6, 2011, Patient A sent a message to Respondent informing him that she had lost her medications and that she was suffering from withdrawal and was unable to stop vomiting.

48. On or about June 9, 2011, Patient A sent a message to Respondent informing him she was found unconscious on the floor and requested a prescription refill for Phenergan-codeine and Ambien.

49. On or about June 16, 2011, Respondent prepared a note in Patient A's medical record indicating Patient A had a long history of opioid abuse, that Patient A reported having suicidal thoughts, was found on the floor of her home after attempting to overdose, and despite his recommendations to participate in a pain management program, she had not gone as instructed.

50. On or about June 21, 2011, during an office visit with Respondent, records indicate Patient A reported going through withdrawals and purchasing Ambien on the street and overdosing on Ambien. According to records, Respondent refilled Patient A's medications for fentanyl and Phenergan-codeine. Respondent also issued a prescription to Patient A for Xanax (1 mg, one tablet every eight hours as needed for anxiety). Records for this encounter do not document an assessment of Patient A's anxiety levels or document any objective treatment goals for prescribing Xanax to Patient A.

51. On or about June 29, 2011, after several unsuccessful attempts to contact Patient A to enroll her in the KP pain management program, records indicate Patient A was discharged from the pain management program and referred to an intensive outpatient program.

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52. On or about September 12, 2011, Patient A was hospitalized for nausea and vomiting and reported lightheadedness causing her to fall. According to records, Patient A was treated for ileus and discharged with pain medications.

53. On or about September 21, 2011, Patient A was hospitalized after a reported suicide attempt. According to records, Patient A reported feeling depressed due to her abdominal pain and injected bleach into her hand. Patient A also reported being kidnapped by her neighbors who forced her to take sedatives. Records for this encounter indicate Patient A's husband reported Patient A was severely addicted to benzodiazepines and narcotics, that Patient A was taking up to thirty (30) tablets of Ambien at a time and over-using her narcotic medications. Patient A was admitted for inpatient psychiatric care with a documented history of present illness including, but not limited to, Ambien dependence, pain medication dependence, and major depression.

54. On or about September 22, 2011, Patient A was evaluated for participation in an inpatient addiction medicine program. Records indicate Patient A stated she wanted to detoxify after her ileostomy was re-anastomosed.[8] Records indicate Patient A was evaluated and found to be a polysubstance abuser. Psychiatry recommended tapering Patient A off her pain medications and benzodiazepines, and discontinuing Patient A's Ambien prescription.

55. On or about September 23, 2011, records indicate Respondent consulted with a team of physicians, including Patient A's primary care physician, psychiatrist, and a detoxification physician. Records indicate Respondent was informed of Patient A's suicide attempts and that Patient A was determined to be a drug addict. According to records, it was decided not to perform an ileostomy takedown until Patient A had reduced her opiate intake and managed her psychiatric issues.

56. On or about September 27, 2011, Respondent met with Patient A to discuss the possibility of her ileostomy reversal. Records for this encounter indicate Patient A informed Respondent that she only wanted Ambien and that she was addicted to Ambien.

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[8] Re-anastomosis is a procedure in which formerly separated structures are reconnected.

57. On or about October 25, 2011, Patient A left messages for Respondent requesting he refill her medications prescribed by her primary care physician, indicating she would not be seeing her primary care physician until November 23, 2011. Records indicate Patient A was informed Respondent would not be able to assist her and she was given instructions to contact her primary care physician.

58. On or about December 18, 2011, records indicate Respondent performed a surgical procedure on Patient A, including, but not limited to, an ileostomy reversal. Upon discharge, on or about December 23, 2011, records indicate Respondent planned to prescribe pain medications to Patient A during the perioperative period, that Patient A would then be referred to the pain medicine clinic, and then to addiction medicine for detoxification.

59. On or about January 24, 2012, records indicate Patient A left messages for Respondent requesting he refill her pain medications and inquired as to her Vans shoes.[9]

60. On or about January 30, 2012, records indicate Respondent issued prescriptions to Patient A for Ambien (10 mg, 60 tablets, two (2) per night), Xanax (2 mg, 75 tablets, every eight (8) hours), Levothyroxine (200 mcg, 30 tablets, one (1) per day).

61. On or about February 1, 2012, records indicate Respondent issued a prescription to Patient A for oxycodone (30 mg, 95 tablets, two (2) every four (4) hours).

62. On or about February 2, 2012, records indicate Patient A reported to her primary care physician that she had experienced several falls due to weakness.

63. On or about February 6, 2012, during Patient A's surgical follow up visit with Respondent, records indicate Respondent issued prescriptions to Patient A for Xanax and Ambien, but noted Patient A would need to seek refills from her primary care physician as these medications were not surgically related.

64. On or about February 24, 2012, Patient A sent a message to Respondent inquiring about her Vans shoes, as follows, "Dr. Rosing, still haven't received my Vans yet. If you haven't

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[9] As discussed in more detail below, Respondent gave several pairs of Vans shoes to Patient A as gifts. The Vans shoes contained hand drawn depictions of pills resembling oxycodone and Xanax and messages to Patient A from Respondent.

ordered them yet I went to the Vans store in the Lake Elsinore Outlet Mall and I wear a size 8.5 not a 9. So when the most wonderful surgeon in the world gets them for me please order an 8.5 if it isn't too late. You are the best thank you."

65. On or about February 25, 2012, records indicate Patient A requested an early refill stating she lost her medications.

66. On or about February 29, 2012, records indicate Respondent spoke with Patient A's husband who informed Respondent that Patient A had been abusing her Ambien and spent $300 to purchase Ambien online.

67. On or about March 1, 2012, records indicate Respondent issued prescriptions to Patient A for hydromorphone (4 mg, 150 tablets, two (2) every four (4) hours) and oxycodone (30 mg, 75 tablets, every six (6) hours).

68. On or about March 6, 2012, a progress note by Respondent indicates he prescribed Xanax to Patient A for sleep and anxiety, that Patient A had requested Ambien, but Respondent refused to prescribe Ambien and informed Patient A that he would never prescribe Ambien to her again.

69. On or about March 20, 2012, Patient A sent a message to Respondent requesting a refill of her oxycodone. According to records, Patient A stated, "Can you have them ready so I can just pick up the scripts? I'm losing faith in my Vans." Records indicate, a nurse responded to Patient A's message informing her Respondent could not issue any more prescriptions to Patient A until she contacted the pain management clinic and that Respondent would otherwise jeopardize his medical license since Patient A has a known addiction to pain medications.

70. On or about April 22, 2012, records indicate Patient A was placed on a 72-hour hold pursuant to Welfare and Institutions Code section 5150 after Patient A reportedly ingested approximately 12 to 15 tablets of Xanax.

71. On or about April 24, 2012, records indicate Patient A requested a refill of her Xanax claiming her husband threw her Xanax in the toilet. According to records, Patient A also reported her mother passed away from taking too much Xanax.

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72. On or about May 11, 2012, records indicate Patient A's husband reported Patient A was at a rehabilitation facility for 120 days.

73. On or about May 17, 2012, Patient A sent a message to Respondent stating, "I am in my 14th day in a [*sic*] in house rehab and have 28 more days. I went through a hard 11 day medical detox unit and now have moved to the more normal side of life. I still suffer a lot of pain but am only taking Tylenol and nothing for sleep.... I'm gonna [*sic*] make it in this world without all the narcotics... I love ya [*sic*]."

74. On or about May 23, 2012, Patient A was admitted for nausea, vomiting and abdominal pain. Records for this encounter indicate Patient A suffered opiate dependence for over ten (10) years. Records document a detailed summary by another physician regarding Patient A's complex medical history and opioid use, with recommendations and instructions to taper Patient A's medications by an addiction medicine physician.

75. On or about May 24, 2012, Patient A was evaluated by Respondent, who scheduled Patient A for an exploratory laparotomy. According to records, Respondent then prescribed Phenergan and Dilaudid to Patient A during this encounter.

76. On or about May 25, 2012, records indicate Respondent performed a surgical procedure on Patient A, including, but not limited to, a rectum exam under anesthesia and a rigid sigmoidoscopy.[10]

77. On or about June 19, 2012, records indicate Patient A suffered a relapse on Ambien and was discharged from the inpatient rehabilitation program.

78. From in or around July 2012 through in or around April 2014, Patient A sought medical care and treatment outside of KP.

79. On or about April 29, 2014, Patient A returned to the KP emergency department with complaints of abdominal pain. According to records, Patient A reported being prescribed oxycodone and morphine.

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[10] A sigmoidoscopy is a procedure in which a physician examines a patient's sigmoid colon, the lower part of the large intestine.

80. From in or around April 2014 through in or around May 2017, Patient A presented to the KP emergency department and KP clinics on a near monthly basis with complaints of pain and regular requests for refills of her medications. Patient A was hospitalized on numerous occasions for complaints of abdominal pain, vomiting, nausea, and constipation.

81. From in or around April 2014 through in or around May 2017, Respondent continued to be involved in the care and treatment of Patient A.

82. On or about May 21, 2014, Respondent saw Patient A in his clinic for a surgical consultation due to complaints of chronic abdominal pain, nausea, vomiting, incontinence and blackouts. According to records, Respondent noted there was nothing surgical to relieve Patient A's condition and advised Patient A to obtain pain medications from her primary care physician.

83. On or about June 9, 2014, according to records, Patient A's drug screen tested positive for opiates and negative for benzodiazepines, despite having an active prescription for Xanax.

84. On or about July 2, 2014, according to records, Patient A's primary care physician issued a prescription to taper Patient A's morphine by ten (10) pills per month, with a plan to then decrease Patient A's oxycodone prescription.

85. On or about July 14, 2014, according to records, Patient A reported feeling "very drowsy and drugged feeling." Patient A also reported having difficulty balancing and experiencing several falls. Patient A's primary care physician noted Patient A appeared drowsy and seemed to nod off in the middle of her conversations.

86. On or about July 22, 2014, Patient A requested an early refill of her Ambien prescription from her psychiatrist. According to records, Patient A's psychiatrist refused to issue the early refill of Ambien and recommended Patient A reduce her Ambien to five (5) mg per day since Patient A was prescribed high doses of benzodiazepines and opiates.

87. On or about July 28, 2014, according to records, Patient A's psychiatrist informed Patient A that she needed to reduce her Xanax, Ambien, and opiates.

88. On or about August 8, 2014, according to records, Patient A suffered a fall causing a tear in her rotator cuff.

89. On or about August 13, 2014, according to records, Patient A reported losing her medications and requested early refills of her Ambien and Xanax prescriptions.

90. On or about October 7, 2014, according to records, Patient A's psychiatrist informed Patient A of the goal to lower Patient A's Xanax, Ambien, and opiates.

91. On or about October 20, 2014, records indicate Patient A suffered a third overdose on opioids in six (6) months. Records indicate Patient A was provided Narcan[11] and discharged home. Patient A's primary care physician referred Patient A to the pain management program for all future narcotic prescriptions.

92. On or about October 22, 2014, records indicate Patient A reported her sister was a heroin addict.

93. On or about October 23, 2014, records indicate Patient A reported her sister and brother had used Patient A's identity to obtain her pain medication.

94. On or about December 16, 2014, Respondent saw Patient A in his clinic. Records for this visit indicate Respondent noted Patient A was still on high-dose opioid therapy, which was likely the cause of her bowel issues. Respondent also noted a discussion regarding surgical options to help relieve Patient A's abdominal pain.

95. On or about January 28, 2015, Patient A presented at Urgent Care after suffering a fall two days earlier. According to records, Patient A thought she may have fallen out of bed but only recalls her husband picking her up off the floor.

96. On or about March 5, 2015, Respondent saw Patient A in his clinic for a preoperative examination for an exploratory laparotomy scheduled for March 24, 2015. According to records, Respondent assessed Patient A with abdominal pain and chronic partial small bowel obstruction. Records indicate Respondent issued a prescription to Patient A for, among other things, oxycodone (30 mg, 120 tablets, two (2) every four (4) hours).

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[11] Narcan, brand name for naloxone, is a medication used to counteract and treat suspected opioid overdose. It is a dangerous drug pursuant to Business and Professions Code section 4022.

97. On or about March 15, 2015, Patient A presented at Respondent's clinic requesting a refill of her oxycodone prescription. According to records, Respondent issued a prescription to Patient A for oxycodone (30 mg, 120 tablets, two (2) every four (4) hours).

98. From on or about March 16, 2015 through on or about April 25, 2015, Patient A was hospitalized for her exploratory laparotomy, which was performed by Respondent on or about April 14, 2015. Records for this encounter indicate on or about March 25, 2015, Respondent issued a prescription to Patient A for oxycodone (30 mg, 120 tablets); on or about April 9, 2015, Respondent issued a prescription to Patient A for oxycodone (30 mg, 90 tablets); and on or about April 24, 2015, Respondent issued prescriptions to Patient A for oxycodone (30 mg, 200 tablets), Xanax (2 mg, 75 tablets), and morphine (30 mg, 60 tablets).

99. On or about April 27, 2015, according to records, Respondent issued a prescription to Patient A for Ambien (10 mg, 60 tablets).

100. On or about April 29, 2015, Respondent saw Patient A in his clinic for a post-surgical follow-up care. Records for this visit indicate Patient A reported experiencing significant pain. According to records, Respondent issued a prescription to Patient A for hydromorphone (4 mg, 150 tablets).

101. On or about May 1, 2015, according to records, Respondent issued prescriptions to Patient A for oxycodone (30 mg, 200 tablets) and hydromorphone (4 mg, 150 tablets).[12]

102. On or about May 6, 2015, Respondent documented a phone call from Patient A's husband who reported Patient A was taking more oxycodone than prescribed and had suffered a fall.

103. On or about May 8, 2015, Patient A presented for a clinical visit when nursing staff noted Patient A exhibited slurred speech and had difficulty paying attention. According to records, Patient A's demeanor was attributed to her pain medications.

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[12] The prescriptions issued by Respondent to Patient A during this time period amounted to a total of 1,073 MED per day.

104. On or about May 27, 2015, Respondent documented a phone call from Patient A reporting nausea and vomiting. According to records, Patient A informed Respondent her husband had found her passed out on the floor twice in the past week.

105. On or about June 9, 2015, Patient A presented to the emergency department with complaints of shoulder and hip pain after suffering multiple falls.

106. On or about June 11, 2015, Patient A presented to the emergency department with complaints of altered mental status, after first presenting at Respondent's clinic and was noted to have slurred speech and a drowsy appearance. According to records, Patient A admitted taking Dilaudid, Phenergan-codeine, Xanax and Ambien. Patient A was discharged with instructions to contact her primary care physician to decrease her medications.

107. On or about June 22, 2015, records indicate Respondent issued prescriptions to Patient A for oxycodone (30 mg, 200 tablets), hydromorphone (4 mg, 100 tablets), zolpidem tartrate (10 mg, 60 tablets), and alprazolam (2 mg, 90 tablets).

108. On or about June 30, 2015, records indicate Patient A contacted Respondent requesting a refill of her hydromorphone. According to records, Respondent issued a prescription to Patient A for hydromorphone (4 mg, 200 tablets).

109. On or about July 15, 2015, records indicate Respondent performed a surgical procedure on Patient A, including, but not limited to, an examination of her rectum under anesthesia.

110. On or about August 13, 2015, records indicate Patient A's psychiatrist determined Patient A should no longer receive benzodiazepines.

111. On or about August 25, 2015, according to records, Respondent issued a prescription to Patient A for alprazolam (2 mg, 90 tablets) and continued to regularly prescribe alprazolam to Patient A through January 17, 2017.

112. On or about August 25, 2015, records indicate Respondent also issued prescriptions to Patient A for oxycodone (30 mg, 200 tablets), hydromorphone (4 mg, 200 tablets), and zolpidem tartrate (10 mg, 60 tablets).

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113. On or about September 9, 2015, Respondent conducted an evaluation of Patient A. According to records, Respondent noted Patient A was experiencing approximately fifteen (15) to twenty (20) bowel movements a day despite receiving the maximum dose for antidiarrheal medications. Records for this visit indicate Respondent discussed the option of additional surgery to lengthen Patient A's common channel[13] and remove Patient A's dilated bowel. Respondent also discussed with Patient A the option of performing another ileostomy.

114. On or about September 11, 2015, records indicate Patient A spoke with Respondent and decided not to proceed with surgery due to her husband facing prison time and would not be available to assist Patient A in the event of complications from surgery.

115. On or about September 16, 2015, records indicate Respondent issued a prescription to Patient A for opium.

116. On or about October 14, 2015, Patient A was hospitalized for additional abdominal surgeries performed by Respondent, including, but not limited to, an exploratory laparotomy, intestine lysis of adhesions, and gastric bypass revision. After surgery, records indicate Patient A removed her monitors and walked out of the hospital. Records for this encounter indicate Patient A was discovered walking around a nearby shopping center and brought back to the hospital. Patient A indicated she did not recall leaving the hospital. According to records, Respondent attributed Patient A's conduct to Ambien and indicated he would no longer prescribe Ambien to Patient A.

117. On or about October 30, 2015, records indicate Patient A spoke with Respondent and reported having a tough time with pain and taking three (3) tablets of oxycodone at a time. According to records, Respondent agreed to increase Patient A's medications.

118. On or about December 1, 2015, Respondent admitted Patient A for abdominal pain. According to records, upon admission, a small baggie containing whitish crystal-like broken rock

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[13] The common channel, also known as the common tract, is a portion of the small intestine where food, bile, and digestive juices mix, and where the majority of fat, protein and associated nutrients are absorbed into the body.

substance resembling methamphetamine was discovered taped to Patient A's chest. During this encounter, on or about December 6, 2015, a urine drug screen for Patient A revealed the presence of hydrocodone, opiates, oxycodone, amphetamines, and benzodiazepines. On or about December 6, 2015, Patient A left the hospital against medical advice.

119. On or about December 15, 2015, records document a phone call to Patient A requesting she return to the hospital for evaluation and removal of her staples. According to records, Patient A exhibited slurred speech and stated she did not want to drive herself for fear of not being able to keep her car in a lane. Patient A was advised not to drive and her appointment to remove her staples was rescheduled.

120. On or about January 21, 2016, a drug screen for Patient A revealed the presence of opiates, methamphetamine, and benzodiazepines.

121. On or about January 28, 2016, records indicate Respondent spoke with Patient A regarding her recent hospitalization after a cleaning lady discovered Patient A on the floor in her home. According to records, Respondent informed Patient A and her caregiver that he would no longer prescribe any medications that might cause imbalance, including benzodiazepines, but would continue prescribing pain medications for Patient A.

122. On or about February 1, 2016, according to records, Patient A contacted Respondent requesting a prescription for Xanax. Records for this encounter indicate Respondent agreed to prescribe Xanax to Patient A for sleep.

123. On or about February 15, 2016, records indicate Respondent issued prescriptions to Patient A for oxycodone (30 mg, 200 tablets), hydromorphone (4 mg, 200 tablets), and alprazolam (2 mg, 50 tablets). According to records, Respondent continued prescribing alprazolam to Patient A on a near monthly basis through March 23, 2017.

124. From on or about March 2016 through on or about September 2016, according to records, Respondent issued prescriptions to Patient A on a regular basis, including but not limited to five (5) prescriptions for hydromorphone (4 mg, totaling 900 tablets), nineteen (19) prescriptions for alprazolam (2 mg, totaling 1,710 tablets), eleven (11) prescriptions for Adderall

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(30 mg, totaling 330 tablets), twenty-three (23) prescriptions for oxycodone (30 mg, totaling 4,500 tablets), and four (4) prescriptions for opium (10 mg/1 mL).

125. On or about September 22, 2016, records indicate Respondent performed a surgical procedure on Patient A, including, but not limited to, an incisional hernia repair with mesh and a rectum exam under anesthesia.

126. On or about October 3, 2016, according to records, Patient A presented in Respondent's clinic for surgical follow-up. Records for this encounter indicate Respondent agreed to refill Patient A's pain medications, but declined to prescribe Dilaudid unless absolutely necessary.

127. On or about October 8, 2016, records indicate Respondent issued a prescription to Patient A for Dilaudid (4 mg, 200 tablets). According to records, Respondent continued prescribing Dilaudid to Patient A on a near monthly basis through January 30, 2017.

128. On or about October 26, 2016, records indicate Respondent performed a surgical procedure on Patient A, including, but not limited to, the placement of a venous access port.[14]

129. On or about November 3, 2016, records indicate Respondent contacted KP's Complex Case Management team requesting assistance in obtaining patient compliance. According to records, Patient A was reportedly non-compliant and tended to be drug-seeking.

130. On or about November 17, 2016, Patient A saw Respondent in his clinic for complaints of severe diarrhea and extreme abdominal pain. Records for this encounter indicate Respondent recommended admitting Patient A for hospitalization but Patient A refused. Records indicate Respondent issued a refill of Patient A's medications, including Adderall (30 mg, 30 tablets) and Dilaudid (4 mg, 200 tablets).

131. On or about December 12, 2016, records indicate Patient A contacted Respondent requesting a prescription for Xanax and Phenergan-codeine. On or about December 12, 2016 and December 17, 2016, records indicate Respondent issued prescriptions to Patient A for alprazolam (2 mg, 100 tablets).

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[14] A venous access port is an implanted access device placed near the collar bone under the skin to allow easy access to a patient's veins for medical treatment of chronic diseases.

132. On or about January 1, 2017, records indicate Respondent spoke to Patient A regarding continued nausea and vomiting. According to records, Respondent recommended surgery but Patient A refused, stating she did not want to undergo major surgery while her husband was incarcerated.

133. On or about January 22, 2017, records indicate Patient A presented to the emergency department with complaints of shortness of breath, nausea, constipation, and abdominal pain. Records for this encounter indicate Patient A's constipation was opioid-induced.

134. On or about February 13, 2017, records indicate Patient A was admitted for abdominal wall pain. According to records, Respondent performed a surgical procedure on Patient A, including, but not limited to, abdominal wall exploration and removal of Patient A's mesh and staples. Records for this encounter indicate Patient A asked nursing staff to mix her Dilaudid medication with Benadryl and later requested her Dilaudid be mixed with Phenergan. Records further indicate Patient A requested her medications be "pushed fast" and "flushed fast with saline." According to records, Patient A presented a large amount of cash to the nursing staff when requesting her pain medications, but was informed she would receive her pain medications only as prescribed and not sooner.

135. On or about March 6, 2017, records indicate Patient A spoke to Respondent after not appearing at her scheduled clinic appointment. Records for this encounter indicate Respondent refilled Patient A's medications for anxiety and post-traumatic stress disorder (PTSD). According to CURES reports, on or about March 6, 2017, Respondent issued prescriptions to Patient A for amphetamine salt combo (30 mg, 30 tablets) and alprazolam (2 mg, 100 tablets).

136. On or about March 31, 2017, records indicate Patient A met with a KP psychiatrist. Records for this visit note Respondent had been prescribing Xanax and Adderall to Patient A. Patient A's psychiatrist indicated there was no clear reason for Patient A to be prescribed Adderall and that Patient A should be weaned off of Xanax. Records for this encounter indicate Patient A expressed a desire to have Respondent continue prescribing her Xanax since her psychiatrist wanted to taper her Xanax prescription.

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137. On or about April 3, 2017, records indicate Respondent contacted Patient A's psychiatrist requesting assistance in tapering Patient A's Xanax prescription. According to records for this encounter, Respondent indicated Patient A was taking more than prescribed and requesting early refills.

138. On or about April 6, 2017, records indicate Patient A presented for a clinic visit with her primary care physician. Records for this visit indicate Patient A was still receiving pain medications prescribed by Respondent and that Patient A was taking eighteen (18) tablets of oxycodone per day, Dilaudid for break through pain, and Xanax (2 mg, six (6) times per day).

139. On or about April 17, 2017, records indicate Patient A's psychiatrist attempted to conduct a telephonic appointment with Patient A with the assistance of Patient A's caregiver. During this encounter, records indicate Patient A was drowsy and not responding verbally. Patient A's psychiatrist determined Patient A was likely experiencing benzodiazepine withdrawal and instructed her caregiver to bring Patient A to the emergency department.

140. On or about May 7, 2017, Patient A's body was discovered on the floor of her home. The cause of death was determined to be acute oxycodone intoxication. Toxicology reports confirmed the presence of oxycodone and alprazolam in Patient A's blood.

141. Throughout Respondent's care and treatment of Patient A, Respondent continued to issue prescriptions to Patient A on a regular basis for high dose opioids and benzodiazepines despite reports of Patient A experiencing adverse side effects and events, including, but not limited to, abdominal pain, nausea, vomiting, constipation, falls, loss of consciousness, and overdose events.

142. Throughout Respondent's care and treatment of Patient A, records do not reflect a diagnosis of necessity by Respondent to support Respondent's prescribing of high-dose opioids and benzodiazepines to Patient A for an extended period of time.

143. Throughout Respondent's care and treatment of Patient A, records do not reflect any risk assessment or risk stratification conducted by Respondent to evaluate Patient A's potential risks from combining high-dose opioid therapy with benzodiazepines and other sedative hypnotic medications.

144. Throughout Respondent's care and treatment of Patient A, records do not reflect a full discussion of the risks and benefits between Patient A and Respondent regarding the long-term use of high-dose opioids, combined use of opioids with benzodiazepines and other sedative hypnotic medications, including, but not limited to, the discussion of the risks of respiratory depression, motor impairment, cognitive impairment, dependence, misuse, addiction, overdose and death.

145. Throughout Respondent's care and treatment of Patient A, records do not reflect any development or establishment of a treatment plan, goals or objectives by Respondent for use in evaluating Patient A's progress or ongoing assessment for functional improvement or reduction in pain.

146. Throughout Respondent's care and treatment of Patient A, records do not reflect any ongoing assessment by Respondent to evaluate Patient A's progress toward treatment objectives and goals, including, but not limited to, evaluation of Patient A's activity level, adverse side effects, aberrant behaviors, and affect.

147. Throughout Respondent's care and treatment of Patient A, records do not reflect appropriate monitoring by Respondent for compliance, including, but not limited to, review of CURES reports, frequent drug screen testing, imposition of controlled substances agreement, and requiring pill counts.

148. Throughout Respondent's care and treatment of Patient A, records do not reflect or document an exit strategy by Respondent to plan for discontinuing Patient A's high-dose opioid regimen and benzodiazepine therapy.

149. Throughout Respondent's care and treatment of Patient A, Respondent's documentation in Patient A's medical records was incomplete and failed to contain important medical information regarding Patient A's condition.

150. On or about October 3, 2019, Respondent participated in an interview by investigators with the Health Quality Investigation Unit (HQIU) to discuss his care and treatment of Patient A.

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151. During his interview with HQIU investigators, Respondent admitted prescribing approximately 200 tablets of oxycodone (30 mg) to Patient A every two (2) weeks throughout the course of his care and treatment of Patient A.[15]

152. During his interview with HQIU investigators, Respondent admitted that although he was not a pain management physician, he was treating Patient A for chronic pain beyond the standard post-surgical window.

153. During his interview with HQIU investigators, when asked about why he was prescribing Xanax to Patient A, Respondent admitted, "There's no reason for me to be doing that," and acknowledged Patient A was addicted to Xanax and pain medications.

154. During his interview with HQIU investigators, Respondent admitted making frequent monthly house visits to see Patient A in her home while her husband was incarcerated and noted he often discovered Patient A in a near comatose state. Respondent also admitted taking possession of Patient A's pills while at her home in order to keep pills away from Patient A.

155. During his interview with HQIU investigators, when discussing Patient A's death, Respondent admitted his actions contributed to Patient A's death, and that "things were out of control, I couldn't control me, I couldn't control her, it was a bad situation and I needed help."

Electronic Communications with Patient A

156. Throughout the course of Respondent's care and treatment of Patient A, Respondent and Patient A exchanged correspondence by many different methods, including, but not limited to, the KP email messaging system and text messaging on various cellular phones.

157. In their correspondence with one another, Respondent and Patient A often used affectionate language, including, but not limited to, "Wifey #2," "Gorgeous," "Sexy," "Sweet [Patient A]," "I love you," "I want you in my life forever," and "Homies for life."

158. In their correspondence with one another, Respondent and Patient A used code words when referring to Patient A's medications and prescriptions. During Respondent's interview with HQIU investigators on or about October 3, 2019, Respondent admitted Patient A's medication

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[15] A prescription for 200 tablets of Oxycodone (30 mg) every two (2) weeks calculates to an MED of 642 mg per day, not including the other controlled substances Patient A was also prescribed.

pills were referred to as "chicken" and Patient A's prescriptions were referred to as "documents" or "scripts" in their correspondence with one another.

159. On or about January 18, 2016, Respondent sent the following message to Patient A, "Let me know if you have any trouble getting your medications filled. We can write a letter and send him whatever you want my sweet friend!"

160. On or about January 30, 2016, Patient A sent the following message to Respondent, "I want you in my life forever!!!"

161. On or about February 7, 2016, Respondent sent the following message to Patient A, "Do you need any refills on stuff?" "If so I can place order after I see you or can order and then see you after work. Just wanted to grab a document from you." Patient A responded to Respondent, "No documents for you. JK." (Common abbreviation for just kidding.) Respondent replied, "You beat [*sic*] be kidding." Patient A responded, "I'm kidding I think I have 1 or 2 for you. LMAO." (Common abbreviation for laughing my ass off.) Respondent replied, "One or two million???" Patient A responded, "I'm kidding I have quite a bit." Respondent replied, "You always do!!" Patient A responded, "I promise to save some for you."

162. On or about April 11, 2017, Patient A sent the following message to Respondent, "I hate life, I may never get to see [Patient B] until 2020." Respondent responded, "Why wouldn't you be able to see [Patient B] until 2020? You mean you can't go see him in jail until 2020?? ...Don't worry Gorgeous. We will get through this and [Patient B] will be home soon, right? How long has he been in? 18 months?...I love you. See you tomorrow, I will bring some gravy for the chicken legs [emoji image of a chicken leg] and thighs." Later the same day, Respondent followed up with the following message to Patient A, "I'm really worried about you and need to actually see you to talk. Please promise me RIGHT NOW that you will not hurt yourself in any way."

163. On or about April 13, 2017, Respondent sent the following message to Patient A, "How are you doing gorgeous?"

164. On or about April 14, 2017, Patient A sent the following messages to Respondent, "Hey sexy...I'm hating life right now I think it's fucked I hate coming off of stuff." Respondent

responded, "I know my friend. I know it's the worst. Are they going really fast or something?" Patient A responded, "I know it's the Xanax is it [*sic*] so hard I've [*sic*] I want to say felt like partying with [Patient C] but I promised [Patient B] I wouldn't do it and I'm trying not to." Respondent responded, "I understand and I hear you. I can order your pain meds on Monday ok? ... I love you [Patient A] I know you gotta [*sic*] do what you gotta [*sic*] do. I would never judge you.... sorry sexy. When are they giving you more Xanax?"

165. On or about April 15, 2017, Patient A sent the following message to Respondent, "I love [emoji image of a heart] you." Respondent responded, "I love you [Patient A]. Hang in there until Monday gorgeous." Patient A responded, "[Patient C] is on her way to bring me Percy's." Patient A then corrected her text, "Percs."[16]

166. On or about April 18, 2017, Respondent sent the following message to Patient A, "I owe you dinner... If you bring the chicken [emoji of a chicken leg] then lunch is on me my friend."

167. On or about April 19, 2017, Patient A sent the following message to Respondent, "I love you for life my friend!!! I hope I can see you soon [emoji image of a chicken leg]." Respondent responded, "I can for sure take care of that for you gorgeous...Anything for wifey #2." Patient A responded, "Thank you #2 hubby."

168. On or about April 24, 2017, Patient A sent the following message to Respondent, "Doc, the internet site says I can place order for chicken." Respondent responded, "Place border [*sic*] and I'll ok it."

169. On or about April 25, 2017, Patient A sent the following message to Respondent, "My anxiety is not being controlled. She is taking me down my zanax [*sic*] to [*sic*] fast." Respondent responded, "Yeah I know she's dropping it pretty quick...I have an idea of how to help...I'll come by tomorrow around noontime and if you save me KFC I can give [Patient C] a deal for you if that makes sense gorgeous." On or about April 26, 2017, Patient A responded, "Anything for you [emoji of a chicken wing]."

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[16] "Percs" in reference to Percocet.

170. On or about April 30, 2017, Respondent sent the following message to Patient A, "Do you still have your meds? Cause [*sic*] I can order them tomorrow I think." Patient A responded, "No." Respondent then replied, "What happened to your Xanax?" Patient A responded, "My niece is bringing me some." Respondent asked, "They didn't fill that one or what?" Patient A responded, "No cause [*sic*] I spilled soda on it."

171. On or about May 1, 2017, Respondent sent the following message to Patient A, "Lemme [*sic*] know [Patient A] if you can place a refill I can get it for you so you're not dying!!" Patient A responded, "I'm dying 2 nights no meds... my other doc is cutting me off to [*sic*] quick." Respondent then replied, "I know and I agree. I placed orders for you and will talk with [Patient C] when she gets here ok?" Patient A responded, "You are the best,...thank you for being my friend, I love you." Later that same day, Respondent sent the following message to Patient A, "They wouldn't fill it. They did fill your Xanax thought [*sic*]."

172. On or about May 2, 2017, Respondent sent the following message to Patient A, "Oh I bet they would fill that for you today if you call in...there will be a different pharmacist. I love you [Patient A] lemme [*sic*] know how it goes today."

173. On or about May 3, 2017, Patient A sent the following message to Respondent, "I will try to save some chicken [emoji image of a chicken leg] lol," [common abbreviation for laughing out loud]. Respondent responded, "You need to if you want my help with the other."

174. On or about May 4, 2017, Respondent sent the following message to Patient A, "Hey gorgeous, I cancelled a case tomorrow so we can hang for a bit. Should hopefully be leaving here around 12:30. Sound OK [emoji image of a chicken leg]?" Later that same day, Respondent sent the following message to Patient A, "Winner, winner, chicken dinner [emoji image of a chicken leg]."

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Gifts to Patient A with References to Controlled Substances

175. Over the course of Respondent's care and treatment of Patient A, Respondent also provided gifts to Patient A, including, but not limited to, three (3) pairs of Vans sneakers decorated with handmade drawings and messages from Respondent to Patient A.

176. One pair of Vans had the following written along the sides, "To my favorite patient keep it old skool [*sic*]!!! From Dr. Rosing."

177. A second pair of Vans had a drawing of a small blue round pill resembling an oxycodone tablet on the outside of one shoe, and a drawing of a small whitish rectangular bar resembling a Xanax tablet on the outside of the other shoe.

178. A third pair of Vans had a section along the side of one shoe filled with drawings of small blue round pills resembling oxycodone tablets and small whitish rectangular bars resembling Xanax tablets.

179. On or about February 3, 2016, Respondent sent the following text message to Patient A, "I love you [Patient A] hope you feel better my friend. Have been working on your other shoe. Looking fun. You're cool with me putting Blues[17] and stuff on it yeah? Cause [*sic*] I did already!!!"

180. On or about February 6, 2016, Respondent sent the following text message to Patient A, "The side isn't done yet but there's a lot of Blues and Xanies.[18] So funny." Later that same day, Respondent texted Patient A saying, "I can add more pills on the outside if you want. Wasn't sure if better like it is or better with a lot more." Later that evening, Respondent texted Patient A again, "If you're anything like me...you can never get enough of a good thing. I filled up the shoe with all the glories."

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[17] "Blues" in reference to oxycodone.

[18] "Xanies" in reference to Xanax.

Prescriptions Issued to Patient A

181. In or around 2015, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, oxycodone, fentanyl, hydromorphone, alprazolam, and zolpidem tartrate, which were filled at several different pharmacies, as follows:

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2015-12-22	Hydromorphone	4 mg	200	16
2015-12-22	Oxycodone	30 mg	200	11
2015-12-11	Alprazolam	2 mg	90	30
2015-12-11	Hydromorphone	4 mg	200	16
2015-12-11	Oxycodone	30 mg	200	11
2015-12-01	Hydromorphone	4 mg	200	16
2015-12-01	Oxycodone	30 mg	169	11
2015-11-18	Hydromorphone	4 mg	200	16
2015-11-18	Oxycodone	30 mg	200	12
2015-11-09	Alprazolam	2 mg	90	30
2015-11-09	Oxycodone	30 mg	200	11
2015-11-06	Hydromorphone	4 mg	180	30
2015-10-27	Oxycodone	30 mg	200	16
2015-10-26	Alprazolam	2 mg	60	20
2015-10-21	Hydromorphone	4 mg	200	16
2015-10-21	Oxycodone	30 mg	200	16
2015-10-13	Alprazolam	2 mg	90	30
2015-10-13	Hydromorphone	4 mg	30	5
2015-10-13	Oxycodone	30 mg	200	25
2015-10-04	Hydromorphone	4 mg	200	16
2015-10-04	Oxycodone	30 mg	200	16

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2015-09-24	Zolpidem tartrate	10 mg	60	60
2015-09-23	Alprazolam	2 mg	90	30
2015-09-21	Hydromorphone	4 mg	200	16
2015-09-21	Oxycodone	30 mg	200	16
2015-08-25	Alprazolam	2 mg	90	30
2015-08-25	Zolpidem tartrate	10 mg	60	30
2015-08-25	Hydromorphone	4 mg	200	16
2015-08-25	Oxycodone	30 mg	200	16
2015-08-14	Fentanyl	50 mcg/1 hr	10	30
2015-08-14	Oxycodone	30 mg	200	16
2015-08-12	Hydromorphone	4 mg	200	16
2015-08-08	Alprazolam	2 mg	75	25
2015-08-06	Alprazolam	2 mg	15	5
2015-08-06	Zolpidem tartrate	10 mg	30	30
2015-08-03	Oxycodone	30 mg	200	16
2015-07-29	Hydromorphone	4 mg	200	16
2015-07-13	Hydromorphone	4 mg	200	16
2015-07-06	Alprazolam	2 mg	90	30
2015-07-06	Zolpidem tartrate	10 mg	30	30
2015-07-06	Oxycodone	30 mg	200	18
2015-06-30	Hydromorphone	4 mg	200	15
2015-06-23	Alprazolam	2 mg	84	28
2015-06-22	Alprazolam	2 mg	6	2
2015-06-22	Zolpidem tartrate	10 mg	60	30
2015-06-22	Hydromorphone	4 mg	100	11
2015-06-22	Oxycodone	30 mg	200	16

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2015-06-09	Zolpidem tartrate	10 mg	30	30
2015-06-07	Alprazolam	2 mg	90	30
2015-06-07	Oxycodone	30 mg	200	16
2015-05-27	Hydromorphone	4 mg	200	16
2015-05-23	Oxycodone	30 mg	200	16
2015-05-12	Alprazolam	2 mg	90	30
2015-05-12	Oxycodone	30 mg	200	25
2015-05-08	Ambien	10 mg	30	30
2015-05-01	Hydromorphone	4 mg	150	12
2015-05-01	Oxycodone	30 mg	200	16
2015-04-27	Zolpidem tartrate	10 mg	60	30
2015-04-25	Alprazolam	2 mg	75	25
2015-04-24	Oxycodone	30 mg	200	16
2015-04-09	Oxycodone	30 mg	90	7
2015-03-25	Oxycodone	30 mg	120	15
2015-03-15	Oxycodone	30 mg	120	10
2015-03-05	Oxycodone	30 mg	120	10

182. In or around 2015, according to records, Respondent issued early refills to Patient A on several occasions, including, but not limited to, May 8, 2015; May 23, 2015; October 13, 2015; October 21, 2015; October 27, 2015; and December 11, 2015.

183. According to CURES, from on or about August 6, 2015 through on or about September 21, 2015, Respondent issued prescriptions to Patient A for opioids in excess of 945 MED per day, in addition to 180 tablets of alprazolam (2 mg) and 90 tablets of Ambien (10 mg).

184. According to CURES, from on or about September 23, 2015 through on or about November 6, 2015, Respondent issued prescriptions to Patient A for opioids in excess of 1,040 MED per day, in addition to 240 tablets of alprazolam (2 mg) and 60 tablets of Ambien (10 mg).

185. According to CURES, from on or about November 9, 2015 through on or about January 2, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 1,104 MED per day, in addition to 180 tablets of alprazolam (2 mg).

186. In or around 2016, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, oxycodone, opium, hydromorphone, Adderall, alprazolam, and zolpidem tartrate, which were filled at several different pharmacies, as follows:

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2016-12-26	Oxycodone	30 mg	200	11
2016-12-22	Hydromorphone	4 mg	180	30
2016-12-22	Amphetamine salt combo	30 mg	30	30
2016-12-17	Alprazolam	2 mg	100	25
2016-12-17	Oxycodone	30 mg	200	11
2016-12-12	Alprazolam	2 mg	100	17
2016-12-09	Oxycodone	30 mg	200	11
2016-12-07	Amphetamine salt combo	30 mg	30	30
2016-12-05	Hydromorphone	4 mg	180	30
2016-11-30	Alprazolam	2 mg	100	25
2016-11-30	Oxycodone	30 mg	200	11
2016-11-21	Oxycodone	30 mg	200	11
2016-11-17	Hydromorphone	4 mg	200	16
2016-11-17	Amphetamine salt combo	30 mg	30	30
2016-11-15	Alprazolam	2 mg	100	16
2016-11-11	Oxycodone	30 mg	200	11
2016-11-02	Alprazolam	2 mg	90	30
2016-11-02	Hydromorphone	4 mg	100	16
2016-11-02	Oxycodone	30 mg	200	11

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2016-10-24	Opium	10 mg/1 ml	236	7
2016-10-24	Oxycodone	30 mg	200	11
2016-10-24	Amphetamine salt combo	30 mg	30	30
2016-10-17	Oxycodone	30 mg	200	16
2016-10-12	Oxycodone	20 mg	100	5
2016-10-08	Alprazolam	2 mg	120	30
2016-10-08	Hydromorphone	4 mg	200	16
2016-10-03	Oxycodone	30 mg	200	11
2016-10-03	Amphetamine salt combo	30 mg	30	30
2016-09-27	Alprazolam	2 mg	90	30
2016-09-27	Hydromorphone	4 mg	200	11
2016-09-27	Oxycodone	30 mg	200	11
2016-09-15	Alprazolam	2 mg	90	30
2016-09-15	Oxycodone	30 mg	200	11
2016-09-09	Oxycodone	30 mg	100	5
2016-09-01	Opium	10 mg/1 ml	118	13
2016-08-30	Amphetamine salt combo	30 mg	30	30
2016-08-30	Alprazolam	2 mg	90	30
2016-08-30	Oxycodone	30 mg	200	11
2016-08-17	Alprazolam	2 mg	90	30
2016-08-17	Alprazolam	2 mg	90	30
2016-08-11	Amphetamine salt combo	30 mg	30	30
2016-08-04	Oxycodone	15 mg	200	11
2016-08-03	Alprazolam	2 mg	90	30
2016-07-29	Alprazolam	2 mg	90	30
2016-07-29	Oxycodone	30 mg	200	12

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2016-07-23	Amphetamine salt combo	30 mg	30	30
2016-07-23	Oxycodone	30 mg	200	11
2016-07-13	Alprazolam	2 mg	90	30
2016-07-13	Amphetamine salt combo	30 mg	30	30
2016-07-13	Oxycodone	30 mg	200	11
2016-07-08	Oxycodone	30 mg	200	12
2016-07-01	Alprazolam	2 mg	90	30
2016-07-01	Oxycodone	30 mg	200	12
2016-06-27	Oxycodone	30 mg	200	12
2016-06-21	Alprazolam	2 mg	90	30
2016-06-21	Oxycodone	30 mg	200	12
2016-06-14	Alprazolam	2 mg	90	30
2016-06-14	Oxycodone	30 mg	200	16
2016-06-07	Alprazolam	2 mg	90	30
2016-06-07	Amphetamine salt combo	30 mg	30	30
2016-06-07	Hydromorphone	4 mg	200	16
2016-06-07	Opium	10 mg/1 ml	236	12
2016-06-07	Oxycodone	30 mg	200	12
2016-05-31	Opium	10 mg/1 ml	236	8
2016-05-28	Oxycodone	30 mg	200	12
2016-05-20	Adderall XR	30 mg	30	30
2016-05-20	Alprazolam	2 mg	90	30
2016-05-20	Oxycodone	30 mg	200	11
2016-05-12	Alprazolam	2 mg	90	30
2016-05-12	Amphetamine salt combo	30 mg	30	30
2016-05-12	Oxycodone	30 mg	200	12

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2016-05-03	Adderall XR	30 mg	30	30
2016-05-03	Alprazolam	2 mg	90	30
2016-05-03	Opium	10 mg/1 ml	236	8
2016-05-03	Oxycodone	30 mg	200	11
2016-04-30	Hydromorphone	4 mg	100	9
2016-04-25	Oxycodone	30 mg	200	12
2016-04-13	Oxycodone	30 mg	200	11
2016-04-13	Alprazolam	2 mg	90	30
2016-04-13	Amphetamine salt combo	30 mg	30	30
2016-04-02	Oxycodone	30 mg	200	17
2016-03-23	Oxycodone	30 mg	200	11
2016-03-23	Alprazolam	2 mg	90	30
2016-03-23	Amphetamine salt combo	30 mg	30	30
2016-03-23	Hydromorphone	4 mg	200	17
2016-03-07	Oxycodone	30 mg	200	11
2016-03-01	Adderall XR	30 mg	30	30
2016-03-01	Alprazolam	2 mg	90	30
2016-03-01	Alprazolam	2 mg	90	30
2016-03-01	Hydromorphone	4 mg	200	16
2016-02-26	Opium	10 mg/1 ml	236	16
2016-02-24	Oxycodone	30 mg	200	11
2016-02-15	Alprazolam	2 mg	50	17
2016-02-15	Hydromorphone	4 mg	200	17
2016-02-15	Oxycodone	30 mg	200	11
2016-02-01	Hydromorphone	4 mg	200	16
2016-02-01	Oxycodone	30 mg	200	11

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2016-01-28	Oxycodone	30 mg	200	11
2016-01-18	Oxycodone	30 mg	200	11
2016-01-07	Oxycodone	30 mg	200	11
2016-01-02	Alprazolam	2 mg	90	30
2016-01-02	Hydromorphone	4 mg	200	16

187. In or around 2016, according to records, Respondent issued early refills to Patient A on several occasions, including, but not limited to, February 1, 2016; May 3, 2016; May 12, 2016; May 20, 2016; June 14, 2016; June 21, 2016; June 27, 2016; July 1, 2016; July 8, 2016; July 13, 2016; July 29, 2016; August 3, 2016; August 4, 2016; August 17, 2016; August 30, 2016; September 27, 2016; October 3, 2016; October 8, 2016; October 24, 2016; November 15, 2016; December 7, 2016; and December 17, 2016.

188. According to CURES, from on or about January 2, 2016 through on or about March 1, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 1,063 MED per day, in addition to 320 tablets of alprazolam (2 mg).

189. According to CURES, from on or about March 1, 2016 through on or about May 3, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 878 MED per day, in addition to 180 tablets of alprazolam (2 mg).

190. According to CURES, from on or about May 3, 2016 through on or about June 7, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 1,512 MED per day, in addition to 270 tablets of alprazolam (2 mg).

191. According to CURES, from on or about June 7, 2016 through on or about July 23, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 1,615 MED per day, in addition to 450 tablets of alprazolam (2 mg).

192. According to CURES, from on or about July 23, 2016 through on or about September 15, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 855 MED per day, in addition to 450 tablets of alprazolam (2 mg).

193. According to CURES, from on or about September 15, 2016 through on or about October 24, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 1,224 MED per day, in addition to 300 tablets of alprazolam (2 mg).

194. According to CURES, from on or about November 2, 2016 through on or about December 9, 2016, Respondent issued prescriptions to Patient A for opioids in excess of 1,423 MED per day, in addition to 290 tablets of alprazolam (2 mg).

195. According to CURES, from on or about December 12, 2016 through on or about January 30, 2017, Respondent issued prescriptions to Patient A for opioids in excess of 1,099 MED per day, in addition to 400 tablets of alprazolam (2 mg).

196. In or around 2017, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, oxycodone, hydromorphone, amphetamine salt combination, alprazolam, which were filled at several different pharmacies, as follows:

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2017-05-02	Oxycodone	30 mg	200	11
2017-04-24	Oxycodone	30 mg	200	11
2017-04-17	Oxycodone	30 mg	200	11
2017-04-08	Oxycodone	30 mg	200	11
2017-03-31	Oxycodone	30 mg	200	11
2017-03-23	Alprazolam	2 mg	100	25
2017-03-23	Oxycodone	30 mg	200	11
2017-03-15	Oxycodone	30 mg	200	16
2017-03-06	Alprazolam	2 mg	100	25
2017-03-06	Amphetamine salt combo	30 mg	30	30
2017-03-04	Oxycodone	30 mg	200	12
2017-02-19	Oxycodone	30 mg	200	12
2017-02-17	Alprazolam	2 mg	75	19

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2017-02-11	Oxycodone	30 mg	200	11
2017-02-07	Amphetamine salt combo	30 mg	30	30
2017-02-02	Oxycodone	30 mg	200	11
2017-01-30	Alprazolam	2 mg	100	25
2017-01-30	Hydromorphone	4 mg	30	5
2017-01-30	Hydromorphone	4 mg	170	14
2017-01-23	Oxycodone	30 mg	200	12
2017-01-17	Alprazolam	2 mg	100	25
2017-01-13	Oxycodone	30 mg	200	11
2017-01-13	Amphetamine salt combo	30 mg	30	30
2017-01-03	Alprazolam	2 mg	100	25
2017-01-03	Oxycodone	30 mg	200	11

197. In or around 2017, according to records, Respondent issued early refills to Patient A on several occasions, including, but not limited to, January 17, 2017; February 17, 2017; and March 23, 2017.

198. According to CURES, from on or about January 30, 2017 through on or about March 23, 2017, Respondent issued prescriptions to Patient A for opioids in excess of 917 MED per day, in addition to 375 tablets of alprazolam (2 mg).

199. According to CURES, from on or about March 23, 2017 through on or about May 4, 2017, Respondent issued prescriptions to Patient A for opioids in excess of 1,255 MED per day, during which time, Patient A was also receiving a prescription for alprazolam from another physician.

Prescriptions Issued to Patient B

200. In or around 2015, Patient B was a 50-year-old male and married to Patient A.

201. From on or about November 6, 2015 through on or about May 22, 2019, Patient B remained incarcerated in state prison.

202. From on or about November 18, 2015 through on or about September 29, 2016, records indicate Respondent issued repeated prescriptions to Patient B which were filled at pharmacies outside of state prison. Records for Patient B do not document any physical examination or determination of medical indication by Respondent for these prescriptions.

203. According to CURES, from on or about November 18, 2015 through on or about September 29, 2016, Respondent issued repeated prescriptions to Patient B for several controlled substances, including, but not limited to, oxycodone-acetaminophen and alprazolam, as follows:

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2016-09-29	Alprazolam	1 mg	90	30
2016-08-18	Oxycodone-acetaminophen	325 mg-10 mg	90	18
2016-08-26	Alprazolam	1 mg	50	16
2016-05-28	Oxycodone-acetaminophen	325 mg-10 mg	100	9
2016-04-25	Alprazolam	2 mg	60	20
2016-04-25	Oxycodone-acetaminophen	325 mg-10 mg	100	9
2016-04-03	Oxycodone-acetaminophen	325 mg-10 mg	75	6
2016-04-03	Oxycodone-acetaminophen	325 mg-10 mg	75	6
2016-02-24	Oxycodone-acetaminophen	325 mg-10 mg	100	16
2016-01-16	Oxycodone-acetaminophen	325 mg-10 mg	100	16
2015-12-11	Oxycodone-acetaminophen	325 mg-10 mg	75	12
2015-11-18	Oxycodone-acetaminophen	325 mg-10 mg	30	5

204. During Patient B's incarceration, Respondent and Patient A exchanged several text messages regarding prescriptions for Patient B.

205. On or about January 15, 2016, Respondent sent the following message to Patient A, "I had forgotten but I also ordered [Patient B's]."

206. On or about January 19, 2016, Respondent sent the following message to Patient A, "I can come by after work and we can hang for awhile [*sic*] and write [Patient B] etc."

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207. On or about February 22, 2016, Patient A sent the following message to Respondent, "Can I ask you a favor to fill [Patient B's] perks[19] as I'm almost out of 30s.[20] I have been in a lot of pain and throwing up. I feel horrible and can't get any 30 till the end of next week. I have a gift for you?" Respondent responded, "Ok I'll put order in. It'll be in around 2:30. You don't have any 30's?!?!?!? Where'd they all go?" Patient A responded, "I have 40 left but they were supposed to be for Scott but maybe I'll split on [*sic*] let me call Scott and I'll find out because you're my favorite though I want to give you what you want to do [*sic*] you always give me what I want but I can't you know me up until next week when it's time anyways I miss you. I will save some for you." Respondent responded with the following text message, "Thanks homie. Homies fo [*sic*] life." Later that same day, Respondent sent a message to Patient A saying, "I am putting in orders for him."

208. On or about October 3, 2019, Respondent was interviewed by HQIU investigators about his prescribing to Patient B during his incarceration. During this interview, Respondent admitted knowing Patient B was in prison and confirmed Patient B was not under his care and treatment while in prison. Respondent further acknowledged the prescriptions issued by him to Patient B were likely provided to Patient A.

209. The prescriptions issued by Respondent to Patient B during his incarceration increased Patient A's daily access to opioids by 94 MED per day.

Prescriptions Issued to Patient C

210. In or around 2016, Patient C was a 43-year-old female and a caregiver for Patient A.

211. In response to a request for records for Patient C, a KP custodian of records issued a certificate of no records for Patient C, indicating Patient C did not receive any care and treatment at the medical facility where Respondent worked as a physician. There is no documentation of any physical examination or determination of medical indication by Respondent for Patient C.

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[19] "Perks" in reference to Percocet, a combination of oxycodone and acetaminophen.

[20] "30s" in reference to oxycodone which Respondent prescribed to Patient A in 30 mg tablets.

212. According to CURES, from on or about September 23, 2016 through on or about January 23, 2017, Respondent issued repeated prescriptions to Patient C for several controlled substances, including, but not limited to, oxycodone-acetaminophen and alprazolam, as follows:

DATE	DRUG NAME	STRENGTH	QTY	DAYS
2017-01-23	Alprazolam	2 mg	75	25
2016-12-31	Oxycodone-acetaminophen	325 mg-10 mg	90	9
2016-12-31	Oxycodone-acetaminophen	325 mg-10 mg	90	9
2016-12-09	Alprazolam	1 mg	90	30
2016-12-09	Alprazolam	1 mg	90	30
2016-11-09	Alprazolam	1 mg	75	25
2016-11-09	Alprazolam	1 mg	75	25
2016-11-09	Oxycodone-acetaminophen	325 mg-10 mg	75	9
2016-10-03	Alprazolam	1 mg	60	20
2016-09-23	Oxycodone-acetaminophen	325 mg-10 mg	100	9

213. On or about October 3, 2019, Respondent was interviewed by HQIU investigators about his prescribing to Patient C. During this interview, Respondent admitted prescribing pain medications to Patient C upon her request. When asked whether Respondent was aware Patient C was filling her prescriptions to then provide them to Patient A, Respondent admitted, "Yeah, probably... I kind of knew that's where it was going."

214. The prescriptions issued by Respondent to Patient C increased Patient A's daily access to opioids by 31 MED per day.

Criminal Conviction

215. On or about May 5, 2020, in the case entitled *People of the State of California v. David K. Rosing,* in the Superior Court of California, County of Riverside, Case No. SWF2007307, Respondent was charged with seven (7) felonies: (1) Penal Code section 187, subdivision (a) (murder) as to Patient A; (2) Penal Code section 368, subdivision (b)(1) (injury to a dependent adult) with a special allegation that the injury proximately caused the death of the

victim pursuant to Penal Code section 368, subdivision (b)(3)(A) as to Patient A; (3) Health and Safety Code section 11153, subdivision (a) (prescribing or dispensing a controlled substance, to wit, oxycodone, to a patient not in the usual course of professional treatment) as to Patient B; (4) Health and Safety Code section 11153, subdivision (a) (prescribing or dispensing a controlled substance, to wit, oxycodone, to a patient not in the usual course of professional treatment) as to Patient C; (5) Health and Safety Code section 11154, subdivision (a) (prescribe, administer, dispense and/or furnish a controlled substance, to wit, oxycodone, to a patient not under their treatment) as to Patient B; (6) Health and Safety Code section 11154, subdivision (a) (prescribe, administer, dispense and/or furnish a controlled substance, to wit, oxycodone, to a patient not under their treatment) as to Patient C; and (7) Health and Safety Code section 11156, subdivision (a) (prescribe, administer and/or dispense a controlled substance, to wit, oxycodone and alprazolam, to an addict) as to Patient A.

216. On or about September 4, 2020, Respondent was arraigned on the criminal complaint and entered a plea of not guilty.

217. On or about October 22, 2020, an order was issued prohibiting Respondent from prescribing any and all controlled substances, as defined in the California Controlled Substances Act, under Schedules II, III, IV, and V, until the conclusion of the criminal proceeding.

218. On or about June 29, 2023, Respondent entered guilty pleas to violating Penal Code section 368, subdivision (b)(1) (injury to a dependent adult), and Health and Safety Code section 11156, subdivision (a) (prescribe, administer and/or dispense a controlled substance, to wit, oxycodone and alprazolam, to an addict), both felonies as charged in the criminal complaint. Respondent's guilty pleas were accepted by the Court and Respondent was sentenced to formal probation for a period of two (2) years with terms and conditions including 180 days in custody.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Prescribing)

219. Respondent has subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that Respondent committed repeated acts of clearly excessive prescribing of dangerous drugs and/or controlled substances or treatment, as more particularly alleged in paragraphs 40 through 218, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Prescribing, Dispensing, and/or Administering Drugs and/or Controlled Substances to an Addict)

220. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2241, of the Code, in that Respondent prescribed, dispensed, and/or administered dangerous drugs and/or controlled substances to an addict, Patient A, as more particularly alleged in paragraphs 40 through 218, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Prescribing, Dispensing, or Furnishing Dangerous Drugs without Prior Examination and/or Medical Indication)

221. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2242, subdivision (a), of the Code, in that Respondent prescribed, dispensed and/or furnished dangerous drugs and/or controlled substances to Patients A, B, and C, without conducting an appropriate prior examination and/or without medical indication, as more particularly alleged in paragraphs 40 through 218, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

222. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter.

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

A. Paragraphs 40 through 221, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to reduce his prescribing of controlled substances to Patient A for opioids and benzodiazepines, and maintained prescriptions for Patient A at levels in excess of 800 MED over an extended period of time, despite reports of Patient A experiencing severe adverse side effects, including, but not limited to, abdominal pain, nausea, vomiting, constipation, falls, loss of consciousness, and overdose events;

C. Respondent failed to establish a diagnosis of necessity for Patient A's long-term use of high-dose opioids and benzodiazepines;

D. Respondent failed to undertake or otherwise perform a risk assessment of Patient A to evaluate the potential risks of long-term high-dose opioid therapy combined with benzodiazepines and other sedative hypnotic medications;

E. Respondent failed to conduct and/or document a full discussion of the risks and benefits with Patient A regarding the long-term use of high-dose opioids, combined use of opioids with benzodiazepines and other sedative hypnotic medications, including, but not limited to, the discussion of the risks of respiratory depression, motor impairment, cognitive impairment, dependence, misuse, addiction, overdose and death;

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F. Respondent failed to develop and establish and/or document the development and establishment of a treatment plan, goals or objectives for use in evaluating Patient A's progress or assessment of Patient A for functional improvement or reduction in pain;

G. Respondent failed to perform and/or document the performance of an ongoing assessment to evaluate Patient A's progress toward treatment goals and objectives, including, but not limited to, evaluation of Patient A's activity level, adverse side effects, aberrant behaviors, and affect;

H. Respondent failed to perform and/or document the performance of compliance monitoring of Patient A, including, but not limited to, review of CURES reports, frequent drug screen testing, imposition of a controlled substances agreement, and requiring pill counts;

I. Respondent failed to obtain and/or document the entry of a controlled substance agreement with Patient A to restrict the use of, among other things, multiple pharmacies, multiple prescribers, and requests for early refills;

J. Respondent failed to establish and/or document an established plan for discontinuing and/or reducing Patient A's high dose opioid therapy and benzodiazepine therapy;

K. Respondent failed to maintain adequate and/or accurate medical records to reflect his medical care and treatment of Patient A;

L. Respondent failed to maintain appropriate professional boundaries with Patient A by making frequent house visits for illicit drug-related activities, including, but not limited to, the obtaining of controlled substances from Patient A;

M. Respondent failed to maintain appropriate professional boundaries with Patient A by providing gifts with references to Patient A's medications, including, but not limited to, oxycodone and Xanax, creating the potential to negatively influence Patient A, who was struggling with addiction to oxycodone and Xanax;

N. Respondent failed to maintain appropriate professional boundaries with Patient A by engaging in communication with Patient A using code words to refer to prescriptions and medications to conceal illicit activities, including, but not limited to, "chicken" and "documents;" and

O. Respondent failed to maintain appropriate professional boundaries with Patient A by engaging in communication with Patient A using inappropriate and intimate language, including, but not limited to, "Wifey #2," "Gorgeous," "Sexy," "Sweet [Patient A]," "I love you," "I want you in my life forever," and "Homies for life."

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

A. Paragraphs 40 through 221, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to conduct and/or document the performance of a physical examination of Patient B prior to prescribing controlled substances to Patient B; and

C. Respondent failed to maintain accurate and/or adequate medical records for Patient B, in that he created a false record of prescribing controlled substances to Patient B knowing they would be provided to Patient A.

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

A. Paragraphs 40 through 221, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to conduct and/or document the performance of a physical examination of Patient C prior to prescribing controlled substances to Patient C; and

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C. Respondent failed to maintain accurate and/or adequate medical records for Patient C, in that he created a false record of prescribing controlled substances to Patient C knowing they would be provided to Patient A.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

226. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts, as more particularly alleged in paragraphs 40 through 225, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Dishonest or Corrupt Acts)

227. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of the Code, in that Respondent committed an act or acts of dishonesty or corruption, as more particularly alleged in paragraphs 40 through 226, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(False Representations)

228. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2261, of the Code, in that Respondent knowingly made or signed a certificate or document directly and/or indirectly related to the practice of medicine which falsely represented the existence and/or nonexistence of a state of facts, as more particularly alleged in paragraphs 40 through 227, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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EIGHTH CAUSE FOR DISCIPLINE

(Creation of False Medical Records with Fraudulent Intent)

229. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2262, of the Code, in that Respondent created false medical records with fraudulent intent, as more particularly alleged in paragraphs 40 through 228, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

230. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and/or accurate medical records, as more particularly alleged in paragraphs 40 through 229, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

TENTH CAUSE FOR DISCIPLINE

(Violation of State Laws Regulating Dangerous Drugs and/or Controlled Substances)

231. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code, in that Respondent violated a state law or laws regulating dangerous drugs and/or controlled substances, as more particularly alleged hereinafter.

A. Paragraphs 40 through 230, above, are hereby incorporated by reference and realleged as if fully set forth herein.

B. Respondent issued prescriptions for controlled substances to Patients A, B, and C, without a having a legitimate medical purpose, and/or not in the usual course of his professional practice, in violation of Health and Safety Code section 11153, subdivision (a).

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C. Respondent issued prescriptions for controlled substances to Patients A, B, and C, who were not under his care and treatment, in violation of Health and Safety Code section 11154, subdivision (a).

D. Respondent issued prescriptions for controlled substances to an addict, Patient A, in violation of Health and Safety Code section 11156.

E. Respondent issued false and/or fraudulent prescriptions for controlled substances for Patients B and C, in violation of Health and Safety Code section 11157.

F. Respondent made false statements in his prescriptions, orders, reports, and/or records, for Patients B and C, in violation of Health and Safety Code section 11173, subdivision (b).

ELEVENTH CAUSE FOR DISCIPLINE

(Conviction of a Crime Substantially Related to the Qualifications, Functions, or Duties of a Physician and Surgeon)

232. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2236, of the Code, and section 1360 of Title 16 of the California Code of Regulations, in that he has been convicted of crimes substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged in paragraphs 40 through 218, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

TWELFTH CAUSE FOR DISCIPLINE

(Violation of Provisions of the Medical Practice Act)

233. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that Respondent violated a provision and/or provisions of the Medical Practice Act in his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 40 through 232, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRTEENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

234. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89674 to disciplinary action under sections 2227 and 2234, of the Code, in that Respondent engaged in conduct which breached the rules or ethical code of the medical profession or which was unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, in his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 40 through 233, 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. A 89674, issued to Respondent David Keith Rosing, M.D.;

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

3. Ordering Respondent David Keith Rosing, 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. Ordering Respondent David Keith Rosing, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and

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

DATED: SEP 2 1 2023

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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