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

In the Matter of the Accusation Against: Irene Helen Sanchez-Esparza, M.D. Physician's and Surgeon's Certificate No. A 50850 Respondent.	Case No.: 800-2021-074667

DECISION

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

This Decision shall become effective at 5:00 p.m. on July 24, 2024.

IT IS SO ORDERED: June 24, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: IRENE HELEN SANCHEZ-ESPARZA, M.D. 4200 Buck Owens Boulevard Bakersfield, California 93308 Physician's and Surgeon's Certificate No. A 50850, Respondent.	Case No. 800-2021-074667 OAH No. 2023090878 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Irene Helen Sanchez-Esparza, M.D. (Respondent) is represented in this proceeding by attorneys Peter R. Osinoff and Derek F. O'Reilly-Jones, whose address is: Bonne Bridges Mueller O'Keefe & Nichols - Los Angeles; 355 South Grand Avenue, Suite 1750; Los Angeles, California 90071.

3. On June 9, 1992, the Board issued Physician's and Surgeon's Certificate No. A 50850 to Irene Helen Sanchez-Esparza, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2021-074667, and will expire on April 30, 2024, unless renewed.

JURISDICTION

4. A First Amended Accusation in Board Case No. 800-2021-074667 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 21, 2024. Respondent timely filed her Notice of Defense contesting the charges.

5. A copy of the First Amended Accusation in Case No. 800-2021-074667 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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CULPABILITY

8. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the First Amended Accusation, and Respondent hereby gives up her right to contest those charges.

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

CIRCUMSTANCES IN MITIGATION

10. Respondent Irene Helen Sanchez-Esparza, M.D. has never been the subject of any disciplinary action.

CONTINGENCY

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

12. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an Accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2021-074667 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

as the originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 50850 issued to Respondent Irene Helen Sanchez-Esparza, M.D. is revoked.

1. STANDARD STAY ORDER. However, revocation is stayed and Respondent is placed on probation for 35 months upon the following terms and conditions.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 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 65 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

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

4. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances listed in Schedule(s) II and III as defined by the California Uniform Controlled Substances Act until Respondent submits a certification of successful completion of the prescribing practices course to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. CONTROLLED SUBSTANCES - Maintain Records and Access to Records and Inventories Respondent shall maintain a record of any controlled substances listed in Schedule(s) II and III as defined by the California Uniform Controlled Substances Act that Respondent ordered, prescribed, dispensed, administered, or possessed and any recommendation or approval which enables a patient or patient's primary caregiver to possess.

Respondent's records of any controlled substances listed in Schedule(s) II and III as defined by the California Uniform Controlled Substances Act must show all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

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

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

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which

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

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

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

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First 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 carrier.

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

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

10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, the First Amended Accusations legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of 17,943.75 (seventeen thousand nine hundred forty-three dollars and seventy-five cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

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

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

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

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

16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to

Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-074667 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Peter R. Osinoff, and Derek F. O'Reilly-Jones. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this

Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

IRENE HELEN SANCHEZ-ESPARZA, M.D.
Respondent

I have read and fully discussed with Respondent Irene Helen Sanchez-Esparza, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

PETER R. OSINOFF
DEREK F. O'REILLY-JONES
Attorneys for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

WENDY WIDLUS
Deputy Attorney General
Attorneys for Complainant

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Stipulated Settlement Sanchez Esparza.docx

Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 2/29/2024

IRENE HELEN SANCHEZ-ESPARZA, M.D.
Respondent

I have read and fully discussed with Respondent Irene Helen Sanchez-Esparza, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2/29/2024

PETER R. OSINOFF
DEREK F. O'REILLY-JONES
Attorneys for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

WENDY WIDLUS
Deputy Attorney General
Attorneys for Complainant

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Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

IRENE HELEN SANCHEZ-ESPARZA, M.D.
Respondent

I have read and fully discussed with Respondent Irene Helen Sanchez-Esparza, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

PETER R. OSINOFF
DEREK F. O'REILLY-JONES
Attorneys for Respondent

ENDORSEMENT

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

DATED: March 1, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Wendy Widlus

WENDY WIDLUS
Deputy Attorney General
Attorneys for Complainant

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **IRENE HELEN SANCHEZ-ESPARZA, M.D.** **4200 Buck Owens Boulevard.** **Bakersfield, California 93308** **Physician's and Surgeon's Certificate No. A 50850,** Respondent.	Case No. 800-2021-074667 **A C C U S A T I O N**

PARTIES

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

2. On June 9, 1992, the Board issued Physician's and Surgeon's Certificate Number A 50850 to Irene Helen Sanchez-Esparza, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2024, unless renewed.

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JURISDICTION

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

4. The Medical Practice Act (the "Act") is codified at sections 2000-2521 of the Business and Professions Code.

5. Section 2001.1 states:

> Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

6. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> (f) Approving undergraduate and graduate medical education programs.
>
> (g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).
>
> (h) Issuing licenses and certificates under the board's jurisdiction.
>
> (i) Administering the board's continuing medical education program.

7. Section 2228 of the Code states:

> The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:
>
> (a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written

or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

8. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the Patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the Patient's guardian or health care surrogate before the Patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

...

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the Patient, or the Patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The Patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the Patient during the visit is not known to the Patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the Patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

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

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

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

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

(e) Section 2314 shall not apply to this section.

STATUTORY PROVISIONS

9. Section 2234 of the Code, states:

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

. . .

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

(b) Gross negligence.

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

. . .

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

. . .

10. Section 2242 of the Code states:

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

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

11. Section 725 of the Code states:

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

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred

dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

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

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

12. Section 740 of the Code states:

For purposes of this article, "prescriber" means a person licensed, certified, registered, or otherwise subject to regulation pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe prescription drugs.

13. Section 741 of the Code states:

(a) Notwithstanding any other law, when prescribing an opioid or benzodiazepine medication to a patient, a prescriber shall do the following:

(1) Offer the patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed within a year from the date a prescription for benzodiazepine has been dispensed to the patient.

(C) The patient presents with an increased risk for opioid overdose, including a patient with a history of opioid overdose, a patient with a history of opioid use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to the patient on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression.

(3) Consistent with the existing standard of care, provide education on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

(b) A prescriber is not required to provide the education specified in paragraphs (2) or (3) of subdivision (a) if the patient receiving the prescription declines the education or has received the education within the past 24 months.

(c) This section does not apply to a prescriber under any of the following circumstances:

(1) When prescribing to an inmate or a youth under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice within the Department of Corrections and Rehabilitation.

(2) When ordering medications to be administered to a patient while the patient is in either an inpatient or outpatient setting.

(3) When prescribing medications to a patient who is terminally ill, as defined in subdivision (c) of Section 11159.2 of the Health and Safety Code.

14. Section 742 of the Code states:

A prescriber who fails to offer a prescription, as required by paragraph (1) of subdivision (a) of Section 741, or fails to provide the education and use information required by paragraphs (2) and (3) of subdivision (a) of Section 741 shall be referred to the appropriate licensing board solely for the imposition of administrative sanctions deemed appropriate by that board. This section does not create a private right of action against a prescriber, and does not limit a prescriber's liability for the negligent failure to diagnose or treat a patient.

COST RECOVERY

15. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

16. Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.

17. Schedule I Controlled Substances: Substances in this schedule have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

18. Schedule II Controlled Substances: Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

19. Schedule III Controlled Substances: Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

20. Schedule IV Controlled Substances: Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

21. Schedule V Controlled Substances: Substances in this schedule have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.

22. Benzodiazepines are central nervous system (CNS) depressants, which are medicines that slow down the nervous system and are available by prescription. These medications are used to treat anxiety disorders including anxiety caused by depression as well as panic disorder in some patients.

23. Alprazolam is a Schedule IV benzodiazepine. It is prescribed under the brand name Xanax.

24. Buprenorphine is a Schedule III partial opioid agonist indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. It is prescribed under the brand name Belbuca.

25. Hydromorphone is a Schedule II controlled substance. It is a derivative of morphine used to relieve pain. It is prescribed under the brand names Dilaudid or Exalgo. Hydromorphone is approximately five times more potent than morphine. Alcohol usage can increase side effects including a risk of respiratory depression that can lead to a fatal overdose. Hydromorphone may interact with other drugs that also cause sedation or respiratory depression. Hydromorphone can be addictive even at regular doses and has a high abuse potential.

26. Lorazepam is a Schedule IV benzodiazepine. The definition and discussion regarding benzodiazepine medications above, is incorporated as if fully set forth herein.

27. Meperidine is a Schedule II controlled substance given by injection under the brand name Demerol. Risks are increased in patients with a personal history of substance abuse, alcohol abuse or addiction. Use in such patients necessitates intensive counseling about the risks and proper use of Demerol injection along with intensive monitoring for signs of addiction, abuse, and misuse.

28. Nortriptyline is a tricyclic antidepressant and is not a controlled substance. It is used to treat symptoms of depression.

29. Oxycodone is a Schedule II opioid analgesic drug prescribed to help manage moderate to severe pain. It is prescribed under many brand names including Xtampza ER, Oxaydo, and Oxycontin. This drug produces a range of side effects, has very high abuse potential, and overdoses can be deadly.

30. Zolpidem is a Schedule IV nonbenzodiazepine drug which acts as a sedative and is used to treat insomnia. It is prescribed under the brand names Ambien, Intermezzo, Edluar, and Ambien CR. Zolpidem is unsafe to use with alcohol.

31. Narcan, or naloxone, is medication used to treat an opioid overdose emergency. Narcan works by rapidly reversing the opioid's effects and should be given as soon as possible when an opioid overdose is suspected.

32. CURES 2.0 (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

33. Complex Regional Pain Syndrome [CRPS], formerly referred to as Reflex Sympathetic Dystrophy Syndrome, is a broad term describing excess and prolonged pain and inflammation that follows an injury to an arm or leg. CRPS has acute and chronic forms. People who have CRPS experience changing combinations of spontaneous pain or excess pain that is much greater than normal following something as mild as a touch. Severe or prolonged CRPS cases are profoundly disabling and there is no treatment that rapidly cures CRPS.

34. Cirrhosis is severe scarring of the liver. It is a serious condition that can be caused by forms of liver diseases and conditions such as alcoholism. Each time the liver is injured it tries to repair itself and in the process, scar tissue forms. As cirrhosis gets worse, more and more scar tissue forms, making it difficult for the liver to do its job. Advanced cirrhosis is life-threatening.

35. Steatosis is an accumulation of fat in tissues and most commonly affects the liver. The main cause of this type of steatosis is heavy alcohol consumption. The progression can lead to cirrhosis which typically has a poor outlook.

36. Left ventricular hypertrophy is the thickening of the left ventricle walls of the lower left heart chamber. The left ventricle is the heart's main pumping chamber. Uncontrolled high blood pressure is the most common cause of left ventricular hypertrophy. Complications include heart failure. Treatment of left ventricular hypertrophy depends on the cause and may include medications or surgery. With left ventricular hypertrophy the thickened heart wall can become stiff and blood pressure in the heart increases. The changes make it harder for the heart to effectively pump blood and the heart may fail to pump with as much force as needed.

37. Hypertensive vasculopathy of brain [also referred to as hypertensive microangiopathy, chronic hypertensive encephalopathy, hypertensive arteriolosclerosis, and hypertensive small vessel disease] is a form of sporadic cerebral small vessel disease that results from the sustained effects of elevated systemic blood pressure on the brain and affects blood flow to your brain. This can result in stroke, brain aneurysm, brain bleed and carotid artery disease. Cerebrovascular diseases may cause a reduction of blood flow to or bleeding in the brain.

38. Leukopenia is a low white blood cell count. Blood is made up of different types of blood cells, including white blood cells also known as "leukocytes." White blood cells are an important part of the immune system. Too few white blood cells can result in a condition known as leukopenia. Leukopenia may not cause symptoms, but can lead to serious complications.

39. Neutropenia refers to lower-than-normal levels of neutrophils in the blood. A neutrophil is a type of white blood cell that is made primarily by a person's bone marrow. White blood cells in general, and neutrophils in particular, fight infections in the body. Neutrophils destroy germs that cause infections, like viruses and bacteria. Insufficient neutrophils makes it harder for the body to fight germs and prevent infections. In severe cases, even bacteria that a healthy body typically tolerates, such as mouth or intestinal bacteria, can cause illness.

40. Thrombocytopenia is a condition in which a person has a low blood platelet count. Platelets [thrombocytes] are colorless blood cells that help blood clot and stop bleeding by clumping and forming plugs in blood vessel injuries. Thrombocytopenia can occur as a side effect of taking certain medications or due to a bone marrow disorder such as leukemia or an immune system problem.

FACTUAL ALLEGATIONS

41. On January 27, 2021, the Board received a complaint regarding Respondent's treatment of the Patient.[1] The complaint alleged Respondent prescribed the Patient a variety of benzodiazepine and opioid combinations despite knowing the Patient had a history of substance abuse, as documented in his medical records.

42. During the investigation that followed, certified copies of the Patient's medical records from Respondent and his past medical providers, the Patient's pharmacy profiles, hospital records, a death certificate and coroner's report were obtained, and a CURES report was generated. The Investigator interviewed the Respondent in the presence of her attorney.

43. The investigation established that in January 2004, the Patient suffered an industrial injury while working as a correctional officer. The Patient's received medical care for his injuries through workers' compensation. After the Patient's prior physician was no longer able to accept workers' compensation, the Patient was referred to Respondent. The Patient saw Respondent regularly from August 2017 to April 2019.

44. On May 24, 2019, the Patient's mother brought him breakfast at approximately 9:30 a.m. When she left for work, the Patient was on the couch and she did not speak with him during the day. When she returned home at approximately 6:30 p.m. she found her son unresponsive on the couch. Paramedics were unable to resuscitate him. The Patient's mother told the coroner's investigator that after her son's initial work accident, he returned to work, reinjured his ankle, had unsuccessful surgery and was medically retired in 2006 with "Reflex Sympathetic Dystrophy Syndrome." Her son lived with chronic pain after his retirement, and he became an alcoholic, drinking 64 ounces of vodka and Gatorade daily. The Patient's mother said he began having seizures three to four years before he died. The Patient's mother identified Respondent as his primary care physician through workmens' compensation whom he saw once a month for prescribiption refills.

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[1] The names of the patient and/or witnesses are anonymized to protect their privacy rights. The names will be provided to Respondent upon written request for discovery.

45. The coronor's autopsy findings were acute ethanol, hydromorphone, and alprazolam intoxication with a history of chronic alcoholism and leg pain, and hypertensive heart disease, with the manner of death being ruled accidental.

46. The Patient's first appointment with Respondent was August 31, 2017. The Patient brought his medical records from his prior providers to his first appointment with Respondent.

47. In her interview, Respondent stated the Patient suffered from complex regional pain syndrome [CRPS] of his lower extremities, and had been treated by different pain management physicians for CRPS who prescribed Ambien, Xanax, and Dilaudid. Respondent stated her standard of practice was to prescribe to patients monthly, and she checked the Patient's CURES report and entered the information into his medical records.

48. Throughout Respondent's treatment period, the Patient's medical records reflect Respondent prescribed oxycodone, Belbuca, Nucynta, hydromorphone, zolpidem, lorazepam, alprazolam, nortriptyline, and in-office Demerol injections.

49. At the Patient's initial visit, Respondent's records document that she received and reviewed medical records from the Patient's prior providers. The past providers' records clearly state that the Patient had a history of methamphetamine use and possible alcohol abuse. The records detail the Patient's prior alcohol use as six beers three times a week and 10 beers per weekend twice a month. Information that the Patient was a heavy alcohol drinker was confirmed by the fact that he had alcohol-related seizures for several years before his death, in addition to the statements made to the coroner's investigator and also that the autopsy found the Patient had suffered moderate to severe liver steatosis with early cirrhosis.

50. Respondent's medical records for the Patient contain a medical history form that was not signed. The records show the questions regarding the Patient's alcohol usage were checked as "seldom." However, notwithstanding the Patient's controlled substance use and chronic pain issues, Respondent's medical records contain no documentation that Respondent clarified exactly how much alcohol the Patient drank. Throughout Respondent's treatment period, Respondent's medical records do not contain information that anyone ever asked the Patient about his use of non-prescription drugs.

51. Respondent's medical records for the Patient document: "Social History: 'Drinks: rarely.'" Throughout Respondent's treatment period, each visit note has the same Past Medical History [PMH], Social History [SH], and Review of Systems [ROS] information. It is improbable that the ROS would be identical for over 20 visits, given the different issues that occured throughout this time. As such, those sections of the medical records appear to be copied and pasted or templated in, thus making those sections unreliable.

52. Throughout Respondent's treatment period, Respondent's medical records contain other untrustworthy entries. For example, it is unclear how the Patient's diagnosis of complex regional pain syndrome of the right lower extremity last documented in 2016 by the prior treating physician became bilateral when Respondent began seeing the Patient in 2017, as Respondent did not note any information to explain the Patient's worsened diagnosis.

53. Throughout Respondent's treatment period the Patient's medical records document eight emergency room visits from January 2017 to August 2018. All the emergency room visits were for alcohol-related problems, including acute intoxication, binge drinking, withdrawal, seizure, suicide ideation, suicide attempt, homicide ideation, and hallucinations.

54. On August 7, 2018, the Patient went to a hospital emergency room. The hospital medical records for this visit document his use of alcohol in three sections. The "History of Present Illness" [HPI] section reports the Patient had been "binge drinking." The "Social History" section reports alcohol use 'regularly.' The PMH lists alcohol abuse, withdrawal seizures, and pancreatitis.

55. In her interview, Respondent stated she never felt the Patient was taking more medication than necessary, that she never smelled alcohol on his person, or that he appeared intoxicated. Respondent further stated she trusted the Patient's initial report of 'seldom' alcohol use.

56. Respondent did not explain why she failed to directly address the Patient's use of alcohol and drugs with him, given her review of the prior records of polysubstance abuse and the emergency room records that unmistakably documented the Patient's alcohol problems. Nor did Respondent explain why the emergency room records did not provide a turning point in her

medical care with regard to prescribing medications, or educating the Patient about the risks and benefits of the various medications she prescribed, as well as making additional efforts to more closely monitor the Patient.

57. Respondent's records reveal that on two visits [November 15, 2017, and February 4, 2019], the Patient was reportedly out of medication. Of significance, the Patient was in withdrawal on one of those occasions. Respondent's records for those visits do not contain any mention of a discussion with the Patient regarding the risks/benefits and proper use of medications she prescribed to him on a continuing basis.

58. Respondent's records disclose that the Patient fell in April 2019. Respondent's records contain no indication that Respondent attempted to determine if side effects from the medications she prescribed to the Patient were a contributing factor to the fall.

59. During Respondent's interview, she implied that she did not need to address the Patient's use of alcohol and drugs, closely monitor, or educate the Patient regarding the risks and benefits of the various medications because the Patient was seeing a pain mangagement physician.

60. During Respondent's treatment, Respondent did not have a pain contract or agreement with the Patient.

61. During Respondent's treatment, the Patient's medical records reflect Respondent checked CURES on October 8, 2018, and March 18, 2019, which met CURES requirements. However, Respondent failed to order toxicology screening tests for the Patient.

62. Respondent's overall pain medication plan is unclear, with doses rising and falling with no stated justification. For example, the Patient was receiving 120 pills of Dilaudid 8 mg monthly for several months. At the patient's February 4, 2019 visit, the opioid dose count was decreased dramaticially by 50 % to 60 pills with no explanation, despite the Patient's documented pain level of 9/10.

63. For the most part, during Respondent's treatment, the medical record documents that the Patient always experienced unremitting severe pain. Nonetheless, Respondent's records do not explain dosing the Patient twice daily with short-acting Dilaudid, given that Dilaudid

analgesia usually lasts only three to four hours.

64. The Patient had three visits after the Narcan law went into effect. Therefore, because Respondent was prescribing both opioids and benzodiazepines every month, Respondent should have educated the Patient about Narcan and offered to provide him with Narcan.

65. Respondent's medical records reflect that Respondent failed to either educate the Patient about Narcan or prescribe Narcan for him. The circumstances of his death reveal the exact situation for which Narcan was intended; the Patient's life could possibly have been saved had he received Narcan education and had the medication at home. Despite the circumstances of the Patient's death, during her interview, Respondent stated she still does not prescribe Narcan for her patients.

66. Throughout Respondent's treatment, Respondent's medical records contain no documentation of ROS regarding depression. Given the Patient's longstanding issues of chronic pain, anxiety, insomnia, and controlled substance use, this would have been important to explore with the Patient. Respondent's prescriptions of twice daily short-acting benzodiazepine is not the typical treatment for chronic anxiety.

67. A psychiatry referral could have been beneficial for the Patient due to his chronic pain, anxiety, insomnia, and controlled substance use. However, throughout Respondent's treatment, Respondent failed to refer the Patient to a psychiatrist for a medication review.

68. The Patient's blood pressure was elevated on 19 of the 20 visits he had with Respondent. During Respondent's treatment Respondent never once addressed this issue.

69. Respondent's medical records for the Patient's September 29, 2017, visit for his complaint of erectile dysfunction state that the Patient has "no blood pressure issues" despite the PMH listing hypertension and the Patient's blood pressure during the visit displaying an elevated measurement of 141/100 and the notes referring to a home blood pressure reported as 132/88.

70. Respondent's medical records for the Patient's August 24, 2018, visit state the Patient does not have insurance. Lack of medical insurance does not absolve Respondent of the duty to address the Patient's elevated blood pressure readings, which were recorded in her office. Respondent failed to discuss the Patient's elevated blood pressure with him and make appropriate

medical recommendations, such as basic lifestyle measures.

71. Respondent's medical records for the Patient's August 15, 2018, visit show that the results of the laboratory tests Respondent ordered for the Patient display elevated uric acid. Respondent's medical records for the Patient's August 17, 2018, visit show she discussed the elevated uric acid with the Patient. However, the laboratory test results also showed leukopenia, neutropenia, and thrombocytopenia. The leukopenia, neutropenia, and thrombocytopenia abnormal results were not addressed by the Respondent or any of her staff.

72. The leukopenia, neutropenia, and thrombocytopenia abnormalities could have been caused by the Patient's alcohol use, and thus could have been another sign to alert Respondent to this critical issue.

STANDARD OF CARE

73. The standard of care for a physician who is prescribing controlled substances is clearly articulated by several sources. The published 2014 California Medical Board Guidelines for Prescribing Controlled Substances for Pain [Pain Management Guidelines] state the following:

74. Compliance with Controlled Substances Laws and Regulations

To prescribe controlled substances, the physician must be appropriately licensed in California, have a valid controlled substances registration, and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and the Medical Board's Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons for specific rules governing issuance of controlled substances prescriptions.

75. History/Physical Examination

A medical history and physical examination must be accomplished by the physician. The medical history and physical examination should include an assessment of the patient's pain, physical and psychological function; the patient's substance abuse history; the patient's history of prior pain treatment; the physician's assessment of the patient's underlying or coexisting diseases or conditions; and the physician's documentation of the presence of a recognized medical

indication for the use of a controlled substance.

76. Treatment Plan, Objectives

The physician's treatment plan should state objectives by which the treatment plan can be evaluated, including the patient's pain relief and/or improved physical and psychosocial function, and also indicate if any further diagnostic evaluations or other treatments are planned. The physician should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

77. Informed Consent

The physician should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

78. Periodic Review

The physician should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

79. Consultation

The physician should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. A patient who is experiencing complex pain problems may require consultation with a pain management specialist. In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications, including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

80. Records

The physician should keep accurate and complete records that include the patient's medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

81. California Assembly Bill 2760 was signed into law in 2018, became effective on January 1, 2019, and is codified in Code sections 740, 741, and 742. The California Medical Board website also references the laws' requirements.

82. Code sections 740, 741, and 742 require prescribers to offer a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to a patient when one or more of the following conditions are present:

A. The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

B. An opioid medication is prescribed concurrently with a prescription for benzodiazepine.

C. The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

83. The law requires prescribers, consistent with the existing standard of care, to provide education to patients, persons designated by the patient, or for minor patients, to their parents or guardian, if they fall under one of the above conditions, regarding overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression.

84. The standard of care for a physician during a patient's medical visits requires both measuring vital signs such as blood pressure as well as addressing abnormally high blood pressure readings regardless of the purpose of the visit. This requires the physician to include educating the patient regarding the issues which involve abnormally high blood pressure readings

along with advising the patient to follow-up, possibly referring the patient to another provider, or diagnosing and managing the blood pressure issue themselves.

85. The standard of care for a physician treating a patient requires the physician to be responsible for managing results of tests that they order. Appropriate management of those results includes educating and advising the patient to follow-up, referring the patient to another provider, or diagnosing and managing the issue themselves.

RESPONDENT'S DEPARTURES FROM THE STANDARD OF CARE

86. Respondent claims she did not know about the Patient's dangerous use of alcohol and prescribed the alprazolam and hydromorphone found in the Patient's system by his autopsy. Given the abundant and easily accessible facts delineated above, the Respondent should have known about the Patient's alcohol use. Respondent's claim that because the Patient never appeared intoxicated she trusted his initial report that he 'seldom' consumed alcohol is not reasonable under these circumstances and is an extreme departure from the standard of care.

87. When the Patient first began treatment with Respondent he provided her with his previous medical records that described the Patient's polysubstance abuse. It was Respondent's responsibility under the applicable standard of care to address both the Patient's alcohol and his drug use more directly with him. The Patient's records from his repeated trips to the emergency room during Respondent's care clearly documented his alcohol problems. Certainly those records should have been a turning point in Respondent's care of the Patient, and Respondent should have immediately changed her prescribing, educating, and monitoring of the Patient. Respondent's failure under these circumstances to change the Patient's care and treatment is an extreme departure from the standard of care.

88. Given the Patient's medical history, Respondent should have taken extra precautions when prescribing controlled substances to the Patient. Respondent should have prescribed fewer controlled substances to the Patient. The respondent's failure under these circumstances to change her prescribing practices is an extreme departure from the standard of care.

89. The respondent failed to discuss the risks and benefits of the medications she prescribed to the Patient. Respondent's suggestion during her interview that she did not need to

have these discussions with the Patient since he was seeing a Pain Management physician is not the acceptable standard of care. Because Respondent was the Patient's treating and prescribing physician Respondent had an independent relationship with the Patient and therefore a duty to obtain informed consent from the Patient and her failure to do so is an extreme departure from the standard of care.

90. As previously mentioned, during both visits, when the Patient was reportedly out of medication and/or in withdrawal, Respondent failed to provide the Patient with any updated, appropriate treatment by elucidating the risks/benefits and proper use of medications she prescribed to him on a continuing basis or by changing the type and/or dosages of those medications. Respondent's failure under these circumstances to clarify the risks/benefits and proper use of medications she prescribed, as well as possibly changing the type and/or dosages of those medications, are extreme departures from the standard of care.

91. Respondent again failed to obtain educated, informed consent from the Patient or by changing the type and/or dosages of the medications she prescribed. She failed to investigate if those medications were a contributing factor in the Patient's fall approximately a month before his death. Respondent's failure to investigate if those medications were a contributing factor in the Patient's fall is an extreme departure from the standard of care.

92. Respondent did not comply with the standard of care with regard to educating the Patient and any of his caregivers about Narcan. Respondent's failure to educate the Patient and any of his caregivers about Narcan is an extreme departure from the standard of care.

93. Respondent did not comply with the standard of care with regard to prescribing Narcan to Respondent. Respondent's failure to prescribe Narcan to Respondent is an extreme departure from the standard of care.

94. Respondent did not comply with the standard of care with regard to her management of the Patient's pain, given her undocumented and sometimes dramatic shifts in the opioid prescriptions she provided. Respondent's pain management of the Patient is an extreme departure from the standard of care.

95. Respondent did not comply with the standard of care with regard to her management

of the Patient's pain when she failed to utilize toxicology screening tests during her care and treatment of the Patient. Respondent's failure to utilize toxicology screening tests during the Patient's care is an extreme departure from the standard of care.

96. Respondent did not comply with the standard of care with regard to her management of the Patient's pain when she failed to utilize pain contracts or agreements during her treatment of the Patient. Respondent's failure to use pain contracts or agreements during her treatment of the Patient is an extreme departure from the standard of care.

97. The Patient's blood pressure was elevated every time it was taken, yet Respondent never addressed this persistent and potentially life-threatening issue with the Patient. As revealed by his autopsy, the Patient was harmed by Respondent's utter failure to address his elevated blood pressure results as he suffered left ventricular hypertrophy of his heart and hypertensive vasculopathy of his brain. Respondent's failure to address the Patient's elevated blood pressure results during her treatment of the Patient is an extreme departure from the standard of care.

98. The laboratory tests Respondent ordered for the Patient on August 15, 2018, showed a number of abnormal results. The Patient's medical records for August 17, 2018, reveal that neither Respondent nor any of her staff addressed the leukopenia, neutropenia, and thrombocytopenia abnormal results with the Patient. Respondent's failure to address the Patient's leukopenia, neutropenia, and thrombocytopenia abnormal results during her treatment of the Patient is an extreme departure from the standard of care.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

(Business and Professions Code, § 2234, subdivision (b))

99. Respondent Irene Helen Sanchez-Esparza, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code in that she was grossly negligent in the care and treatment of the Patient. The circumstances are as follows:

100. The facts and circumstances alleged in paragraphs 42 through 99 are incorporated here as if fully set forth.

101. Respondent was grossly negligent in her care and treatment of the Patient, taken

individually or collectively, when she treated the Patient as follows:

(a) Respondent failed to follow the standard of practice when she prescribed alprazolam and hydromorphone to the Patient, in the face of evidence indicating the Patient's dangerous use of alcohol and other medications.

(b) Respondent failed to follow the standard of practice when she failed to change her prescribing, educating, and monitoring of the Patient.

(c) Respondent failed to follow the standard of practice when she failed to change her prescribing practices to the Patient.

(d) Respondent failed to follow the standard of practice when she failed to obtain informed consent from the Patient.

(e) Respondent failed to follow the standard of practice when she failed to investigate if the medications she prescribed to the Patient contributed to his fall.

(f) Respondent failed to follow the standard of practice when she failed to educate the Patient and any of his caregivers about Narcan.

(g) Respondent failed to follow the standard of practice when she failed to prescribe Narcan to the Patient.

(h) Respondent failed to follow the standard of practice when she failed to appropriately treat and manage the Patient's pain.

(i) Respondent failed to follow the standard of practice when she failed to utilze toxicology screening tests during her care and treatment of the Patient.

(j) Respondent failed to follow the standard of practice when she failed to utilize pain contracts or agreements during her treatment of the Patient.

(k) Respondent failed to follow the standard of practice when she failed to address the Patient's elevated blood pressure results during her treatment of the Patient.

(l) Respondent failed to follow the standard of practice when she failed to address the Patient's leukopenia, neutropenia, and thrombocytopenia abnormal results during her treatment of the Patient.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

((Business and Professions Code, § 2234, subdivision (c))

102. Respondent Irene Helen Sanchez-Esparza, M.D. is subject to disciplinary action under section 2234, subdivision (c)of the code in that she was repeatedly negligent in the care and treatment of the Patient. The circumstances are as follows:

103. The facts and circumstances alleged in paragraphs 42 through 99 are incorporated here as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Inappropriate Prescribing of Controlled Substances Resulting in Harm to Patient)

((Business and Professions Code, § 2228.1, subddivision (a), subsections (1)(D) and (2))

104. Respondent Irene Helen Sanchez-Esparza, M.D. is subject to disciplinary action under section 2228.1, subdivision (a), subsections (1)(D) and (2) of the Code in that Respondent's prescribing of controlled substances resulted in harm to the Patient. The facts and circumstances alleged in paragraphs 42 through 99 are incorporated here as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

((Business and Professions Code, § 2234)

105. Respondent Irene Helen Sanchez-Esparaz, M.D. is further subject to disciplinary action under section 2234 of the Code, in that the facts and circumstances alleged in paragraphs 42 through 99 are incorporated here as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 50850, issued to Irene Helen Sanchez-Esparza, M.D.;

2. Revoking, suspending or denying approval of Irene Helen Sanchez-Esparza, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Irene Helen Sanchez-Esparza, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Irene Helen Sanchez-Esparza, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: AUG 0 1 2023

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

Complainant

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