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

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| In the Matter of the Accusation and Petition to Revoke Probation Against:<br><br>Harry Lifschutz, M.D.<br><br>Physician's and Surgeon's Certificate No. G 42802<br><br>Respondent. | MBC File # 800-2022-092680 |

**ORDER CORRECTING NUNC PRO TUNC**
**CLERICAL ERROR IN "CHAIRPERSON'S NAME" PORTION OF DECISION**

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "chairperson's name" portion of the Decision in the above-entitled matter and that such clerical error should be corrected to indicate that Randy W. Hawkins, M.D. presided over this meeting.

IT IS HEREBY ORDERED that the chairperson's name "Laurie Rose Lubiano, J.D." contained on the Decision Order Page in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "Randy W. Hawkins, M.D.".

Order Date: JUN 0 6 2024

Randy W. Hawkins, M.D., Vice Chair
Panel A

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

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| In the Matter of the Accusation and Petition to Revoke Probation Against:<br><br>Harry Lifschutz, M.D.<br><br>Physician's and Surgeon's Certificate No. G 42802<br><br>Respondent. | Case No.: 800-2022-092680 |

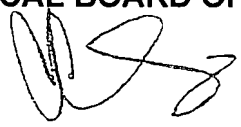
## DECISION

The attached Proposed Decision 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 June 28, 2024.

IT IS SO ORDERED: May 29, 2024.

MEDICAL BOARD OF CALIFORNIA



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

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

## In the Matter of the Accusation and Petition to Revoke Probation Against:

## HARRY LIFSCHUTZ, M.D., Respondent

## Physician's and Surgeon's Certificate No. G 42802

## Case No. 800-2022-092680

## OAH No. 2023050403

## PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on January 16 through 19, and February 6 and 7, 2024, by telephone/video conference.

LeAnna E. Shields, Deputy Attorney General, Department of Justice, represented complainant, Reji Varghese, Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (board).

Nicholas Jurkowitz, Attorney at Law, Fenton Law Group, LLP, represented respondent, Harry Lifschutz, M.D., who was present.

The matter was submitted on February 7, 2024.

## SUMMARY

Complainant asserts that respondent's license should be subject to discipline because he committed gross negligence, repeated negligent acts, failed to maintain accurate and adequate records, violated the Medical Practice Act, and committed general unprofessional conduct in his care, treatment, and prescribing of high dose opioids to Patients A, B, and C. Complainant further asserts that respondent violated numerous terms of his disciplinary probation, which he has been under since 2019. Complainant seeks the recovery of costs. For the reasons stated in this decision, revocation of respondent's license is not necessary to ensure public protection based on the causes for discipline and probation violation as found. Respondent's probation is extended for three years under the same terms and conditions including the requirement that he successfully complete a medical record keeping course.

## PROTECTIVE ORDER

A protective order has been issued on complainant's motion sealing Exhibits 5 to 18, 20 to 24, 32, and Exhibits B, V, and Y. The confidential names list has also been placed under seal. It is not practical to redact these documents. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

## FACTUAL FINDINGS

### Jurisdiction

1. Complainant filed the accusation and petition to revoke probation on February 15, 2022. Respondent timely filed a Notice of Defense.

2. Complainant alleges that respondent engaged in gross negligence and repeated negligent acts relating to his prescription of controlled substances to three patients, A, B, and C. Complainant also seeks to revoke respondent's disciplinary probation for his alleged violation of seven conditions of probation.

3. At the start of the hearing, complainant withdrew paragraph 87, under the Third Cause to Revoke Probation, and paragraphs 89, and 90, under the Fourth Cause to Revoke Probation. The pleading is amended accordingly to reflect the withdrawal of these charges, and these charges are not considered.

### License History and Disciplinary History

4. On July 25, 1980, the Medical Board issued Physician's and Surgeon's. Certificate No. G 42802 to respondent.

Respondent has twice been subject to board discipline.

First, in the matter entitled *In the Matter of the Accusation Against: Harry Lifschutz, M.D.*, Physician's and Surgeon's Certificate No. G 42802, Case No. 18-2002-134149, respondent's license was placed on probation, with terms and conditions, effective June 4, 2007, for a period of five years for committing gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate and accurate records.

Next, in the matter entitled *In the Matter of the Third Amended Accusation Against: Harry Lifschutz, M.D.*, MBC Case No. 800-2014-004065, the board issued a Decision and Order on July 30, 2019, effective August 29, 2019, in which his license was revoked, the revocation stayed, and his license was placed on probation for a period of four years with certain terms and conditions for committing gross negligence, repeated negligent acts, and failure to maintain adequate and accurate records.

## Summary of Allegations in Current Accusation, and Respondent's Treatment of Patients, Prescriptions for Controlled Substances, and Testimony of the Parties' Experts

5. Complainant alleges, as noted, respondent committed gross negligence, repeated negligent acts, failed to adequately and accurate document the patients' medical records, and violated the Medical Practice Act, in his care and treatment of Patients A, B, and C.

6. Respondent's care and treatment of these patients are documented in the patients' medical records, respondent's progress notes for these patients, Controlled Substance Utilization Review and Evaluation System (CURES) reports, pharmacy records, which include copies of prescription scripts respondent wrote and patient pharmacy reports, respondent's June 28, 2022, interview with the Health Quality Investigation Unit (HQIU) of the Department of Consumer Affair's Division of Investigation, and other information of record. Complainant called Karen Jamison, M.D. to testify as an expert; respondent called Jack Berger, M.D., and Standiford Helm, M.D., as experts. In summary, these materials and the testimony of these experts show the following:

## PATIENT A

7. On July 9, 2019, Patient A, a then 69-year-old female, saw respondent for a follow-up monthly visit. At that time, respondent had been treating Patient A for several years. Respondent stated in the progress note for this visit (captioned "Interval Pain Management Note") that Patient A was known to him as a patient with a longstanding history of diffuse arthritis and diffuse skin tenderness over her body. Patient A presented with severe pain, which she rated as 9/10 and was reduced to 6/10 with stiffness in the morning when she gets out of bed. This language under Patient A's description of her symptoms, it is noted, is the same in each of Patient A's progress notes. The July 9, 2019, note documents that Patient A had been on opioids for over 20 years, and she admitted to becoming "extremely dependent" on opioids.

8. Respondent assumed Patient A's care to manage her pain on an interim basis, and she was a "legacy patient." Another physician had been managing her pain with prescriptions of "high dose" opioids. It is not clear from the record why that doctor stopped treating Patient A. Respondent intended to prescribe Patient A opioids until another physician, a pain management specialist, could take over her pain management care. Respondent noted Patient A resisted being weaned off of opioids or taking Suboxone as an alternative to opioids.[1]

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[1] Suboxone is the brand name for buprenorphine and naloxone. It is classified as a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022.

9. Respondent identified Patient A's diagnoses as severe arthritis, lumbar disc disease, foramina stenosis, adult-onset diabetes, and other medical issues. Respondent added she was refractory to all types of therapy, including Tylenol, anti-inflammatories, and multiple failed medications. What respondent meant by "refractory" to all medications is not clear. Respondent also noted Patient A's insurance did not approve continued OxyContin prescriptions in early 2019, and this necessitated, as he put it, an "effort to recreate her pain relief." Respondent documented he reviewed CURES reports, and he noted a pain agreement was in place. He also noted he obtained second opinions from pain management specialists, and these physicians were not interested in assuming Patient A's pain management care.

10. Respondent documented, under a section of the note captioned "Prescriptions Given," he prescribed to Patient A oxycodone (Percocet) with acetaminophen (10/325 #120 for a 20-day supply), OxyContin (20 mg, #60), and Lyrica, which he noted was not approved by Patient A's insurance in the past.[2] Patient A's

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[2] Percocet is the brand name for oxycodone and acetaminophen (10 mg oxycodone combined with 325 mg of acetaminophen). It 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 (B & P) Code section 4022. OxyContin is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to B & P section 4022. Lyrica is a Schedule V controlled substance pursuant to Health and Safety Code section 11058 and a dangerous drug pursuant to B & P section 4022. It is used to treat neuropathic pain for patients with peripheral diabetic neuropathy.

pharmacy records, however, document he also prescribed Patient A tramadol (# 90 for 22 days). He did not document in his July 9, 2019, note he wrote a prescription for tramadol.[3] For his plan, he identified tapering Patient A off of opioids, trying to get Lyrica reapproved, and following up with Patient A for evaluation every two to three weeks. The language in the plan, it is noted, is the same in all of respondent's progress notes.

11. On August 6, 2019, Patient A followed-up with respondent. Per respondent's note for this visit, respondent wrote prescriptions to Patient A for Percocet (10/325 mg, #120), morphine extended release (ER) (30 mg, #60),[4] and he "increased" the tramadol dosage (50 mg, #90), even though respondent did not identify in the July 9, 2019, medical record note that he prescribed tramadol to Patient A. His note does not explain why he increased this dose.

12. On September 3, 2019, Patient A returned to see respondent for her monthly visit. According to the note for this visit, respondent issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Also, according to records, a urine drug screen (UDS) was performed and per the toxicology report, Patient A tested negative for morphine. As noted below, Patient A did not start taking morphine ER until November 2019, according to CURES and her pharmacy records.

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[3] Tramadol, an opioid analgesic, is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d), and a dangerous drug.

[4] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug.

13. The note dated September 3, 2019, documents that respondent saw Patient A in his office and administered a trigger point injection to her.[5] He noted that Patient A's insurance no longer covered Patient A's OxyContin and oxycodone. The note documents he wrote in place of these medications a prescription for tramadol to help Patient A with neuropathic pain and noted he was "still fighting for Lyrica approval." A handwritten script dated September 3, 2019, shows that respondent wrote prescriptions for 120 pills of Percocet, 90 pills of 50 mg tramadol, and 60 pills of baclofen, a muscle relaxant. The note does not document he prescribed baclofen, Percocet, and tramadol to Patient A at this visit.

14. At Patient A's next visit, on October 1, 2019, the progress note indicates that respondent issued prescriptions to Patient A for Percocet, tramadol, and Lyrica. Details for these prescriptions were not indicated. Records for this visit do not indicate respondent addressed the inconsistent UDS result from the prior visit.

15. On November 5, 2019, according to the visit note, respondent wrote prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (15 mg, #30), and tramadol (50 mg, #90). Respondent stated that the morphine was prescribed on a trial basis to be taken "HS" or once a day. On this same date, Patient A picked up the prescription for morphine ER per CURES. This note is the earliest documented instance that shows Patient A picked up the morphine ER from the pharmacy.

According to a lab report, a UDS was performed on November 5, 2019. The screen was "run" by the lab on November 20, 2019, and the result for morphine was

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[5] Respondent's September 3, 2020, note is placed in Patient A's records next to the September 3, 2019, note documenting the trigger point injection he administered.

"negative." Respondent did not record the result in his notes or document discussing it with Patient A.

16. As documented in the December 3, 2019, progress note, Patient A told respondent the morphine is helping her "tremendously," and she can sleep through the night with less stiffness. Respondent continued Patient A on substantially the same medication regimen except that he increased the morphine dosage to "twice a day (BID)" from once a day, but his note does not document why he did this. He issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (15 mg, #60), and tramadol (50 mg, #90). The note for this visit again records that a UDS was performed. Per the result of this screen, which was collected on December 3, 2019, Patient A tested negative for morphine. Respondent's progress notes do not reflect that he acknowledged this result or discussed it with Patient A.

17. In the note dated January 7, 2020, respondent noted Patient A "is not sleeping and not functioning well at all." He wrote prescriptions to her for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Records for this visit again do not show respondent addressed the inconsistent urine drug screen result from the prior visit, even though Patient A obtained a refill from the pharmacy of the morphine for a 30-day supply on December 13, 2019.

The note records that respondent increased the morphine up to 30 mg a day and the tramadol to 50 mg as needed three times a day. The note does not record why he did this.

18. The February 4, 2020, progress note again shows that a UDS was done, and the lab results were again negative. It is noted that Patient A picked up the

prescription for morphine on January 19, 2020. There was no documentation of a discussion with Patient A about the UDS results.

19. On March 3, 2020, per records for this visit, respondent wrote prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). A UDS was performed, but the results are not recorded.

20. On April 1, 2020, respondent issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Per the note, respondent increased the tramadol to six times a day, but respondent does not record why he did this.

21. According to the progress note for April 28, 2020, respondent prescribed Patient A Percocet (10/325 mg, #120), morphine ER (30 mg, #60), tramadol (50 mg, #90) and Lyrica (50 mg, #90). In addition, per the note, a UDS was performed. Patient A's urine tested negative for morphine. Patient A had refiled the morphine prescription on April 1, 2020.

22. The progress note for May 5, 2020, records that respondent issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Records for this visit do not show respondent addressed the inconsistent UDS result from the prior visit.

23. In the visit note for June 2, 2020, respondent wrote that he prescribed Patient A Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Records for this visit do not show respondent addressed the inconsistent UDS result from the April visit.

24. On July 4, 2020, Patient A had a telemedicine visit with respondent. According to the note, respondent issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). The note does not indicate that respondent addressed the inconsistent UDS result from the April visit. Further, copies of respondent's prescription issued to Patient A for Percocet indicate a quantity of 100 pills was prescribed, rather than the 120 pills he recorded.

25. In the August 6, 2020, note, respondent documented he prescribed to Patient A Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). A UDS was performed. On this occasion, the result of this screen was positive for morphine, the first instance of a positive reading. On this date, Patient A signed a Pain Management Agreement.

26. Two days later, on August 8, 2020, Patient A saw respondent for another office visit. According to the note, respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Without explanation, he reduced the quantity of Percocet to 90 from 120 pills. According to CURES, respondent prescribed to Patient A Percocet in a quantity of 120 pills, not 90 pills. As noted, the actual script respondent wrote on August 6, 2020, was for 120 pills. No reason was given for increasing or decreasing Percocet. Records for this visit do not indicate respondent addressed the inconsistent UDS result from the prior visit or why he prescribed the same drugs only two days after previously doing so.

27. On September 3, 2020, Patient A returned to see respondent. The visit notes for this date record that respondent issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). A copy of respondent's prescription script he wrote for Patient A on this date indicates that he also prescribed Lyrica to Patient A, but he did not document this in Patient A's progress note.

28. In the October 1, 2020, progress note, respondent recorded he issued prescriptions to Patient A for Percocet (10/325 mg, #120), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Copies of respondent's prescriptions to Patient A on this date identify that respondent also wrote a prescription for Lyrica for Patient A, but respondent did not notate this in Patient A's progress note.

29. The October 29, 2020, progress note documents that respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Copies of respondent's prescriptions issued to Patient A on this date indicate that respondent wrote a prescription for Lyrica to Patient A, but he again did not document this prescription in Patient A's records. In addition, according to CURES and a copy of respondent's prescription script he wrote, respondent prescribed to Patient A Percocet in a quantity of 120 pills, not 90 pills.

30. On December 3, 2020, respondent recorded that he issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). He stated in the note that morphine ER was to be taken twice a day; however, per the pharmacy history report for Patient A, his prescription instructed Patient A to take the morphine three times a day. Copies of respondent's prescriptions issued to Patient A on this date indicate Lyrica was again provided to Patient A, but respondent did not record this in Patient A's record. As documented in a copy of respondent's prescriptions issued to Patient A on this date, respondent's prescription to Patient A for morphine ER for a quantity of 90, rather than 60 pills. Patient A picked up this prescription on December 13, 2020, as shown on the CURES report.

31. At Patient A's December 30, 2020, visit, the note states respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). However, the script he wrote shows he prescribed Percocet in a

quantity of 120 pills, not 90 pills, as he documented in his progress note for this visit. A copy of a script for morphine ER for this date is not found in the record.

32. For Patient A's January 28, 2021, office visit, respondent documented he wrote prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). According to CURES and a copy of respondent's prescription script on this date, respondent prescribed to Patient A Percocet in a quantity of 120, rather than 90 pills. Patient A, per her pharmacy records which were received as evidence, picked up 120 pills of the Percocet from the pharmacy for a 20-day supply.

There is not a script in the record for morphine ER for this date. However, a copy of a script for morphine ER dated January 12, 2021, shows that respondent prescribed 90 pills of 30 mg of this drug to Patient A, and he also prescribed Lyrica to her. An accompanying progress note for January 12, 2021, is not found in the record.

33. The progress note for Patient A's next visit, February 25, 2021, records that respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). According to the pharmacy's prescription history report for Patient A, Patient A refilled the prescription for Percocet on February 26, 2021, which respondent wrote for her for 120 pills of Percocet, not 90, as his note records. The prescription of Percocet was for a 30-day supply. Patient A also refilled a prescription for 90 pills of tramadol for a 22-day supply. On March 1, 2021, she refilled a prescription for 90 pills of morphine ER for a 30-day supply, per the pharmacy records.

34. Just eight days later, on March 4, 2021, Patient A saw respondent. Per the note for this visit, captioned as usual "Prescriptions Given", respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and

tramadol (50 mg, #90). There was no explanation of why these refills were given just eight days later.

35. Per the March 23, 2021, progress note, respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). Again, there was no explanation of why these refills were given just 19 days later.

36. On April 13, 2021, per respondent's progress note, respondent issued prescriptions to Patient A for Percocet (10/325 mg, #90), morphine ER (30 mg, #60), and tramadol (50 mg, #90). On April 14, 2021, Patient A obtained from the pharmacy 45 pills of tramadol for an 11-day supply. On April 16, 2021, Patient A obtained 90 pills of morphine ER for a 30-day supply from the pharmacy.

37. No progress notes were offered as evidence for the period after April 13, 2021, though allegations regarding respondent's treatment of Patient A refer to his prescriptions of opioids to Patient A through July 10, 2021.

38. For the period after April 13, 2021, respondent's prescriptions of opioids to Patient A are documented in Patient A's pharmacy records and CURES as follows:

On June 7, 2021, Patient A obtained 120 pills of Percocet for a 30-day supply, 90 pills of tramadol for a 22-day supply, and 90 pills of morphine ER for a 30-day supply.

On July 10, 2021, Patient A obtained 120 pills of Percocet for a 30-day supply, 90 pills of tramadol pills for a 22-day supply, and 90 pills of morphine ER for a 30-day supply.

39. Respondent's progress notes have the same language for Patient's A's symptoms and pain rating (9/10 without medication and 6/10 with medication, stiffness

in morning and possible fibromyalgia). The progress notes also have the same language for respondent's treatment plan, as mentioned earlier.

## TESTIMONY OF COMPLAINANT'S EXPERT, DR. JAMISON, REGARDING RESPONDENT'S TREATMENT OF PATIENT A

40. Complainant called Dr. Jamison as an expert to testify regarding respondent's treatment of Patient A and the other patients in this matter. Dr. Jamison is board certified in internal medicine and serves as Transitional Year Residency Program Director at Scripps Mercy Graduate Medical Education, where she oversees medical residents. She also works in a small private practice in San Diego. Dr. Jamison has been an expert reviewer for the board since 2022.

41. Dr. Jamison is familiar with the applicable standards of care and the definitions of extreme and simple departures from standards of care. In assessing whether respondent departed from any standards of care, she reviewed the evidence of record regarding Patient A, and she prepared a report summarizing her conclusions, which, for the most part, was consistent with her testimony.

42. With respect to Patient A, Dr. Jamison identified several issues where she found departures from standards of care: Her testimony is summarized as follows:

### Appropriate Dosing of Opiates and Referral to Pain Management Specialists

43. Dr. Jamison testified that the standard of care requires physicians to involve pain management experts for patients requiring high doses of opiates, if the Morphine Milligram Equivalent (MME) dose is above 80 or 90 mg. MME is used to equate different opioids into one standard value, based on morphine and its potency.

The standard of care further requires avoiding polypharmacy of opiates when using single short acting opiates for chronic pain.

Dr. Jamison concluded that respondent departed from the applicable standard of care because he did not refer Patient A to a pain management specialist while he was prescribing her high dose opioids, including two short acting opioids. Respondent was not an expert in pain management, and he was prescribing high dose opioids to Patient A. In her testimony, she said respondent increased the MME when he first inherited Patient A until February 2021. (During the hearing the parties spent considerable time addressing the MMEs and the accuracy of Dr. Jamison's calculation of the MMEs, depending on whether the prescriptions were for 30-day supplies or not. The issue is academic because respondent does not dispute that he was prescribing high dose opioids to each of the three patients at issue. The calculation was complicated by respondent's failure to document accurately the quantities of opioids, and opioids he was prescribing the patients, as discussed in this decision.) Respondent, however, agrees he was not a pain management expert, and he also does not dispute he was prescribing high dose opioids to Patient A.

Dr. Jamison further concluded that the departure from the standard of care constituted an extreme departure.

44. In reaching her conclusions, Dr. Jamison explained that Patient A needed to be referred to a pain management specialist because she was requiring higher levels of opioids, and she was not getting relief. Dr. Jamison felt it was unsafe for respondent to prescribe the two short acting opiates to her at the same time considering she was in her 60s and had multiple medical problems. As a result, Patient A was at a risk of respiratory depression due to the increasing doses of opioids respondent prescribed her

between January 2020 and February 2021. Dr. Jamison did not reference in her report respondent's prescriptions after February 2021.

45. Dr. Jamison also stressed, on this issue of the need to refer Patient A to a pain management specialist, that respondent said in his board interview he was not comfortable prescribing Patient A the opiates he was prescribing her, and he wanted to refer her to a specialist. Dr. Jamison commented that, based on her experience involving one of her own patients, she was able to find a pain management specialist after some persistence.

## Medical Record Maintenance and Periodic Review

46. Dr. Jamison also faulted respondent for his record keeping regarding Patient A and periodic review of those records. She identified the applicable standard of care for medical record maintenance and periodic review as follows: The standard of care requires the physician must maintain accurate and complete records demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation. Additionally, compliance monitoring must be done periodically to meet the standard of care.

Dr. Jamison found that respondent departed from this standard of care and committed an extreme departure when he failed to document inconsistent morphine toxicology results that showed respondent was negative for morphine despite the prescribing morphine to her. Her concern was that Patient A may have been hoarding the morphine or diverting it. As she put it in her testimony, considering her age and the risk of respiratory depression, these negative results warranted a discussion, and any such discussion was not documented in Patient A's chart.

47. In her analysis, Dr. Jamison cited respondent's August 6, 2019, note in which respondent documented he prescribed Patient A morphine 40 mg twice a day, but morphine was not seen on her toxicology result. Dr. Jamison found this result concerning because the note appeared to be erroneous per CURES, which shows that Patient A did not obtain morphine ER until November 2019.

At any rate, Patient A tested negative for morphine in December 2019 despite obtaining morphine in November 2019. As noted, respondent did not document that he discussed this result with Patient A at any time.

48. In addition, Dr. Jamison found that respondent committed a simple departure from the standard of care because he failed to accurately document his prescriptions of controlled substances to Patient A. She articulated the standard of care as follows: The standard of care requires the physician to maintain accurate and complete records demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed, and periodic review documentation.

49. Dr. Jamison stated respondent's notes in Patient A's record rarely changed, and the records did not reflect the actual treatment plan, and also his notes were inconsistent with the medications he prescribed to Patient A. She commented that inconsistent documentation was a "repetitive occurrence" throughout his records.

50. As an example, she cited respondent's August 6, 2019, progress note. In this progress note, respondent states he prescribed Patient A morphine ER in addition to tramadol and Percocet. But CURES and pharmacy reports show, as noted above, the morphine was not started until November 2019.

Another example she cited is respondent's December 3, 2020, progress note. The note states that Patient A was on morphine twice a day, but the prescription respondent wrote says she was to take morphine three times a day.

In another example Dr. Jamison cited, respondent did not document in his September 3, 2019, note that he prescribed the muscle relaxant baclofen to Patient A although he prescribed this drug to her per a September 3, 2019, handwritten prescription script for this drug.

Dr. Jamison further cited that respondent prescribed tramadol and Lyrica to Patient A on September 3, 2020, but he did not record this in the record.

In another example of respondent's inconsistent record keeping, Dr. Jamison pointed to respondent's October 29, 2020, note where he recorded that he wrote a prescription for 90 pills of Percocet. But in fact, he wrote a prescription that day for 120 pills of Percocet. Respondent also wrote a prescription for Lyrica, but he did not document he prescribed this drug to Patient A in his note.

## TESTIMONY OF RESPONDENT'S EXPERTS DRS. BERGER AND HELM REGARDING RESPONDENT'S TREATMENT OF PATIENT A

51. Respondent called as an expert Jack Berger, M.D.

Dr. Berger reviewed the applicable evidence of record in this matter and prepared a report regarding respondent's care of the patients at issue in this matter. He is familiar with the applicable standards of care, and the definitions of simple and extreme departures from standards of care. His testimony is materially consistent with the report he prepared regarding his evaluation of respondent's treatment of the three patients.

52. His testimony is summarized as follows: Dr. Berger received his M.D. degree in 1978 from the University of Bologna in Italy. He completed residencies in anesthesiology at Los Angeles County University of Southern California Medical Center in 1981, and at UCLA Medical Center in 1982. He became board certified by the American Board of Anesthesiology in 1984 with added qualifications in Pain Management in 1994, and by the American Board of Pain Management, an organization that disbanded in 2019. He has served as a consultant for the board, performed medical-legal evaluations, and served about 15 years ago as a reviewer for the Motion Picture Health Insurance for Anesthesia and Pain Management Claims reviews. Dr. Berger served as Professor of Anesthesiology, the Director of the Regional Anesthesia Resident Training, and Program Director for Regional Anesthesia Fellowship until 2020 at the Keck School of Medicine, University of Southern California (USC). He is now Professor Emeritus of Clinical Anesthesiology. He described himself as "divesting patients" as he approaches retirement. He sees about five patients. Dr. Berger has further served as Clinical Director of Pain Management at USC University Hospital and Norris Comprehensive Cancer Hospital and Chairman of the Department of Anesthesiology and Vice Chair at Charter Community Hospital, among other professional affiliations. Dr. Berger is a member of numerous professional societies in the field of pain management and has served in many leadership positions and on numerous committees. Dr. Berger has actively been involved in research in the field of pain management and has been the co-author of many published papers and abstracts through 2021, 20 or 30 articles have been published in in peer reviewed journals. He also has written book chapters for textbooks in the pain management field. Dr. Berger has been a frequent presenter in continuing medical education for health professionals in pain management.

Dr. Berger also teaches a course in a certificate program at USC in pain management. Respondent obtained a certificate from this program and attended one of the classes Dr. Berger taught.

**PATIENT A**

53. Dr. Berger considered respondent's treatment of Patient A to constitute only simple departures from the standard of care for record keeping. He testified he agreed with Dr. Jamison's assessment that respondent's record keeping was incomplete and constituted simple departures from the standard of care. In other respects, he does not agree with Dr. Jamison's opinions.

54. Before he addressed the issues Dr. Jamison identified with respect to Patient A, Dr. Berger began his testimony by noting that all three patients at issue in this matter were "legacy" patients respondent inherited, were opioid dependent, and they had developed tolerances to the opioids. He defined a legacy patient as a patient on high dose opioids whose pain management physician suddenly retired leaving the management of opioid prescriptions to another physician. This physician, Dr. Berger noted, per the board's recent guidelines on prescribing high dose opioids should not abandon such a patient. He commented that for such legacy patients a physician can rarely get them off opioids.

55. Dr. Berger stressed that the board recognized the challenge a physician faces who inherits such a legacy patient on high dose opioids. In this regard he cited the board's recent guidelines regarding prescribing opioids to patients. He cited this section from these guidelines:

> It is recognized that between the Board's death certificate project and the CDC 2016 Guidelines, a chilling effect was

felt and physicians became less willing to treat patients with chronic pain. This situation became significantly worse with the abrupt closure of 29 pain management centers in May 2021.

Approximately 20,000 patients were left without referrals or treatment plans resulting in potentially dangerous disruptions in care for patients receiving treatment with opioid therapy.

As the Board discussed the need to update the 2014 prescribing guidelines, it was emphasized that a change in tone was necessary to provide support and guidance to physicians to prescribe in a way that is effective for their patients and to also have enough flexibility to deal with pain patients that don't fall into the normal guidelines.

Aside from giving physicians more autonomy in treating their patients for pain, statutory changes had been enacted that needed to be integrated into the guidelines. The Board began the process of updating its guidelines by identifying physicians who practice medicine in various specialties including pain management specialists, family practice physicians, members of academia and others, to serve as subject matter experts and help the Board revise the guidelines. The goal was to provide resources and an updated structure for the management of patients being treated for pain.

(Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 2023, pp. 2-3.)

56. The difficultly, Dr. Berger testified, is that pain management specialists do not want to take these patients.

57. With respect to Patient A, other than the documentation issues, Dr. Berger did not agree with Dr. Jamison that respondent's failure to notate in Patient A's record that he discussed with Patient A the negative results on UDS for morphine constitutes a distinct departure from the standard of care for failing to discuss the results with Patient A and take appropriate action, as alleged in the pleading. Dr. Berger at the same time recognized these negative results could indicate diversion or not following the prescriptions for morphine.

58. Dr. Berger said that respondent discussed the inconsistent morphine UDS results with Patient A, even though respondent did not record these discussions in Patient A's record. Dr. Berger based his understanding on a discussion he had with respondent on October 20, 2023. Dr. Berger documented his discussion with respondent regarding these inconsistent results as follows:

> [Respondent] acknowledged he was aware of the discrepancies between his encounter prescriptions and CURES, because sometimes she could not fill her prescriptions.

Dr. Berger, thus, termed respondent's failure to document the discussion a documentation issue, not an issue regarding respondent's follow-up regarding the negative results as alleged in the pleading, and a simple departure from the standard of

care. Further, Dr. Berger did not explain when respondent became aware of these discrepancies.

59. In response to questions on cross-examination, Dr. Berger acknowledged that respondent's attorney helped Dr. Berger write the final version of his report, but he termed any suggested edits to the final version of his report "non-substantive."

Dr. Berger, in addition, acknowledged he did not review CURES reports for Patient A, or the other two patients in this matter.

60. Respondent also called as an expert in pain management Standiford Helm, M.D. Dr. Helm's testimony was limited to areas that Dr. Berger did not cover in his testimony.

Dr. Helm obtained his Medical Degree from Tufts University in 1977 and completed an internship in Internal Medicine at Boston City Hospital in 1978 and a residency at UCLA in 1980. He is a Diplomate of the American Board of Anesthesiology with a subspecialty certification in pain medicine. Dr. Helm is also a Diplomate of the American Board of Pain Medicine and a Diplomate of the American Board of Pain Physicians with competency and certification in regenerative medicine and in interventional pain. He has been a member of numerous societies in the field of pain medicine and has held leadership positions in them. Dr. Helm is on the editorial board of numerous publications in the field of pain management and medicine and has authored numerous peer reviewed articles and studies in the field of pain management. Dr. Helm is a clinical professor at the Division of Pain Medicine, Department of Anesthesiology and Peri-Operative Care at the University of California-Irvine. From 1984 to 2021, Dr. Helm served as the Medical Director of The Helm Center for Pain

Management in Laguna Woods and before that as staff anesthesiologist at Western Medical Center and Mission Hospital Medical Center.

Dr. Helm reviewed the materials of record in this matter and prepared a report, which was received as evidence.

61. In his testimony Dr. Helm stressed with respect to respondent's treatment of Patient A the difficulty physicians who treat patients on high dose opioids have in finding pain management specialists. He said there are not enough pain management specialists to treat these patients.

At any rate, Dr. Helm, like Dr. Berger, opined that respondent appropriately prescribed opioids to Patient A because a pain management specialist treated Patient A before respondent saw her. Accordingly, respondent did not need to refer Patient A to a pain management specialist. Dr. Helm also noted that respondent talked to two pain management specialists about Patient A.

62. Dr. Helm spent some time on direct and cross examination addressing Dr. Jamison's MME calculations for the opioids respondent prescribed Patient A. He said her calculations "were probably not" correct based on his review of her testimony because the timing of the prescriptions was for 30 days, not 20 days, and patients are expected to take the medications over 30-day periods, not 20 days, as CURES documents these prescriptions. Dr. Helm did not, however, dispute that respondent prescribed Patient A high dose opioids.

63. Dr. Helm agreed with Dr. Berger that respondent's prescriptions of opioids to Patient A were within the standard of care.

## PATIENT B

64. Respondent saw Patient B, a then 38-year-old female, between August 27, 2019, and April 27, 2020. As respondent documented in Patient B's August 27, 2019, progress note, Patient B saw respondent for an evaluation for chronic pain and opioid dependency. Patient B had a remote history of malignant carcinoma of the uterus and was status post-surgery with complications. She was scheduled for surgery in a few weeks.

65. Patient B was seeing a pain management doctor at a clinic where respondent worked, and that doctor had relocated to San Diego. When Patient B showed up for her appointment with that doctor, Patient B saw respondent instead.

Respondent identified Patient B's diagnoses as chronic pain, malignant neoplasm of the uterus, chronic radiculopathy, and opioid dependency. Respondent noted that Patient B was transitioning to a new pain management specialist due to problems she had with transportation.

66. Respondent reviewed CURES for his treatment plan for Patient B, he commented that due to her history and pending surgery, she was not a good candidate for pain medication reduction until she was stable. Respondent reviewed Patient B's previous medications and renewed Patient B's medications. He wrote prescriptions for Dilaudid (4 mg, #180) and fentanyl transdermal patches (50 mcg/hour, #10).[6] A UDS was performed in which Patient B tested positive for alprazolam, marijuana, and

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[6] Dilaudid is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and dangerous drug; fentanyl is a Scheduled II controlled substance pursuant to section 11055, subdivision (c), and dangerous drug.

morphine. Patient B was not prescribed alprazolam by respondent. Respondent noted the positive lab result for alprazolam with this notation: "Took one tab [illegible] a number of days ago."[7]

67. Patient B saw respondent next on October 8, 2019, for her monthly follow-up visit. In his note this date, respondent wrote that Patient B came to the CBI clinic where respondent worked because her insurance carrier transferred her pain management care to the CBI clinic. Other providers, he noted, were unable to write prescriptions for her because they did not have "active Medi-Cal numbers." Respondent discussed Patient B's care with two pain management physicians, who were affiliated with the clinic, Drs. Bohm and Fliegel. Respondent agreed to see Patient B for a number of months until she could transition to a pain management physician.

68. Respondent noted that Patient B took alprazolam, although as noted above she did not have a prescription for it. Respondent advised her against taking the drug without a prescription, and she agreed to not take someone else's anxiety medication.

69. Respondent recorded as his plan for Patient B that he spoke with the two pain management physicians mentioned above. For his plan, he slightly tapered Patient B's medications. He reduced the 4 mg Dilaudid to 150 pills and continued the prescription for fentanyl transdermal patches (50 mcg/hour, #10).

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[7] Alprazolam, the generic name for Xanax, is a benzodiazepine and Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and dangerous drug.

70. Patient B reported to respondent at her November 4, 2019, office visit that she was having difficulty "with the insurance company and other treating pain physicians," and she had "no access to other pain physicians on her insurance." Patient B also reported she was not tolerating the tapering of Dilaudid well and did not want further tapering. She reported her pain level as 9/10. Respondent did not document accurately that he increased the Dilaudid to 180 pills, per CURES. He reported in his note he maintained her at 150 pills. Also, according to the note, a UDS was performed, but the results were not documented. Respondent documented that "office toxicology" was requested.

71. As documented in Patient B's subsequent notes for office visits on December 3, 2019, January 7, 2020, February 4, 2020, March 3, 2020, April 1, 2020, and April 28, 2020, respondent recorded he issued prescriptions to Patient B for 150 pills of 4 mg Dilaudid, when he in fact provided Patient B with a quantity of 180 pills, per CURES. Respondent also did not document he wrote a prescription for trazadone for Patient B in his March 3, 2020, note.[8] Respondent documented in the December 3, 2019, January 7, 2020, and February 4, 2020, notes that "office toxicology was requested." The record documents that on November 5, 2019, and December 3, 2019, urine screens were done and sent to the lab. The results of these UDS are not part of the record, however.

72. Per his notes, respondent told Patient B, first in her March 3, 2020, visit with him, and again on April 1, 2020, he could no longer treat her in the absence of an adequately trained pain management physician.

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[8] Trazadone is an antidepressant and dangerous drug.

73. Respondent saw Patient B one last time on April 28, 2020. He noted that Patient B seemed to have been redirected to a pain management physician "finally." Respondent advised Patient B he would issue one final prescription and referred her to her primary care physician for this physician to find another pain management physician to continue her treatment. He told Patient B he was no longer comfortable writing her prescriptions for pain management due to "inadequate pain management evaluation in this clinic" and in the absence of her records from UC San Diego. Respondent's prescription for Dilaudid again incorrectly identified the quantity he prescribed as 150 pills when he prescribed to her 180 pills. He also did not record he stopped prescribing trazadone to Patient B.

Respondent noted that Patient B's "office toxicology urine" was "intact", meaning he found no discrepancies.

74. Patient B's records contain only one urine toxicology report. The report is dated August 27, 2019. Respondent, as mentioned above, documented that he requested office toxicology at Patient B's November 2019, December 2019, January 2020, and February 2020, office visits. Results of these, if done, are not part of the record.

75. Respondent did not obtain a pain management agreement with Patient B.

## TESTIMONY OF DR. JAMISON REGARDING RESPONDENT'S TREATMENT OF PATIENT B

76. Dr. Jamison identified these issues where she found respondent departed from the standards of care concerning his care and treatment of Patient B: Appropriate use of consultants; pain consent and management agreement; and not performing urine drug screens and acting upon discrepant toxicology results.

## Appropriate Use of Consultants

77. With regard to the first issue, respondent not referring Patient B to a pain management specialist, Dr. Jamison stated, as noted earlier, that the standard of care requires physicians to refer patients who require high dosages of opioids to experts in pain management. In her opinion, respondent departed from the standard of care because he did not refer Patient B to a pain management specialist, and she considers the departure to be extreme.

78. Dr. Jamison reached both conclusions because fentanyl and Dilaudid are generally prescribed to patients who have multi-disciplinary pain management programs managed by pain management specialists due to the high risks of addiction and complications from the use of both drugs. She felt respondent must have understood this because he felt uncomfortable caring for Patient B. Nevertheless, he still prescribed the two opioids to Patient B.

Dr. Jamison addressed respondent's consultation with Drs. Bohm and Fliegel at the clinic and whether this consultation constituted a referral. She described his discussion with them as a "curbside" discussion, and not a referral.

## Pain Consent and Management Agreement

79. Regarding the next issue Dr. Jamison identified: not obtaining a pain management agreement for Patient B, Dr. Jamison testified that the standard of care requires a pain management agreement if the patient is expected to take opioids for more than three months. She cited the board's 2014 prescribing guidelines for pain as requiring this. She added the standard in the community is to have such an agreement in place before any refills are given.

Respondent departed from this standard of care because he did not have such an agreement in place despite treating Patient B for 10 months. She identified the departure as a simple departure.

### Not Performing Urine Drug Screens and Acting Upon Discrepant Toxicology Results

80. Regarding the third issue Dr. Jamison identified: not performing urine drug screens and acting upon discrepant toxicology results, Dr. Jamison stated that the standard of care requires such testing at least every three months. Per the record, respondent obtained only one toxicology report for Patient B, with this result testing positive for both alprazolam and morphine. Both drugs were not prescribed to Patient B. She found the departure to be a simple departure from the standard of care both for not performing these tests at least every three months and also not acting on the discrepant results.

### Testimony of Drs. Berger and Helm Regarding Respondent's Care and Treatment of Patient B

81. Dr. Berger testified that he found no departures from the standards of care in respondent's care and treatment of Patient B. He regarded any issues as medical record documentation issues.

82. With regard to the issue of not obtaining for Patient B a pain management consult, like with Patient A, a pain management specialist was not available for such a referral. Dr. Berger said "it was nearly impossible" to find such a pain management specialist to see Patient B.

83. With regard to not having a pain management agreement in place, Dr. Berger said one was not required because respondent did not intend to continue taking care of Patient B. An agreement was necessary only for a long-term doctor-patient relationship. As he said in his testimony, no actual rule exists that requires a pain management agreement before the first, second, or third visits. In this context, he commented that respondent documented he did not feel it was reasonable to decrease her medications due to upcoming surgeries; thus, he was maintaining her on the opioid medication regimen, while she was waiting to have surgery, until she was transitioned to another provider.

84. With respect to the drug screen inconsistencies, Dr. Berger stated these were due to Patient B occasionally taking leftover medications, and respondent discussed this with her and cautioned her about this. Dr. Berger stated that the only inconsistent UDS was the positive result for alprazolam, and he felt respondent acted within the standard of care when he discussed this result with the patient. As Dr. Berger expressed it in his testimony, respondent did not need to have follow-up UDS because he trusted the patient.

85. Dr. Helm testified regarding respondent's treatment of Patient B, and as he testified in his analysis of Patient A, the record documents respondent tried very hard to get Patient B to a pain management specialist. However, he was unable to find one due to insurance barriers.

86. Concerning urine drug screens, Dr. Helm disagreed with Dr. Jamison that a specific mandate exists regarding the frequency of such screens. Such screens may be every six months unless there are issues. And respondent did address the issue regarding Patient B's use of alprazolam. In addition, Dr. Helm understood that

respondent obtained other UDS, which he documented in his notes, but the clinic records were not available to respondent.

### PATIENT C

87. On July 26, 2019, Patient C, a then 72-year-old female, saw respondent for a follow-up monthly visit. Patient C was a long-term patient of respondent's for about 15 years for various vascular issues. Her documented medical history included atherosclerotic coronary artery disease, kidney disease, poorly controlled diabetes, hypertensive heart disease, ischemic cardiomyopathy, ischemic peripheral vascular disease in both lower extremities, degenerative joint disease in her back, neuropathy, rheumatoid arthritis, and unstable angina symptoms prompted, as he documented in his progress note, by anxiety. He identified these diagnoses: significant degenerative joint disease of the back, extensive peripheral vascular disease with poor ambulation, significant peripheral neuropathy related to vascular disease and diabetic mellitus, diabetes mellitus "somewhat poorly controlled," and extensive coronary artery disease.

In 2019, respondent transitioned to become Patient C's primary care physician to treat her chronic pain. Her previous primary care physician was no longer treating her.

88. To treat Patient C's chronic pain, respondent prescribed her 120 pills of Norco[9] (10/325 mg, #120), and tramadol. The tramadol prescription, respondent noted, was pending insurance approval. He also prescribed Patient C Xanax (0.5 mg, #90). He advised Patient C regarding the risk in the use of Xanax, a benzodiazepine, with the

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[9] Norco is the brand name for the combination opioid hydrocodone with acetaminophen. It is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b), and a dangerous drug.

opioid Norco. Respondent documented that he reviewed CURES and reviewed monthly UDS. His plan was to taper Patient C's opioids. Respondent noted, however, that she was tapered from four pills to three pills a day of Norco, but Patient C was unable to tolerate the lower dosage of this drug due to discomfort. Respondent commented in the note that tramadol has been effective in treating her neuropathic pain.

Respondent documented that he recommended psychiatric and home health evaluations to Patient C, but she refused.

89. At Patient C's August 30, 2019, office visit, respondent issued prescriptions to Patient C for Norco (10/325 mg, #120) and Xanax (0.5 mg, #90). He advised Patient C regarding the risk inherent in the use of Xanax, a benzodiazepine, with the opioid Norco. As with the prior note, respondent recorded that a prescription for tramadol (50 mg, #60) was pending approval by Patient C's insurance, but per CURES, Patient C was able to fill respondent's prescription for tramadol this date.

90. Patient C returned to see respondent on October 4, 2019, and he prescribed Norco (10/325 mg, #120) and Xanax (0.5 mg, #90). The tramadol prescription was still pending approval by Patient C's insurance. But Patient C was able to fill respondent's prescription for the drug, according to CURES.

91. On October 30, 2019, respondent documented that Patient C's insurance approved tramadol. In addition to the prescription for tramadol, respondent prescribed to Patient C Norco (10/325 mg, #120), and Xanax (0.5 mg, #90).

92. In addition, though not documented in his note on this date, respondent also wrote a prescription for 200 pills of Virtussin (#200).[10] Virtussin is a medication that contains codeine and is commonly prescribed to treat coughing and chest congestion.

93. After October 30, 2019, respondent's progress notes for Patient C's monthly visits with him on December 2, 2019, December 26, 2019, January 24, 2020, February 21, 2020, and March 20, 2020, contain the same language as the notes identified above, including the language that Patient C's insurance finally approved tramadol. He continued to prescribe Patient C Norco (10/325 mg, #120), Xanax (0.5 mg, #90), and tramadol (50 mg, #60). He also prescribed to Patient C Virtussin (#200), but he did not notate he prescribed this drug to Patient C in his progress notes for these dates.

94. As documented in the progress note for Patient C's April 17, 2020, visit with respondent, respondent recorded that Patient C agreed to a "slight taper" of Norco. Respondent prescribed Norco (10/325 mg, #90), Xanax (0.5 mg, #90), and tramadol (50 mg, #60) to Patient C. But per CURES, respondent prescribed 120 pills of Norco to Patient C, not 90 pills as he documented.

Respondent also did not document, again per CURES, that he prescribed Virtussin (#200)to Patient C.

95. After April 17, 2020, until April 9, 2021, respondent documented in monthly progress notes he prescribed to Patient C Norco (10/325 mg, #90), Xanax (0.5 mg, #90), and tramadol (50 mg, #60) between May 18, 2020, and April 9, 2021. (These

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[10] Virtussin is a combination opioid containing codeine and acetaminophen, and a Schedule II controlled substance under Health and Safety Code section 11056, subdivision (e).

progress notes are dated May 18, 2020, June 24, 2020, July 8, 2020, July 29, 2020, August 21, 2020, September 18, 2020, October 14, 2020, November 18, 2020, December 14, 2020, January 13, 2021, February 12, 2021, March 10, 2021, and April 9, 2021.) He noted in each of these notes that Patient C agreed to the slight taper of Norco with the prescription for tramadol increased.

96. In each progress note, respondent documented Patient C was "[p]ositive for generalized anxiety disorder." Also in each progress note, he documented that Patient C had "anxiety provoked" unstable anginal symptoms. Respondent did not formally refer Patient C to a psychiatrist, or consult with a psychiatrist, although he recommended that Patient C see a psychiatrist, but she refused his recommendation.

97. A lab result dated March 15, 2021, shows that Patient C had poorly controlled diabetes with an A1C level of 11.7. (Respondent in his notes described her diabetes as "somewhat poorly controlled.") To highlight the abnormal result, respondent circled this number. However, he did not record he discussed this result at Patient C's next visit on April 9, 2021, or at any time.

98. Respondent's records for Patient C do not include documentation of urine drug screens being performed, or results of screens, although respondent's notes indicate that monthly UDS were performed.

99. At every visit, respondent documented that Patient C had tenderness to deep palpation along her spine.

100. From July 26, 2019, until on or about April 9, 2021, throughout respondent's care and treatment of Patient C, respondent did not consult with a psychiatrist regarding the long term and high dose prescriptions of Xanax he provided

to Patient C, who was at the time elderly and simultaneously receiving multiple opioid prescriptions.

## TESTIMONY OF DR. JAMISON REGARDING RESPONDENT'S TREATMENT OF PATIENT C

101. Dr. Jamison identified the following medical issues where she found departures from standards of care:

### Respondent Failed to Perform a Thorough Assessment and Evaluation of Patient C's Source of Pain to Determine the Appropriate Use of Narcotics to Treat Patient C's Pain

102. Dr. Jamison stated that respondent departed from the standard of care with respect to his assessment and evaluation of Patient C to determine the appropriate use of opioids to treat her pain. She articulated the standard of care to require a physician to fully assess the patient, identify his or her medical history, identify prior successful and failing treatments and co-existing conditions or risk of addiction. The physician is also to conduct a focused physical exam to evaluate the patient's pain. The standard of care further requires reviewing the indications for the use of opiates as opposed to non-opiate treatment options for pain control.

Dr. Jamison found that respondent departed from this standard of care because he did not adequately assess Patient C's possible sources of her pain, and he did not consider non-opioid alternatives. She found this departure to be a simple departure.

103. Dr. Jamison stated that Patient C's leg pain, as Patient C described it, was likely due to diabetic neuropathy. Dr. Jamison stated that Patient C had uncontrolled

diabetes as confirmed by March 15, 2021, A1C reading of 11.7. She stressed that diabetic neuropathy is not treated with opioids. It is managed through different modalities including neuropathic agents and proper diabetic management.

104. Dr. Jamison also noted that the tenderness on palpation to Patient C's back that respondent identified in his physical exam warranted further evaluation for potential causes of pain. This tenderness on palpation could indicate spinal fracture, fibromyalgia, myofascial pain, or muscular pain, and these conditions are generally not treated with narcotics; they are best treated with local treatment, physical therapy, or non-opiate medications.

## Respondent Failed to Consult with a Psychiatrist Regarding His Long-Term Prescribing of High Dose Xanax

105. Dr. Jamison in addition identified as an issue respondent's need to consult with a psychiatrist in light of the Xanax he prescribed to Patient C. She identified the applicable standard of care here as follows: The standard of care requires that, for patients with significant mental health diagnoses and who require further management, these patients should receive appropriate psychiatric consultative resources. Mental illnesses that complicate narcotic usage include generalized anxiety, panic disorder, substance abuse, or addiction disorders.

Respondent departed from the standard of care because he did not consult with a psychiatrist despite prescribing Xanax in dosages of three times a day to Patient C due to her anxiety, along with high dose opioids. Dr. Jamison found the departure to be a simple departure.

106. Dr. Jamison reached this conclusion due to Patient C's advanced age of 72 at the time, that Patient C was "very sick" in her view, and the combination of Xanax and

opioids placed her at high risk of "profound and life-threatening sedation," respiratory depression, reduced mental status, and falls. Dr. Jamison stressed the need to be very careful when prescribing benzodiazepines to elderly patients. In this regard she cited two "black box" warnings regarding prescribing benzodiazepines with opioids to elderly patients that the Food and Drug Administration has issued. [11]

107. In support of her conclusion on this issue, Dr. Jamison highlighted several factors. She stated that respondent's notes do not reflect he sought psychiatric consults for Patient C, although he said in his interview that he tried to refer her multiple times. His progress notes only state Patient C refused a psychiatric referral. Respondent, in his notes, does not indicate he explained the importance to Patient C of the need for this referral. As Dr. Jamison stated, it is common practice to let a patient know of the dangers of using opiates and benzodiazepines together and to suggest the patient either get a psychiatry evaluation or stop using the dangerous combination. This would allow the patient to understand the gravity of the danger and often helps the patient to agree to a psychiatric consultation. Respondent should have insisted Patient C either see a psychiatrist, or he should have stopped prescribing the Xanax to her, with an appropriate taper.

108. Dr. Jamison, further, felt that respondent did not seem to understand the complexity of the Xanax medication he prescribed to Patient C for treating her anxiety. At his HQIU interview, respondent said "I don't have that answer" to the question

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[11] Boxed warnings (formerly known as Black Box Warnings) are the highest safety-related warning that medications can have assigned by the Food and Drug Administration. These warnings are intended to bring the consumer's attention to the major risks of the drug. <https://www.ncbi.nlm.nih.gov/books/NBK538521/>

whether long-term use of Xanax is indicated for anxiety. Respondent also said in this interview, he did not feel comfortable tapering her Xanax without a psychiatrist's help. But he continued to prescribe Xanax to Patient C anyway without consulting a psychiatrist.

### Medical Record Maintenance and Periodic Review

109. In the third issue Dr. Jamison identified, medical record maintenance and periodic review, the applicable standard of care is the same she discussed with respect to Patient A. The standard of care requires the physician must maintain accurate and complete records demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation. Additionally, compliance monitoring must be done periodically to meet the standard of care.

Respondent departed from the standard of care on this issue because his notes essentially are an exact copy of each other except for changes to the reason for Patient C's visits or her vital signs. Notably, the physical exam respondent documented did not change between 2019 and 2021. The notes also contain the exact wording used in May 2020 and April 2021 that Patient C agreed to a slight taper, but the doses he prescribed did not change. Dr. Jamison further noted that the records lack periodic drug screening to confirm compliance. Dr. Jamison found the departure to be a simple departure.

### Testimony of Drs. Berger and Helm Regarding Respondent's Treatment of Patient C

110. Dr. Berger found that respondent met the standard of care in his care and treatment of Patient C except for his documentation of Patient C's chart.

111. Concerning the first issue Dr. Jamison identified: respondent's failure to perform a thorough assessment and evaluation of Patient C's source of pain to determine the appropriate use of narcotics to treat Patient C's pain, Dr. Berger disagreed that respondent departed from the standard of care. He believes respondent did a thorough assessment of Patient C's source of pain based on his history of treating Patient C since 2008 for vascular issues. Dr. Berger, moreover, did not disagree with respondent's prescriptions and dosing of the mediations he prescribed, including the combination of Xanax, opioids, and Virtussin.

112. Concerning the issue of respondent's medical review and documentation of his care and treatment of Patient C, he agreed there are documentation issues, but Dr. Berger stressed here he does not have a concern regarding respondent's treatment of Patient C. Respondent should have done a better job documenting why he added or changed medications. But he said that the fact that something is not documented does not mean the treatment did not take place.

113. Dr. Helm testified with respect to respondent obtaining a psychiatric consult for Patient C. In this respect he saw two issues: A psychiatrist may not have been available for Patient C within her network and, second, the request for the benzodiazepine came from Patient C's cardiologist. Fundamentally, Dr. Helm did not agree a psychiatric consult was needed because the "driving force" for the benzodiazepine was from Patient C's cardiologist.

114. Dr. Helm also addressed the issue whether respondent was required to obtain UDS from Patient C, and how often he should have obtained these screens. Dr. Helm stated that there is no specific mandate regarding obtaining UDS screens in a patient who is receiving opioids. But, he said it should be done every six months, or if there are any issues, more frequently. He said the board's 2014 guidelines do not apply

as the standard of care for a physician who is not a specialist in pain management, although he admitted on cross-examination that he testified in another hearing that the guidelines reflect the standard of care.

## SUMMARY OF ALLEGATIONS REGARDING RESPONDENT'S ALLEGED FAILURE TO COMPLY WITH THE TERMS OF HIS PROBATION

115. Complainant argues that respondent violated seven conditions of his probation (Conditions Nos. 1 to 3, 5, 6, 7, and 9). Evidence in support of complainant's contentions consists of records from respondent's probation file, the testimony of respondent's probation monitor, Kimberly Andrew, Sandra Borja, Staff Services Manager at the board, and a Locum Tenens agreement respondent purportedly signed with a physician, who was subject to board probation. The following summarizes this evidence:

### PROBATION CONDITION NO. 1

116. Probation Condition No. 1 states as follows:

> 1. 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 20 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 45 hours of CME of which 20 hours were in satisfaction of this condition.

117. Respondent did not comply with this condition. He did not submit proof that he completed 45 CME "Category I certified" hours by August 29, 2021. Respondent was required to provide proof that he completed these CME course by August 29, 2021, which was the end of the second year he was on probation. Ms. Andrew in a letter dated September 10, 2021, informed him that he was not in compliance with this requirement, and he had until September 15, 2021, to comply with this condition. Before this date, respondent submitted CMEs to Ms. Andrew, which she rejected because she found 11.75 hours of them to be duplicates. Respondent then completed the additional 11.75 hours on September 10, 2021, and submitted the certificates to Ms. Andrew on this date. On September 20, 2021, Ms. Andrew acknowledged she received these certificates as a matter of respondent's compliance with Condition No. 1 for the 2020-2021 probation year.

**PROBATION CONDITION NO. 2**

118. Probation Condition No. 2 states:

2. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the

program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

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

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length

of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

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

119. Respondent successfully completed the University of California-San Diego's Physician Assessment and Clinical Education (PACE) program. But as

documented in PACE's report, PACE had concerns regarding his ability to practice pain management medicine and recommended that respondent discontinue "refilling medications for conditions you are not monitoring." PACE, further, recommended that respondent complete the USC Master's program in Pain Management, take education courses in this area, and return to be reassessed to determine his competency in this area.

120. In a letter dated May 12, 2020, the board advised respondent that he was to discontinue to practice pain management or the practice of refilling medications for conditions he was not monitoring until PACE assessed him. This letter also advised respondent he was to stop practicing pain management or the practice of refilling prescription medications for conditions he was not monitoring until he returned for an assessment in Pain Management by PACE. Respondent did not return for this assessment.

121. Respondent continued to practice pain management, per the report of his practice monitor, Lynette Cederquist, M.D. Dr. Cederquist served as respondent's practice monitor through PACE's Practice Enhancement Program (PEP). As referenced in the board's Quarter IV report for the October through December 2020 time period, Dr. Cederquist noted that respondent had about 10 to 15 patients for whom he was prescribing opioids, but he was making strides in getting them transferred to other providers. She commented that these patients were at respondent's Indio clinic in an area with few resources and limited access to providers.

122. Sandra Borja, Staff Services Manager in the probation unit, in a December 22, 2022, email to respondent's attorney, summarized PACE's recommendation that respondent discontinue "refilling medications for conditions you are not monitoring" this way: PACE made this recommendation in a letter dated May 12, 2020.

Respondent, Ms. Borja said, needed to comply with this recommendation per Condition No. 2 within 30 days. At some point after this date, his monitor, Dr. Cederquist, discussed with respondent a plan to taper the patients down or off opioids within six months. Dr. Cederquist discussed with him on March 19, 2021, that he needed to stop practicing chronic pain management and opioids in his practice.

123. On June 17, 2021, respondent's former attorney, John Harwell, sent a letter to Ms. Borja, and asked her for a dispensation to continue to treat these patients. He stated respondent needed to continue to treat these patients as a matter of their health and welfare and felt to do otherwise would be to abandon them which respondent did not want to do.

124. In response, Ms. Borja, in an email to Mr. Harwell dated June 22, 2021, gave respondent until June 25, 2021, to comply with PACE's recommendations. She wrote that "he must work to transfer all pain patients" to another physician by June 25, 2021. She noted, further, that respondent would be given "no additional extension of time" to comply with the recommendations.

125. Respondent completed the USC Pain Management program and obtained a certificate and master's degree from that program. He did not, however, return to PACE for further assessment to determine his competency in the area of pain management.

**PROBATION CONDITION NO. 3**

126. Probation Condition No. 3 requires respondent to have a practice monitor and make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and to retain the records for the entire term of probation.

As alleged, respondent failed to timely make his patient list and records available to PEP and Dr. Cederquist in June 2020.

127. In a letter dated July 17, 2020, Ms. Andrew informed respondent that PEP did not receive his charts for June 2020. Respondent offered into evidence an email PEP sent to him dated July 10, 2020. In this email PEP acknowledged receipt of this patient list and asked respondent for the patient records PEP had identified from the list he had sent. It seems to have been the practice at PEP to select the patient charts it wanted respondent to provide the program based on the patient list respondent sent. The patient charts and lists for June 2020 were not sent together. This understanding is confirmed in an email dated August 3, 2020, in which PEP advised respondent to provide the patient charts it had identified from the list he provided. Other than the patient list for June 2020, respondent timely submitted the lists to PEP, per Ms. Andrew.

### PROBATION CONDITION NO. 5

128. Complainant asserts that respondent violated Condition No. 5, which requires him to notify his employer of his discipline. This condition states:

> 5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Third Amended 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.

129. Complainant asserts that respondent did not comply with this condition because he was working locum tenens at a clinic and did not provide the Chief Executive Officer or Medical Director of this clinic with the Decision and Third Amended Accusation.

130. Complainant relies on an agreement between Rim Marcinkus, M.D., and respondent entitled Locum Tenens Independent Contractor Agreement. The board learned about this agreement because Dr. Marcinkus was under board probation and the board discovered this agreement. However, it did not provide respondent with this agreement until the hearing, and it was admitted over respondent's objection.

131. The agreement contains the signatures of both Dr. Marcinkus and respondent and is dated May 17, 2022. It is for the time from May 21, 2022, to August 18, 2022. It obligates respondent to assume Dr. Marcinkus's responsibilities at his medical office during Dr. Marcinkus's absence. Respondent did not provide the board with proof that he had gave Dr. Marcinkus a copy of the Decision and Third Amended Accusation.

132. As discussed later in this decision, respondent testified he did not sign the agreement. In an email string dated October 7, 2022, and October 10, 2022, between respondent and Ms. Andrew, respondent expressed surprise such an agreement was in place, he denied he had a locum tenens agreement, and he asked Ms. Andrew for a copy of it. She refused to provide it.

## PROBATION CONDITION NO. 6

133. Probation Condition No. 6 requires respondent to obey all federal, state and local laws. Complainant asserts that respondent violated this section because he was cited for speeding in violation of Vehicle Code section 22349, subdivision (a), on July 2, 2020. Respondent included the citation in his quarterly submission to the board at the time.

## PROBATION CONDITION NO. 7

134. Probation Condition No. 7 requires respondent to submit quarterly declarations no later than the 10th day after the quarterly reporting period. Ms. Andrews acknowledged that because quarterly declarations needed to be mailed, the declarations submitted were a little late. As alleged, he failed to submit timely declarations for the third quarter of 2019, first quarter of 2020, first quarter of 2022, second quarter of 2022, and third quarter of 2022. Per a tracking form, respondent's third quarterly declaration was received by the board on October 11, 2019; the first quarterly declaration for 2020 was received on April 13, 2020; the first quarterly declaration for 2022 was received on April 11, 2022; the second quarterly declaration for 2022 was received on July 11, 2022; and the third quarterly declaration was received on October 14, 2022, all of which were received late.

## PROBATION CONDITION NO. 9

135. Probation Condition No. 9 requires respondent to be available upon request for an interview with the board either at respondent's place of business or at the probation unit office. Complainant asserts that respondent violated this section because he failed to attend a board interview on June 1, 2022. A letter addressed to respondent dated May 18, 2022, notified respondent that this interview was to take place on June 1,

2022, at the board's San Dimas office. It is noted that there is not a proof of service attached to this letter. Respondent did not appear on this date. Ms. Andrew sent respondent a non-compliance letter dated June 1, 2022, and respondent replied. In an email at 12:08 p.m. on June 1, 2022, to Ms. Andrew respondent asked her to provide him with her email to him confirming this date. An interview was then rescheduled, after a series of communications between respondent, Ms. Andrew and respondent's attorney, for June 22, 2022. Respondent attended that interview.

## Respondent's Testimony

136. Respondent's testimony is summarized as follows:

Respondent obtained his medical degree in 1979 from McGill University in Canada. He completed a surgical internship in 1980 at the University of California-San Diego, and a residency in surgery at the University of California-Irvine in 1983. He practices medicine in El Centro.

137. Respondent saw the three patients at issue in this matter at the clinic where he was working at the time, CBI, which was a multi-specialty clinic and heavily involved, as he put it, in pain management. He was not there as a pain management physician. He rented space at CBI. His role was to perform minor procedures such as trigger point injections. He stopped affiliating with CBI in 2019. CBI had two locations, one in Indio and one in Brawley. Respondent saw patients A and B at the Brawley clinic location. He saw Patient C at the Indio clinic location. He had been treating Patient C for 15 years.

Respondent cannot now access medical records because the clinic closed and has changed names. For Patients A's and B's records, he has his personal records of their care, but the clinic maintained other records he cannot access.

138. For the last 9 to 10 years, respondent has had an office-based practice where he does mostly consultations for patients with diabetes. He does not consider himself to be a primary care doctor; he provides supplemental primary care; most of his patients have a second or third doctor. He sees a lot of urgent care patients. Respondent does not plan to practice pain management medicine.

139. Respondent discussed the care he provided each of the patients, and the challenges he faced treating their chronic pain. He acknowledged up front that his documentation of the records for all three patients was insufficient. He now understands that for pain management patients, the records need to be exhaustive for a subsequent provider to follow and treat the patients. He believes he has improved his record keeping with Dr. Cederquist's help.

**PATIENT A**

140. With regard to his treatment and care of Patient A, respondent testified he started treating her after her doctor "disappeared." He assumed her care because no one else was available at the clinic. Respondent said Dr. Bohm at the clinic was her previous pain management doctor.

141. Respondent described Patient A as very articulate, functioning, and stable on the medication regimen and dosages she was taking. He acknowledged she described her pain levels as "9/10" throughout her record. He further noted that she was taking opioids for 20 years and was dependent on them. Respondent said he could not reduce the opioids because the opioids she was taking were keeping her "functional." He prescribed Lyrica as a medication alternative to opioids in effort to reduce the dosages of opioids she was taking due to the "synergistic" effect of the combination of medications.

142. Respondent said he tried to replace the OxyContin she was taking and lower her MMEs, but she came back "miserable" despite his efforts to lower the MMEs due to "breakthrough pain."

Patient A was finishing the morphine early; the prescription was supposed to last 30 days, which is why, in his view, she was testing negative on the UDS. He said she was not taking the morphine on a "consistent" basis. Respondent said he was not concerned that Patient A was diverting the morphine because, as he put it, morphine is not a diversion drug. He acknowledged the negative UDS results were concerning, and he admitted he should have documented the negative morphine results in her records.

143. Respondent disagrees with the assertion that he failed to refer Patient A to a pain management specialist. He said a pain management specialist was not available.

He also disagrees he did not have her submit to regular UDS.

**PATIENT B**

144. With regard to his treatment and care of Patient B, respondent said she was in need of a pain management physician, she had multiple medical issues, including a history of cancer, abdominal wall fistulas, and out of control diabetes. She came to the clinic from a pain management specialist, Advanced Pain Associates in El Centro. He was familiar with the pain management specialist who worked there and considered him to be a very good specialist in the field of pain management. He had the pain management records from that doctor's office. Respondent said Patient B was having insurance and transportation issues that made it difficult for her to continue to see that physician. He discussed her with Drs. Bohm and Fliegel, who worked at the clinic and were pain management specialists. But they did not agree to take over her care, and they did not advise him on how to take care of Patient B.

145. Respondent said Patient B was very stable on the medication regimen she was taking; she was taking the medications a year before she saw him. He agreed to treat her until she could find a pain management specialist, and until her surgeries and cancer treatment were completed. After her surgery, respondent said he planned to taper her dosages, but her surgery kept getting delayed.

146. Respondent testified he did not enter into a pain management agreement because he did not intend to treat her for more than a month or two. At some point, he recognized he was not able to transition her to a pain management specialist because no such doctor was at the clinic, who could take over her care. He said that this was due in part because he was the only physician who had a "Medi-Cal number" that allowed him to prescribe medications to Patient B.

Respondent agreed he was uncomfortable with Patient B's medications and dosages because the combination of medications she was taking was not what he would want to see in a young patient. But even though he was uncomfortable, he continued to treat her because Patient B had nowhere else to go considering the medications she was taking, including fentanyl.

147. Respondent stopped treating Patient B because her primary care physician resurfaced, and respondent could not continue to treat her with no surgery being performed.

**PATIENT C**

148. With regard to his care and treatment of Patient C, she had been his patient "forever" until she passed away last year. He started seeing her in 2007 due to ischemia in her legs and diabetes. An internist had referred her to him. He did not

consider himself her primary care doctor, however. Respondent did not treat her pain until 2019.

149. Respondent testified that he did not start Norco and Xanax for Patient C. She was already on these drugs when she saw him in 2019. He said this was not the "right combination," but he was reluctant to stop the Xanax because stopping Xanax was harder than stopping opioids.

150. Respondent said that anxiety episodes can provoke heart disease and Patient C had a significant history of heart disease and heart attacks. Her cardiologist recommended that she continue on "current cardiac and non-cardiac medications" as this cardiologist wrote in a report dated February 18, 2021. (Respondent, it is noted, continued the Xanax in 2019.) Patient C's prior primary care doctor, Dr. Pham, prescribed the Xanax to her.

151. Concerning his failure to obtain a consult from a psychiatrist, respondent said that psychiatrists rarely took Patient C's insurance, and he could not get her to agree to see a psychiatrist. He said staff at the clinic called Patient C's insurance and could not obtain approval for a psychiatrist.

152. With respect to Dr. Jamison's opinion that he did not do a thorough assessment of Patient C to find a source of her pain and treat it, respondent said his examinations were shorter. But he had been treating her for 12 years, and he understood that she had terrible circulation and other medical conditions.

153. Concerning why he did not document the cough syrup Virtussin to Patient C, respondent said he did not have a good response.

## ALLEGATIONS REGARDING PROBATION VIOLATIONS

154. Respondent addressed each of the causes to revoke his probation, the problems he had with compliance, and efforts he made to comply with the terms of probation. He has been on probation since 2019.

155. With respect to the issue of his failure to comply with the CME requirements, under Probation Condition No. 1 respondent described the problem as a misunderstanding. Respondent commented that he made his best efforts to comply with this requirement and went above and beyond the requirement.

Respondent said at issue was 20 additional hours of CME, and he thought he could meet his CME requirements by the 360 hours of courses he took at USC's pain management program. He did not realize the courses needed to be certified as "Category 1" courses to meet the requirements. He was informed that the courses were not "Category 1" in a July 13, 2021, email. He submitted CMEs to Ms. Andrew on September 7, 2021. The CMEs were due on August 29, 2021. Respondent completed the CMEs, but Ms. Andrew determined that the CMEs had 11.75 hours of duplicates and rejected these courses. Respondent completed the additional 11.75 hours on September 10, 2021, and submitted the certificates to Ms. Andrew. As a matter of his compliance with Condition 1 for the 2020 - 2021 probation year, Ms. Andrew acknowledged receipt of these in an email she sent to respondent on September 20, 2021.

156. With regard to Probation Condition No. 2, the requirement that he comply with PACE's recommendations, respondent believes he did not violation this condition. At issue here, as discussed, is whether respondent failed to comply with the recommendation that he stop practicing pain management until he completes

additional training and demonstrates competency in this area. Ms. Andrew notified him that he was to stop refilling prescriptions for pain for conditions he was not monitoring. Dr. Cederquist, his PEP practice monitor, recommended that he stop practicing pain management until he receives additional training.

157. Respondent testified the board granted him a special dispensation at the request of his then attorney, John Harwell, to continue to treat pain patients. Mr. Harwell made this request in a letter he sent to Sandra Borja, Staff Services Manager, on June 17, 2021. He stated respondent needed to continue to treat these patients as a matter of their health and welfare and felt to do otherwise would be to abandon them, which respondent did not want to do.

158. Ms. Borja, in an email to Mr. Harwell dated June 22, 2021, gave respondent until June 25, 2021, to comply with Dr. Cederquist's recommendations. She wrote that "he must work to transfer all pain patients" to another physician by June 25, 2021. She noted further that respondent would be given "no additional extension of time" to comply with the recommendations.

159. Respondent stopped treating pain patients by June 25, 2021, the extension date. Respondent testified he stopped practicing pain management entirely.

160. Further, because respondent is no longer practicing pain management, he does not believe he is required to undergo additional PACE training because he was required to do so only if he intended to continue to practice pain management.

161. With regard to Probation Condition No. 3, which alleges that respondent did not timely submit his monthly patient list and patient records for June 2020 to his PEP monitor, Dr. Cederquist, respondent acknowledged a delay in sending his notes because his dictation transcriber fell ill at that time. He said the delay was not long. The

PEP program acknowledged receipt of this patient information in an email to him dated July 10, 2020. In this email, PEP identified the patient charts it wanted to review. This suggests that respondent sent the patient list well before July 10, 2020, so that PEP could identify the patient charts it wanted to review.

162. Respondent commented that PEP did not send him a notice that the patient list and records were not timely for June 2020.

163. Regarding his alleged violation of Probation Condition No. 5, which requires respondent to submit timely proof that he provided a copy of the board's decision and Third Amended Accusation to the Chief of Staff or Chief Executive Officer where respondent was locum tenens to Dr. Marcinkus, respondent vigorously disputes that he signed the Locum Tenens Independent Contractor Agreement with Dr. Marcinkus.

Respondent testified he did not sign the agreement, and he questions the authenticity of the signature on this agreement. The board had obtained this document from Dr. Marcinkus's disciplinary probation file, and complainant did not provide a copy of it to respondent until the hearing when it was introduced over respondent's objection and admitted. Respondent, it is noted, asked for this agreement before the hearing but complainant told him that he could not provide it to him.

Respondent explained that he agreed to see Dr. Marcinkus's patients while Dr. Marcinkus was suspended from practicing medicine, due to board discipline. But he saw only two patients at respondent's clinic location in Indio, not at Dr. Marcinkus's office. Locum tenens, respondent pointed out, means to replace the physician at his location. He said he would not agree to see patients at Dr. Marcinkus's office location.

164. With regard to Probation Condition No. 6, which requires respondent to obey all laws, on July 2, 2020, respondent was issued a speeding ticket. The only information in the record is a copy of the Superior Court notice to respondent to pay the citation which respondent provided to Ms. Andrew. Respondent testified he successfully completed traffic school for the speeding ticket and the citation was dismissed.

165. With regard to Probation Condition No. 7, which relates to the submission of timely quarterly declarations, and the assertion he violated this condition, respondent denied he failed to submit the declarations timely.

The declarations were due by the 10th of each month after the quarter. Ms. Andrews, as mentioned above, acknowledged that because quarterly declarations needed to be mailed, probationers submitted the declarations a little late. Respondent submitted into evidence copies of quarterly declarations he signed for the third quarter of 2019 on October 9, 2019, the fourth quarter on January 6, 2020, the first quarter of 2020, on April 9, 2020, the second quarter of 2020 on July 8, 2020, the third quarter of 2020 on October 8, 2020, the fourth quarter on January 7, 2022, the first quarter of 2022, on April 8, 2022, the second quarter of 2022 on July 8, 2022, and the third quarter of 2022 on October 8, 2022, all of which were before the 10th. He testified that he sent each of these by FedEx ground or overnight before the 10th of the month. He testified probation never notified him the declarations were not timely.

166. With regard to Condition No. 9, which requires respondent to be available upon request for a board interview, either at respondent's place of business or at a probation unit office, the allegation is that respondent did not attend a scheduled interview on June 1, 2022, for the "Quarterly II" time period. Respondent disagreed he violated this requirement.

167. Respondent testified he did not "refuse" to attend the interview; he asked that it be rescheduled, which it was. He said he did not receive the email or other communication advising him of the "Quarterly II" June 1, 2022, interview. On June 1, 2022, once he learned Ms. Andrew claimed he missed his interview, he reached out through his attorney to Ms. Andrew and Ms. Borja to reschedule it. Ms. Andrew sent him a notice dated June 1, 2022, that "rescheduled" the interview for June 16, 2022. On June 15, 2022, at 1:11 p.m., Ms. Andrew sent respondent an email where she rescheduled the interview for June 22, 2022, at the board's probation unit office. It does not appear she discussed rescheduling this with respondent. Respondent attended that interview at the board's probation unit office.

168. The record shows there was confusion regarding the June 1, 2022, date of the "Quarterly II" interview. Originally, Ms. Andrew scheduled the interview for June 23, 2022, at the probation unit office, per an email Ms. Andrew sent to respondent on May 18, 2022, at 9:42 a.m. She asked him to confirm his availability for that date by close of business, which he did. Respondent in email stated he was not available. Ms. Andrew then sent another email, at 11:43 a.m. scheduling the interview for June 1, 2022. Respondent did not confirm his availability for that date. Both emails Ms. Andrew sent had the subject heading "*Correction* 2022 Qtr. II Interview." She sent respondent a letter confirming the time and place of this interview on June 1, 2022.

## Testimony of Other Witnesses

169. Respondent called several witnesses: Valerie Gutierrez, who is a medical assistant at respondent's medical office, Karla Barajas, who worked with respondent at CBI, and Donald Torigian, respondent's patient.

170. Ms. Gutierrez testified that she has worked with respondent for over 20 years. She works both as his medical assistant and office assistant at his Indio office. As part of her duties, she is responsible for scheduling patients. She sees documents that pertain to respondent's schedule, and she never saw the locum tenens agreement respondent purportedly signed with Dr. Marcinkus. She was never made aware of such an agreement. Moreover, she never scheduled respondent to see patients at Dr. Marcinkus's office. She is aware of only one patient from Dr. Marcinkus's office who saw respondent at respondent's Indio office.

171. Ms. Barajas used to work with respondent at CBI. Her duties included getting patient charts and prescriptions ready and getting lab results including UDS. Ms. Barjas testified that CBI had a policy regarding UDS. Patients who were seen at the office for opioids were required to submit to such screens before opioids were prescribed. These patients needed to leave a urine screen sample, or they would not receive prescriptions for opioids. This policy was in place to ensure patients left UDS samples. Every result was to be in the file; she was responsible for handing the lab results to the doctor. She remembers handing such results to respondent.

172. Mr. Torigian has been respondent's patient for several years. He described respondent as a very caring doctor who is very accessible. Respondent gives Mr. Torigian his full attention, answers all his questions, and covers everything that needs to be covered.

## Character Letters

173. Respondent submitted character letters from these persons: Ryszard Skulzki, M.D., who has known respondent for 22 years as a friend and colleague, Robert

Reinke, M.D., who worked with respondent from 2009 to 2015, and Gordon Jenkins, who has been respondent's patient since 1986.

174. These persons describe respondent as a dedicated and caring physician who is well-regarded in the community. They each are generally aware of the allegations against respondent.

## The Parties' Arguments

175. Complainant in closing argued that due to respondent's negligent conduct, the numerous probation violations, his failure to take responsibility for his conduct, and respondent's disciplinary history, the only disposition consistent with public protection is revocation. Complainant argued further that the evidence of record supports Dr. Jamison's conclusions with respect to departures from the standards of care and respondent's expert, Dr. Berger, acknowledged medical record documentation problems.

In addition, complainant asserted that respondent did not dispute he violated the terms of his probation, except with respect to the Probation Condition No. 5.

Complainant asked that full costs be awarded, noting that respondent did not state he has a limited ability to pay costs.

176. Respondent in his closing statements argued that revocation is not necessary to protect the public. All the allegations involve, as respondent sees them, record keeping and documentation violations. Respondent stressed that these allegations differ from respondent's prior disciplinary actions, which involved respondent's administration of surgical services.

Respondent argued that Patients A, B, and C had nowhere else to go, and were patients already on high dose opioids when they saw respondent. Respondent worked in a rural area with limited access to specialists, including pain management specialists, and consultants.

Respondent stated that Drs. Bergers's and Helm's opinions should be found more persuasive than Dr. Jamison's opinions because she is not a pain management specialist. He added that Dr. Jamison's MME calculations were inaccurate because they were based on daily doses and not 30-day prescriptions.

With regard to the probation violations, respondent addressed each of these in turn.

With respect to respondent's failure to timely submit the CMEs, in violation of Condition No. 1, respondent tried to comply and submit the required CMEs by the end of August, and when Ms. Andrew told him the courses he took were too similar, he took additional courses, and he supplied her with proof he had completed these courses by mid-September.

With respect to the allegation he violated Condition No. 2 because he continued to treat pain management patients after the PACE program recommended that he stop treating these patients, respondent made several arguments: First, the board granted him a dispensation until June 25, 2021, to treat these patients, and he complied with the requirement. Respondent also made a due process argument because he never agreed to a restriction on his ability to practice medicine in his prior discipline.

The PACE program, respondent emphasized, recommended that respondent discontinue the practice of refilling pain medications for pain patients he was "not monitoring." But the only patients he was prescribing pain medications to were patients

he was monitoring, and complainant did not present evidence he refilled medications for patients he was not monitoring. Respondent added that he could not "abandon" patients he was actively monitoring out of concern for their health and welfare.

Respondent also argued that he did not need to go back to PACE for additional certification from PACE because he did not intend to practice pain management.

With regard to the asserted violation of Condition No. 3, his failure to provide PEP with a timely patient list in June 2020, respondent noted that PEP had the patient list for that month and did not notify respondent it did not.

With respect to the asserted violation of Condition No. 5, that respondent did not provide timely proof he supplied Dr. Marcinkus with the Decision and Third Amended Accusation from his prior discipline, respondent said he never had a locum tenens agreement with Dr. Marcinkus. He further questioned the weight to be given to the agreement admitted as evidence due to his "suspicious" signature on the document.

Concerning the asserted violation of Condition No. 6, that respondent did not obey all laws due to his speeding ticket, respondent stated this is not the type of offense that would constitute a probation violation.

Concerning the allegation that respondent did not timely submit quarterly declarations, in violation of Condition No. 7, respondent stated that complainant did not present any evidence when the probation unit received the documents, probation did not notify respondent the declarations were late, and the declarations were completed on or near the 10th of the month after the quarter.

Concerning the assertion that respondent did not submit to a board interview on June 1, 2022, in violation of Condition No. 9, respondent never received Ms. Andrew's

May 18, 2022, communication setting the June 1, 2022, interview, and Ms. Andrew changed the interview to June 22, 2022. Respondent attended that interview.

In terms of the disposition of this matter, respondent noted that respondent's probation has been extended due to the pendency of this matter. His probation was to end in 2023. Respondent has thus served an additional one year of probation. He stressed that Dr. Cederquist in her monitoring report for the Second and Third Quarters of 2021, rated his performance as satisfactory with only documentation issues.

In summation, respondent asked, first, that he be reprimanded for the conduct as found relating to documentation issues. In the alternative, respondent asked that his probation be extended without a restriction on his ability to engage in the solo practice of medicine or on his ability to supervise nurse practitioners or physician assistants.

177. In reply, complainant repeated that the only disposition consistent with public protection is revocation. Complainant argued respondent has lacked consistency while under the supervision of a practice monitor, and the ability to take responsibility for his past conduct. He continued to provide pain management until he was forced to stop last year. Complainant added that Dr. Cederquist in May 2020 had found respondent needed to improve, found his performance unsatisfactory, and at one point she deemed him unsafe to practice medicine. Notably, there was no evidence that complainant ever acted on that report.

In terms of the weight to be given to Dr. Berger's opinions, complainant stated that Dr. Berger never reviewed CURES reports, and he had help writing his report from respondent's attorney. His report is thus not that of an independent expert but of an advocate.

## Evaluation of Evidence

178. The decision in this matter first requires evaluating the allegations detailed in the accusation and resolving any conflicts that exist between the testimony of the experts consistent and the evidence of record. An evaluation will next be made regarding the allegations concerning causes to revoke respondent's probation.

### EVALUATION OF CAUSES FOR DISCIPLINE

179. As mentioned, this decision requires evaluating the testimony of the three experts, and the weight to be given their opinions consistent with the evidence. Factors to consider in this analysis include their qualifications and credibility, the factual bases of their opinions, the reasons for their opinions, and any biases that could color their opinions and review of the evidence. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

After giving due consideration to these factors, the following conclusions are made:

### FIRST CAUSE FOR DISCIPLINE

180. The accusation identifies conduct where respondent is alleged to have committed gross negligence in his care and treatment of Patients A and B.

With respect to Patient A, as stated in paragraph 65, the accusation alleges that respondent committed gross negligence because he did not document Patient A's inconsistent UDS or take appropriate action to address Patient A's inconsistent UDS results.

Dr. Jamison's opinion here is found more persuasive than Dr. Berger's and consistent with the credible evidence of record.

181. Dr. Jamison found that respondent committed an extreme departure from the standard of care because he did not take appropriate action after receiving inconsistent UDS results for morphine to assess for possible diversion or medicine noncompliance.

182. Despite the prescriptions of morphine, Patient A's test results were repeatedly negative. Patient A started picking up her prescriptions for morphine on November 5, 2019, and she was tested on this date, with the result negative for morphine. She was tested on December 3, 2019, and the test result was again negative for morphine.

The next negative result, on February 4, 2020, is particularly concerning for possible misuse of the morphine or diversion. Patient A picked up her 30-day supply morphine on January 19, 2020, and on February 4, 2020, *just over two weeks later*, she tested negative for morphine.

Patient A was further tested on March 3, 2020, but the test results were not recorded. She again was tested on April 28, 2020, and the result for morphine was negative. On August 6, 2020, the test result was positive for morphine, the only positive result recorded.

183. Dr. Berger minimized respondent's failure to document the negative morphine results or take appropriate steps. He termed respondent's error just a documentation issue. This was not just a documentation issue. Documentation of opioids and patient compliance with the prescribing of opioids is an essential part of the

prescribing doctor's duties. Dr. Berger himself recognized this duty. Dr. Berger said the results were concerning for possible misuse or diversion.

184. But more fundamentally, Dr. Berger based his opinion that respondent was aware of the results on a discussion he had with respondent, discussions it needs be noted respondent never recorded. Respondent, Dr. Berger said, told him he discussed the results with Patient A. Dr. Berger documented this discussion in his report. He wrote that respondent was aware of "the discrepancies" because "sometimes [Patient A] could not fill her prescriptions." Respondent, however, did not say this in his testimony. He said that Patient A was not taking the morphine on a consistent basis. He did not testify she had trouble filling the prescriptions for morphine.

185. Putting aside the credibility of respondent's statement to Dr. Berger, Dr. Berger's understanding that Patient A had trouble filling the prescriptions for morphine is incorrect based on the evidence of record. Patient A did not have problems picking up her morphine prescriptions. CURES contradicts what respondent told Dr. Berger. (Dr. Berger, it is noted, did not review the CURES reports.)

186. With regards to Paragraph 66, the allegation that respondent failed to refer Patient A to a pain management specialist while he was prescribing her high dose opioids and two short acting opioids, Dr. Berger's and Dr. Helm's testimony here, as experts in the field of pain management and extensive experience in this area, are found more persuasive than Dr. Jamison's and credited accordingly.

Dr. Berger testified that it was nearly impossible for respondent to find a pain management specialist for Patient A given her long term history of dependency on opioids. As he put it, pain management specialists do not want to take patients like Patient A.

187. The board itself recognized the difficulty finding such specialists in its 2023 *Guidelines for Prescribing Controlled Substances for Pain*. It is worth repeating the section Dr. Berger quoted in his testimony here (which is quoted earlier):

> It is recognized that between the Board's death certificate project and the CDC 2016 Guidelines, a chilling effect was felt and physicians became less willing to treat patients with chronic pain. This situation became significantly worse with the abrupt closure of 29 pain management centers in May 2021.
>
> Approximately 20,000 patients were left without referrals or treatment plans resulting in potentially dangerous disruptions in care for patients receiving treatment with opioid therapy.
>
> As the Board discussed the need to update the 2014 prescribing guidelines, it was emphasized that a change in tone was necessary to provide support and guidance to physicians to prescribe in a way that is effective for their patients and to also have enough flexibility to deal with pain patients that don't fall into the normal guidelines.
>
> Aside from giving physicians more autonomy in treating their patients for pain, statutory changes had been enacted that needed to be integrated into the guidelines. The Board began the process of updating its guidelines by identifying physicians who practice medicine in various specialties

> including pain management specialists, family practice physicians, members of academia and others, to serve as subject matter experts and help the Board revise the guidelines. The goal was to provide resources and an updated structure for the management of patients being treated for pain.

(Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 2023, pp. 2-3.)

188. In his testimony, Dr. Helm emphasized the difficulty physicians have finding pain management specialists.

189. Respondent, in turn, credibly stated he simply was not able to find a pain management specialist for Patient A.

190. With regard to the allegation that respondent committed gross negligence with regard to Patient B, as detailed in paragraph 68, respondent did not obtain an official pain management consultation during his care and treatment of Patient B, Dr. Berger's testimony here is also found more persuasive than Dr. Jamison's. He testified, as a recognized expert in the field of pain management, that it was nearly impossible to obtain an expert in pain management who would see Patient B.

**SECOND CAUSE OF DISCIPLINE**

191. The accusation alleges that respondent committed repeated negligence acts with respect to his care of the three patients at issue in this matter.

192. First, with regard to Patient A, as detailed in paragraph 71, respondent is alleged to have committed a simple departure from the standard of care by failing to accurately document his prescription of dangerous drugs to Patient A.

193. Dr. Jamison's testimony in this regard is persuasive and well-based on the evidence of record. Respondent's expert, Dr. Berger, acknowledged respondent's documentation for Patient A was deficient.

As found above, respondent repeatedly did not correctly or adequately document dosages of opioids he was prescribing to Patient A, he did not document when he started Patient A on morphine and tramadol, and he repeatedly did not document he prescribed Lyrica to Patient A. Respondent also, in a note dated September 3, 2019, did not document in Patient A's record that he wrote prescriptions for Percocet and baclofen for Patient A.

194. With regard to Patient B, complainant alleges in paragraph 73 that respondent committed a simple departure from the standard of care because he did not obtain or enter into a pain management agreement with Patient B.

195. Dr. Jamison's testimony here is found persuasive and credited over Dr. Berger's opinion that respondent did not need to obtain such an agreement.

Respondent treated Patient B with high dose opioids, Dilaudid and fentanyl, over a 10-month period. His intention was to treat her short term until she had surgery and or obtained a pain management physician to treat her. Dr. Berger stressed in his testimony that respondent did not intend to treat her long term. But the fact remains respondent treated her long term for 10 months during which time she also took alprazolam from another person. Thus, she clearly needed to be under a pain

management agreement to ensure she understood the refill patterns, the risks of addiction, and the side effects of the medications respondent was prescribing her.

196. Complainant also alleges with respect to Patient B, that respondent committed negligence when he did not perform routine UDS and failed to take appropriate action with regard to inconsistent results.

Here, the credible evidence of record support's respondent's testimony that Patient B was subject to routine UDS at the CBI clinic where respondent worked. Karla Barajas, who worked with respondent at CBI during the time period at issue here, testified credibly that CBI had a policy that required every patient who received opioids at the clinic to submit to UDS before the prescriptions would be written. If the patient did not submit to the UDS, the patient would not get his or her prescription. Ms. Barajas was directly involved in ensuring this happened. Ms. Barajas gave the lab results to the physician. She remembered giving such results to respondent.

197. With regard to Patient C, complainant alleges in paragraph 76 of the accusation that respondent was negligent because he did not do a thorough assessment and evaluation of Patient C's source of pain to determine the appropriate use of narcotics to treat her pain.

On this issue, Dr. Jamison's testimony is found more persuasive than Dr. Berger's. Dr. Jamison testified that Patient C's leg pain, as she described it, was likely due to diabetic neuropathy due to uncontrolled diabetes, and diabetic neuropathy is not treated with opioids. A March 15, 2021, A1C reading of 11.7 showed Patient C had uncontrolled diabetes. Respondent appears to have circled this result, but he did not identify it in his progress note, or document he discussed it with Patient C. Dr. Jamison

testified this condition needs to be managed through neuropathic agents and proper diabetic management.

198. Dr. Jamison also found the tenderness on palpation to Patient C's back that respondent noted in his physical exam required further evaluation for potential causes of pain. Such tenderness, she stated, could indicate spinal fracture, fibromyalgia, myofascial pain, or muscular pain, and these conditions are generally not treated with narcotics.

Dr. Berger testified that respondent conducted a thorough assessment of Patient C's source of pain because he had been treating Patient C since 2008 and knew Patient C. But Dr. Berger did not contradict Dr. Jamison's testimony regarding Patient C's neuropathic pain due, possibly, to her uncontrolled diabetes based on the March 15, 2021, A1C reading of 11.7. He also did not address the tenderness to her back as requiring further inquiry, which Dr. Jamison felt was important.

199. Again, with regard to Patient C, complainant alleges in paragraph 77 of the accusation that respondent committed negligence when he did not consult with a psychiatrist.

Here, the evidence supports respondent's testimony that he tried to refer Patient C to a psychiatrist, but she refused. He also stated that obtaining a referral to a psychiatrist faced insurance barriers, and his office was unable to obtain a referral. Dr. Jamison testified, nonetheless, respondent should have worked harder to persuade Patient C to see a psychiatrist.

Dr. Jamison may be correct that respondent should have worked harder to have Patient C agree to see a psychiatrist in the first place, but Patient C refused to see a psychiatrist. Ultimately, this was her decision. This allegation was not proven.

200. Finally, with regard to Patient C, as alleged in paragraph 78, complainant alleges that respondent committed negligence when he did not accurately document Patient C's progress notes or that there was any progress resulting from his care of Patient C.

There is no dispute concerning this issue, and Dr. Jamison's opinion here is found persuasive and consistent with the record.

With this stated, it is worth noting the extent of respondent's documentation problem. First, respondent's notes for Patient C are the same, for the most part; respondent did not document why he prescribed the combination opioid Virtussin to her; and respondent incorrectly recorded he prescribed 90 pills of Norco to Patient C on April 17, 2020, when he in fact prescribed 120 pills of the drug to her.

### THIRD THROUGH FIFTH CAUSES FOR DISCIPLINE

201. The disposition of the Third through Fifth Causes for Discipline (Failure to Maintain Accurate and Adequate Records, Violations of the Medical Practice Act, and General Unprofessional Conduct) incorporates the findings made in the First and Second Causes for Discipline above and are addressed in the Legal Conclusions section of this decision.

### EVALUATION OF CAUSES TO REVOKE PROBATION

202. Respondent does not contest that he violated several terms of his probation. He, however, disputes that he failed to comply with Conditions 2 and 5, with respect to recommendations PACE made, and the requirement he notify the CEO or Medical Director of the facility where he worked locum tenens of his discipline. He also

disputes he refused to attend the June 1, 2022, interview with the board, as required under Condition No. 9.

203. With regard to the allegation he did not comply with Condition No. 2, the evidence does not support the conclusion that respondent violated this term. Several reasons support this conclusion: First, respondent was advised by PACE to stop "refilling medications for conditions you are not monitoring." There is simply no evidence he continued to refill medications for conditions he was not monitoring.

204. Second, the board gave him until June 25, 2021, to stop treating pain management patients. In her letter dated June 22, 2021, Ms. Borja wrote that "[respondent] must work to transfer all pain patients" to another physician by June 25, 2021. She added he would be given "no additional extension of time" to comply with the recommendations.[12] Respondent complied with this extension and stopped treating pain management patients.

205. Finally, with regard to the condition that he return to PACE for further assessment, this term is found to only apply if respondent continued to practice pain management medicine. Respondent testified he had no intention of doing pain management medicine, and he has no intention of practicing pain management medicine going forward.

206. With regard to respondent's compliance with Condition No. 3, which requires respondent to timely provide patient lists and records to his probation monitor, the evidence shows that respondent must have provided PEP with the June 2020 patient

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[12] PACE did not recommend that he transfer all of his pain patients, but he stopped filling prescriptions for patients he was not monitoring.

list because PEP asked him for patient records it must have selected from that list, per a July 10, 2020, email PEP sent to respondent.

207. With regard to Condition No. 5, respondent stated he did not have a locum tenens agreement with Dr. Marcinkus and thus was not required to notify him of his discipline. His testimony here is found credible and supported by the evidence of record in this matter. This evidence includes his communications with Ms. Andrew where he expressed surprise the board said he had such an agreement. Respondent further credibly testified he would not have acted as a locum tenens physician at Dr. Marcinkus's facility given its location.

208. In addition, respondent's testimony on this issue is supported by the testimony of his medical assistant, Ms. Gutierrez. Ms. Gutierrez testified that as part of her duties she scheduled patients to see respondent. She knows of only one patient from Dr. Marcinkus's office who saw respondent at respondent's office. She never scheduled respondent to see patients at Dr. Marcinkus's office. Ms. Gutierrez testified that she never saw the locum tenens agreement, and it would be the type of document she would see for purposes of scheduling respondent's patients.

209. With regard to Condition No. 9, which requires respondent to attend board interviews upon request, the evidence shows that respondent did not violate this condition. Respondent credibly testified he did not receive Ms. Andrew's letter, and/or email, setting the June 1, 2022, interview and/or confirming it. He was unaware of the June 1, 2022, interview. Once Ms. Andrew notified him that he missed this interview, respondent immediately responded to Ms. Andrew, and the interview was rescheduled to June 22, 2022. Respondent attended that interview at the board's probation unit office.

210. The remaining probation violation charges are, for the most part, not in dispute, and are addressed in the Legal Conclusions section of this decision below.

## Costs of Enforcement

211. Complainant seeks recovery of enforcement and investigative costs in the total amount of $67,018.50 for the period between October 17, 2022, and January 12, 2024, pursuant to Business and Professions Code section 125.3.

212. In support of the request for recovery of investigative costs, the Health Quality Investigation Unit (HQIU) of the Division of Investigation submitted a declaration requesting $6,833.50 signed by a representative of HQIU who certified these costs. The declaration details the work performed by three HQIU investigators, the time spent on each task, and the hourly rate.

213. Complainant, in addition, submitted a declaration requesting $2,500 for the expenses billed by complainant's expert, Dr. Jamison. This declaration is signed by a designated representative of the board and details the time spent and hourly rate for Dr. Jamison's evaluation of case related materials, report writing, hearing preparation and examinations.

214. In support of the request for recovery of enforcement costs, the Deputy Attorney General who prosecuted the case signed an initial declaration dated January 10, 2024, and supplemental declaration on January 12, 2024, requesting $57,685 relating to the legal work performed in this matter. Attached to the declarations are two documents entitled "Master Time Activity by Professional Type." These documents identify the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate for the Supervising Deputy

Attorney General, Deputies Attorney General, analyst, and paralegals from October 17, 2022 through January 12, 2024, for the total prosecution costs.

215. The Deputy Attorney General's declaration identifies the specific tasks performed to satisfy the requirements of section 1042, subdivision (b). California Code of Regulations, title 1, section 1042, subdivision (b), requires that this declaration must include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs."

216. But this declaration does not distinguish between the time spent on legal tasks associated with the prosecution of respondent for violations of the Medical Practice Act, and respondent's asserted failure to comply with his disciplinary probation. Under Section 125.3, subdivision (a), complainant may seek recovery of costs only associated with "violations of the licensing act." Section 125.3 thus precludes cost recovery for violations relating to respondent's probation violations.

217. Accordingly, considering the nature and scope of the charges in the petition to revoke respondent's probation, and the time spent at the hearing addressing these charges, the Attorney General's costs are reduced by half to $28,842.50. These costs are deemed reasonable pursuant to section 1042, subdivision (b).

218. Costs submitted by HQIU are found to be related to the investigation of respondent's violation of the Medical Practice Act and reasonable under the requirements of section 1042, subdivision (b). The same is true for costs associated with Dr. Jamison's report.

Therefore, the total reasonable costs of enforcement of this matter are $38,176. Respondent did not present any evidence regarding his ability to pay costs, but it is

noted that respondent practices in an extremely impoverished area, where there is a shortage of physicians, and where his patients face insurance coverage issues.

## LEGAL CONCLUSIONS

### Purpose of Physician Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

### Standards of Proof

2. Complainant bears the burden of proof of establishing that the charges in the accusation are true.

The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. The standard of proof on a petition to revoke probation is preponderance of the evidence. (*Sandarg v. Dental Board of California* (2010) 184 Cal.App.4th 1434, 1441.)

## Disposition Regarding Causes for Discipline

### CAUSE EXISTS UNDER THE FIRST CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR CONDUCT CONSTITUTING GROSS NEGLIGENCE

4. Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient A as described in paragraph 65 of the accusation. Respondent failed to document inconsistent urine screens showing Patient A tested negative for morphine or take appropriate action to address these screens. As found above, Dr. Jamison's opinion on this issue is found persuasive.

### CAUSE EXISTS UNDER THE SECOND CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR REPEATED NEGLIGENT ACTS

5. Complainant proved by clear and convincing evidence that respondent committed repeated negligent acts in violation of Section 2234, subdivision (c), in his care and treatment of Patients A, B and C.

With regard to Patient A, respondent committed a negligent act when he did not accurately document Patient A's care and treatment in his records, including his documentation of controlled substances and dangerous drugs as described in

paragraph 71 of the accusation. Dr. Jamison persuasively testified in this regard, as found above.

With regard to Patient B, respondent committed a negligent act when he did not obtain or enter into a pain management agreement with Patient B, as described in paragraph 73 of the accusation, as found above based on Dr. Jamison's persuasive testimony.

With regard to Patient C, respondent did not conduct a thorough assessment and evaluation of Patient C to assess her source of pain to determine the appropriate use of narcotics to treat her pain as described in paragraph 76 of the accusation. Dr. Jamison's testimony here, as found above, is also found persuasive.

With regard to Patient C, respondent did not accurately document his care and treatment of Patient C, including documenting any progress resulting from his treatment of Patient C, as described in paragraph 78 of the accusation.

**CAUSE EXISTS UNDER THE THIRD CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS**

6. Complainant proved by clear and convincing evidence that respondent failed to maintain accurate and adequate records for Patient A and Patient C as found above, pursuant to Section 2266.

**CAUSE EXISTS UNDER THE FOURTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR VIOLATIONS OF THE MEDICAL PRACTICE ACT**

7. Complainant proved by clear and convincing evidence that respondent committed violations of the Medical Practice Act pursuant to Section 2234, subdivision (a), as found above under the First through Third Causes for Discipline.

**CAUSE EXISTS UNDER THE FIFTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR GENERAL UNPROFESSIONAL CONDUCT**

8. Complainant proved by clear and convincing evidence that respondent committed unprofessional conduct as found above under the First through Fourth Causes for Discipline. (*Shea v. Board of Medical Examiners, supra*, 81 Cal.App.3d at 575.)

**CAUSES DO NOT EXIST UNDER THE FIRST CAUSE FOR DISCIPLINE**

9. Complainant did not prove by clear and convincing evidence that respondent committed gross negligence as alleged in paragraphs 66 and 68 of the accusation as found above. Drs. Bergers's and Helm's testimony is found persuasive that pain specialists were not available for Patients A and B, at the time.

**CAUSES DO NOT EXIST UNDER THE SECOND CAUSE FOR DISCIPLINE**

10. Complainant did not prove by clear and convincing evidence that respondent was negligent when he failed to perform UDS for Patient B and failed to take appropriate action with regard to inconsistent UDS as alleged in paragraph 74 of the accusation based on the above findings.

11. Complainant did not prove by clear and convincing evidence that respondent was negligent when he failed to consult with a psychiatrist relating to his prescription of Xanax to Patient C as alleged in paragraph 77 of the accusation based on the above findings.

## Disposition Regarding Causes to Revoke Probation

### CAUSE EXISTS UNDER THE FIRST CAUSE TO REVOKE PROBATION

12. Complainant proved by a preponderance of the evidence that respondent did not timely provide proof of completion of CME hours.

### CAUSE EXISTS UNDER THE SIXTH CAUSE TO REVOKE PROBATION

13. Complainant proved by a preponderance of the evidence that respondent failed to abide by all laws when he violated Vehicle Code section 22349, subdivision (a), on July 2, 2020, when he drove his car above the speed limit.

### CAUSES DO NOT EXIST UNDER THE SECOND, THIRD, FOURTH, FIFTH, SEVENTH, AND EIGHTH CAUSES TO REVOKE PROBATION

14. Complainant did not prove that cause exists to revoke respondent's probation as alleged under the Second, Third, Fourth, Fifth, Seventh, and Eight Causes to Revoke Probation as found above.[13]

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[13] At the start of the hearing complainant withdrew the charges at paragraphs 87, 88, and 89.

## The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

15. With causes for discipline and revocation of his probation having been found, a determination that needs to be made regarding the degree of discipline and the terms and conditions to impose.

As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy, supra*, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

The board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) offers this guidance concerning the imposition of discipline:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

16. For each of the violations established relating to respondent's care and treatment of Patients A, B, and C, the board's disciplinary guidelines provide that revocation is the maximum discipline and provide the following minimum recommended terms and conditions:

> For gross negligence and repeated negligent acts under Business and Professions Code section 2234, subdivisions (b) and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices. In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.

## Disciplinary Considerations and Disposition Regarding the Degree of Discipline

17. After considering the board's guidelines, evidence of mitigation, and the evidence of record as a whole, it is determined that respondent's probation should be extended for three years on the same terms and conditions previously imposed, with the added requirement that he successfully complete a medical record keeping course.

This determination is made for these reasons: Respondent did not adequately monitor the opioid use of all three patients and document the opioids he was

prescribing them. With respect to Patient B, he did not adequately assess the source of her pain to appropriately treat her.

All of the patients were dependent on high dose opioids. His records failed to adequately record both the opioids he was prescribing them, their dosages, and with regard to Patient C, that he was prescribing her Virtussin, which contains codeine, in addition to two other opioids. Quite simply, his records documenting his prescriptions of high dose opioids are very hard to follow. It is a difficult task to reconcile the prescriptions he issued and in certain instances understand why he was prescribing the medications. The only way to even try to reconcile his prescriptions was by reviewing CURES, pharmacy records, the scripts he wrote, and other information regarding the medications respondent prescribed to these patients.

18. With this noted, because these patients were legacy patients, and they were on high dose opioids long term and dependent on them to given them pain relief, respondent was faced with the daunting task of treating their pain conditions. Each patient posed challenges. Patient A was not getting the pain relief she needed after OxyContin was discontinued. Patient B was a cancer patient, and respondent intended to treat her for just a short time period until her surgery. Patient C had complications due to out-of-control diabetes, and she refused to see a psychiatrist to address her anxiety. Respondent, however flawed his treatment and documentation were, conscientiously tried to treat each of the patients, and he did not want to abandon them. As discussed, pain management physicians willing to take over the care of these patients were not available.

Respondent also appears to have benefited from Dr. Cederquist's monitoring. Continued monitoring will help ensure he practices medicine safely.

Respondent, in addition, in general appears to be a caring and compassionate physician.

19. Concerning the probation violations as found, these violations do not warrant revocation of his license. Respondent substantially complied with these terms of probation. The speeding ticket is not a basis to revoke probation. With this noted, respondent appears to have taken seriously his responsibilities as a probationer and tried to communicate effectively with his probation monitor.

20. Therefore, after giving due consideration to the evidence in the record as a whole, due to the nature and extent of respondent's conduct, extending respondent's probation for three years under the same terms and conditions that have been imposed is warranted to ensure public protection, with the exception that he will not have to repeat PACE, or take additional education courses other than the medical record keeping course. The remaining terms and conditions will remain in effect. This conclusion represents departures from the board's guidelines in these respects: It is not necessary for public protection that respondent's probation be extended five years. A three-year extension of probation is adequate with the terms and conditions already in place as noted. In addition, public protection does not require that respondent be prohibited from the solo practice of medicine, or be prohibited from supervising physician assistants and advanced practice nurses. These terms will, thus, not be imposed. Respondent, however, will be required as noted to successfully complete a medical record keeping course.

## Costs of Enforcement

21. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate 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." "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." (Bus. & Prof. Code, § 125.3, subd. (c).)

22. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the administrative law judge must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct. The scope of the investigation was appropriate to the allegations. The charges were sustained, and respondent provided no evidence regarding his ability to pay the costs.

23. After consideration of the factors under *Zuckerman, supra,* a reduction of 50 percent, or $19,088 against the amount of reasonable costs of $38,176 is required because respondent successfully challenged certain allegations in the accusation and petition to revoke probation, and he successfully argued against revocation of his license. Accordingly, reasonable costs are assessed at $19,088.

## ORDER

Physician's and Surgeon's Certificate No. G 42802 issued to respondent Harry Lifschutz, M.D., is revoked. However, the revocation is stayed, and respondent's probation is extended for three years under the same terms and conditions imposed under Case No. 800-2014-004065, except for the requirements under Condition No. 1, relating to Education Courses, and Condition No. 2, that he complete a Clinical Competence Assessment Program, with these additional requirements:

1. 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.

2. Probation Monitoring and Enforcement Costs

Respondent shall pay the costs associated with the enforcement of this matter in the amount of $19,088. Respondent may negotiate a payment plan with the Board. In addition, respondent shall pay 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.

DATE: February 29, 2024

Abraham M. Levy (Feb 29, 2024 12:19 PST)

ABRAHAM M. LEVY

Administrative Law Judge

Office of Administrative Hearings