

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

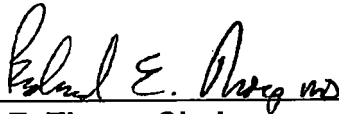
DECISION

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

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 WENDY WIDLUS
Deputy Attorney General
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8

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

13 In the Matter of the Accusation Against:

14 IRENE HELEN SANCHEZ-ESPARZA, M.D.

15 4200 Buck Owens Boulevard
16 Bakersfield, California 93308

17 Physician's and Surgeon's Certificate No. A 50850,

18 Respondent.
19

Case No. 800-2021-074667

OAH No. 2023090878

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

20
21 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
22 entitled proceedings that the following matters are true:

23 **PARTIES**

24 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
25 California (Board). He brought this action solely in his official capacity and is represented in this
26 matter by Rob Bonta, Attorney General of the State of California, by Wendy Widlus, Deputy
27 Attorney General.
28

1 **CULPABILITY**

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

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

9 **CIRCUMSTANCES IN MITIGATION**

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

12 **CONTINGENCY**

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

22 12. Respondent agrees that if she ever petitions for early termination or modification of
23 probation, or if an Accusation and/or petition to revoke probation is filed against her before the
24 Board, all of the charges and allegations contained in First Amended Accusation No. 800-2021-
25 074667 shall be deemed true, correct and fully admitted by respondent for purposes of any such
26 proceeding or any other licensing proceeding involving Respondent in the State of California.

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

1 as the originals.

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

5 **DISCIPLINARY ORDER**

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

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

10 2. **EDUCATION COURSE.** Within 60 calendar days of the effective date of
11 this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its
12 designee for its prior approval educational program(s) or course(s) which shall not be less than 40
13 hours per year, for each year of probation. The educational program(s) or course(s) shall be
14 aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified.
15 The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition
16 to the Continuing Medical Education (CME) requirements for renewal of licensure. Following
17 the completion of each course, the Board or its designee may administer an examination to test
18 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
19 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

6 Respondent shall submit a certification of successful completion to the Board or its
7 designee not later than 15 calendar days after successfully completing the course, or not later than
8 15 calendar days after the effective date of the Decision, whichever is later.

9 4. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION.

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

16 5. CONTROLLED SUBSTANCES - Maintain Records and Access to

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

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

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

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

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

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

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

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

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

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

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

19 7. NOTIFICATION. Within seven (7) days of the effective date of this
20 Decision, the Respondent shall provide a true copy of this Decision and First Amended
21 Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges
22 or membership are extended to Respondent, at any other facility where Respondent engages in the
23 practice of medicine, including all physician and locum tenens registries or other similar agencies,
24 and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance
25 coverage to Respondent. Respondent shall submit proof of compliance to the Board or its
26 designee within 15 calendar days.

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

28 //

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

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

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

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

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

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

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

24 12. GENERAL PROBATION REQUIREMENTS.

25 Compliance with Probation Unit

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

27 Address Changes

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

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

5 Place of Practice

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

9 License Renewal

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

12 Travel or Residence Outside California

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 ACCEPTANCE

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

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

3
4 DATED: _____
5 IRENE HELEN SANCHEZ-ESPARZA, M.D.
6 Respondent

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

10 DATED: _____
11 PETER R. OSINOFF
12 DEREK F. O'REILLY-JONES
13 Attorneys for Respondent

14 **ENDORSEMENT**

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

17 DATED: _____
18 Respectfully submitted,
19 ROB BONTA
20 Attorney General of California
21 ROBERT MCKIM BELL
22 Supervising Deputy Attorney General

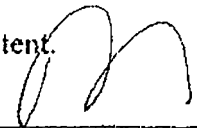
23
24 WENDY WIDLUS
25 Deputy Attorney General
26 Attorneys for Complainant

27 LA2023601964
28 Stipulated Settlement Sanchez Esparza.docx

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

3
4 DATED: 2/29/2024 
5 IRENE HELEN SANCHEZ-ESPARZA, M.D.
6 Respondent

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

10 DATED: 2/29/2024 
11 PETER R. OSINOFF
12 DEREK F. O'REILLY-JONES
13 Attorneys for Respondent

14 **ENDORSEMENT**

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

17 DATED: _____

18 Respectfully submitted,

19 ROB BONTA
20 Attorney General of California
21 ROBERT MCKIM BELL
22 Supervising Deputy Attorney General

23 WENDY WIDLUS
24 Deputy Attorney General
25 Attorneys for Complainant

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27 Stipulated Settlement Sanchez-Esparza.docx

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

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4 DATED: _____
5 IRENE HELEN SANCHEZ-ESPARZA, M.D.
6 Respondent

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

10 DATED: _____
11 PETER R. OSINOFF
12 DEREK F. O'REILLY-JONES
13 Attorneys for Respondent

14 **ENDORSEMENT**

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

17 DATED: March 1, 2024

18 Respectfully submitted,
19 ROB BONTA
20 Attorney General of California
21 ROBERT MCKIM BELL
22 Supervising Deputy Attorney General

23 *Wendy Widlus*

24 WENDY WIDLUS
25 Deputy Attorney General
26 Attorneys for Complainant

27 LA2023601964
28 Stipulated Settlement Sanchez Esparza.docx

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Attorneys for Complainant

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
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11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2021-074667

13 **IRENE HELEN SANCHEZ-ESPARZA,**
14 **M.D.**

A C C U S A T I O N

15 **4200 Buck Owens Boulevard.**
16 **Bakersfield, California 93308**

17 **Physician's and Surgeon's Certificate**
18 **No. A 50850,**

Respondent.

19 **PARTIES**

20
21 1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as
22 the Executive Director of the Medical Board of California, Department of Consumer Affairs
23 (Board).

24 2. On June 9, 1992, the Board issued Physician's and Surgeon's Certificate Number A
25 50850 to Irene Helen Sanchez-Esparza, M.D. (Respondent). That license was in full force and
26 effect at all times relevant to the charges brought herein and will expire on April 30, 2024, unless
27 renewed.

28 //

1 JURISDICTION

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

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

7 5. Section 2001.1 states:

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

12 6. Section 2004 of the Code states:

13 The board shall have the responsibility for the following:

14 (a) The enforcement of the disciplinary and criminal provisions of the Medical
15 Practice Act.

16 (b) The administration and hearing of disciplinary actions.

17 (c) Carrying out disciplinary actions appropriate to findings made by a panel or
18 an administrative law judge.

19 (d) Suspending, revoking, or otherwise limiting certificates after the conclusion
20 of disciplinary actions.

21 (e) Reviewing the quality of medical practice carried out by physician and
22 surgeon certificate holders under the jurisdiction of the board.

23 (f) Approving undergraduate and graduate medical education programs.

24 (g) Approving clinical clerkship and special programs and hospitals for the
25 programs in subdivision (f).

26 (h) Issuing licenses and certificates under the board's jurisdiction.

27 (i) Administering the board's continuing medical education program.

28 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

1 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.

2 (b) Requiring the licensee to submit to a complete diagnostic examination by
3 one or more physicians and surgeons appointed by the board. If an examination is
4 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.

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

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

9 8. Section 2228.1 of the Code states:

10 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),
11 the board shall require a licensee to provide a separate disclosure that includes the
12 licensee's probation status, the length of the probation, the probation end date, all
13 practice restrictions placed on the licensee by the board, the board's telephone
14 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:

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

17 ...

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

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

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

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

27 (1) The Patient is unconscious or otherwise unable to comprehend the
28 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.

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

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

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

5 (d) On and after July 1, 2019, the board shall provide the following
6 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.

7 (1) For probation imposed pursuant to a stipulated settlement, the causes
8 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
9 the settlement is not an admission of guilt.

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

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

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

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

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

16 **STATUTORY PROVISIONS**

17 9. Section 2234 of the Code, states:

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

21 ...

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

24 (b) Gross negligence.

25 (c) Repeated negligent acts. To be repeated, there must be two or more
26 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.

27 ...

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

1
2 10. Section 2242 of the Code states:

3 (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
4 4022 without an appropriate prior examination and a medical indication, constitutes
5 unprofessional conduct. An appropriate prior examination does not require a
6 synchronous interaction between the patient and the licensee and can be achieved
7 through the use of telehealth, including, but not limited to, a self-screening tool or a
8 questionnaire, provided that the licensee complies with the appropriate standard of
9 care.

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

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

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

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

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

25 (3) The licensee was a designated practitioner serving in the absence of the
26 patient's physician and surgeon or podiatrist, as the case may be, and was in
27 possession of or had utilized the patient's records and ordered the renewal of a
28 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.

22 11. Section 725 of the Code states:

23 (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or
24 administering of drugs or treatment, repeated acts of clearly excessive use of
25 diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or
26 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.

27 (b) Any person who engages in repeated acts of clearly excessive prescribing or
28 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

1 dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than
2 180 days, or by both that fine and imprisonment.

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

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

8 12. Section 740 of the Code states:

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

12 13. Section 741 of the Code states:

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

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

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

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

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

27 (2) Consistent with the existing standard of care, provide education to the
28 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 (1) When prescribing to an inmate or a youth under the jurisdiction of the
2 Department of Corrections and Rehabilitation or the Division of Juvenile Justice
3 within the Department of Corrections and Rehabilitation.

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

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

8 14. Section 742 of the Code states:

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

16 COST RECOVERY

17 15. Section 125.3 of the Code states:

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

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

26 (c) A certified copy of the actual costs, or a good faith estimate of costs where
27 actual costs are not available, signed by the entity bringing the proceeding or its
28 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.

1 (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.

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

4 (2) Notwithstanding paragraph (1), the board may, in its discretion,
5 conditionally renew or reinstate for a maximum of one year the license of any
6 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.

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

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

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

13 DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 FACTUAL ALLEGATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 57. Respondent's records reveal that on two visits [November 15, 2017, and February 4,
5 2019], the Patient was reportedly out of medication. Of significance, the Patient was in
6 withdrawal on one of those occasions. Respondent's records for those visits do not contain any
7 mention of a discussion with the Patient regarding the risks/benefits and proper use of
8 medications she prescribed to him on a continuing basis.

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

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

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

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

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

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

1 analgesia usually lasts only three to four hours.

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

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

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

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

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

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

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

1 medical recommendations, such as basic lifestyle measures.

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

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

11 STANDARD OF CARE

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

16 74. Compliance with Controlled Substances Laws and Regulations

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

23 75. History/Physical Examination

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

1 indication for the use of a controlled substance.

2 76. Treatment Plan, Objectives

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

9 77. Informed Consent

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

12 78. Periodic Review

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

19 79. Consultation

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

1 80. Records

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

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

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

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

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

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

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

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

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

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

7 **RESPONDENT'S DEPARTURES FROM THE STANDARD OF CARE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 **FIRST CAUSE FOR DISCIPLINE**

21 (Gross Negligence)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 //

1 P R A Y E R

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

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

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

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

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

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

15
16 DATED: AUG 01 2023



17 REJI VARGHESE
18 Executive Director
19 Medical Board of California
20 Department of Consumer Affairs
21 State of California

22 *Complainant*

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