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

In the Matter of the Accusation Against: **Robert Bruce Rushton, M.D.** Physician's and Surgeon's Certificate No. G 47055 Respondent.	MBC File # 800-2020-067079

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "LICENSE NUMBER" PORTION OF DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "license number" portion of the Decision in the above-entitled matter and that such clerical error should be corrected so that the license number will conform to the Board's issued license.

IT IS HEREBY ORDERED that the license number contained on the Disciplinary Order page in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as *G 47055*.

Date: August 27, 2024

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against: Robert Bruce Rushton, M.D. Physician's & Surgeon's Certificate No. A 47055 Respondent.	Case No. 800-2020-067079

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 14, 2024.

IT IS SO ORDERED: May 17, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D, Chair
Panel B

ROB BONTA
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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: **ROBERT BRUCE RUSHTON, M.D.** **844 S. Dora Street** **Ukiah, CA 95482** **Physician's and Surgeon's Certificate No. G 47055** Respondent.	Case No. 800-2020-067079 OAH No. 2023110306 **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 Aaron L. Lent, Deputy Attorney General.

2. Respondent Robert Bruce Rushton, M.D. (Respondent) is represented in this proceeding by attorney Benjamin J. Fenton, Esq., whose address is: 1990 S. Bundy Drive, Suite 777, Los Angeles, CA 90025.

3. On or about March 1, 1982, the Board issued Physician's and Surgeon's Certificate No. G 47055 to Robert Bruce Rushton, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-067079, and will expire on March 31, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-067079 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 27, 2023. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2020-067079 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-067079. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2020-067079.

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

CONTINGENCY

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

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2020-067079 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, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 47055 issued to Respondent ROBERT BRUCE RUSHTON, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a) (4). This public reprimand, which is issued in connection with Respondent's care and treatment of Patients 1 and 2 as set forth in Accusation No. 800-2020-067079, is as follows:

"You failed to properly document, assess, and monitor, as well as prescribe controlled substances to Patient 1. You conducted an inadequate examination and failed to properly document your care and treatment of Patient 2."

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

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

this Decision.

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

Failure to successfully complete and provide proof of attendance to the Board or its designee of the prescribing practices course within 60 calendar days of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

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

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

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

Failure to successfully complete and provide proof of attendance to the Board or its designee of the medical record keeping course within 60 calendar days of the effective date of

this Decision, unless the Board or its designee agrees in writing to an extension of time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

3. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $22,500.00 (twenty-two thousand five hundred dollars). Costs shall be payable to the Medical Board of California.

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 pay the amount in full or comply with the payment plan shall be considered unprofessional conduct and may serve as the grounds for further disciplinary action.

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

4. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2020-067079 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 4/23/2024

ROBERT BRUCE RUSHTON, M.D.
Respondent

I have read and fully discussed with Respondent Robert Bruce Rushton, 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: 4/23/2024

BENJAMIN J. FENTON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: April 24, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
MICHAEL C. BRUMMEL
Supervising Deputy Attorney General

AARON L. LENT
Deputy Attorney General
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Robert Bruce Rushton, M.D.** **844 S. Dora Street** **Ukiah, CA 95482** **Physician's and Surgeon's Certificate No. G 47055,** Respondent.	Case No. 800-2020-067079 **ACCUSATION**

PARTIES

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

2. On March 1, 1982, the Board issued Physician's and Surgeon's Certificate Number G 47055 to Robert Bruce Rushton, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 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. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

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

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

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

"(b) Gross negligence.

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

". . . ."

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

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

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

RESPONDENT'S PRACTICE

8. Respondent practices as a primary care physician in Ukiah, California, where he owns and operates a family and internal medicine clinic.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts)

Patient 1[1]

8. In 2013, Respondent began treating Patient 1, a then forty-six-year-old female. Patient 1 reported a history of chronic back pain. Respondent regularly prescribed opioids to treat Patient 1's back pain and benzodiazepines to treat Patient 1's anxiety.

9. At one of the earliest visits, Respondent documented in Patient 1's medical records that she had attempted suicide via an alcohol overdose, that she had been diagnosed as bipolar, and suffered from post-traumatic stress disorder. Respondent described Patient 1 as a binge alcoholic with frequent urine drug tests showing no alcohol because of her binge pattern. Respondent also noted in the records that Patient 1 had a history of seizure disorder for which she was taking Ativan.[2]

10. Between 2013 through 2022, Respondent regularly prescribed numerous controlled substances to Patient 1 without ongoing psychiatric consultation despite knowing that Patient 1 had been diagnosed with bipolar disorder and alcohol abuse disorder and had a history of suicide attempts. Respondent did not document a pain management consultant's treatment plan or an adequate physical examination or neurologic exam for Patient 1 despite the patient's history of back surgery, multiple traumas, compression fractures, seizures, and ongoing controlled substance prescribing.

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[1] Patients are referred to by number to protect their privacy.

[2] Lorazepam (trade name Ativan) is a controlled substance and a benzodiazepine used to treat anxiety. Benzodiazepines, when taken in conjunction with opiates, increase the risk of respiratory arrest.

11. On February 6, 2013, Respondent noted that Patient 1 was taking Suboxone (an opioid agonist/antagonist), clonazepam (a benzodiazepine), gabapentin (an anticonvulsant), and trazodone (antidepressant).

12. On February 28, 2013, Respondent prescribed hydrocodone[3] 5/325. A few months later, Respondent increased the hydrocodone to 10/325.

13. In June 2013, Patient 1 presented to Respondent for suture removal from a suicide attempt. Patient 1 had attempted suicide by slashing her wrist. Respondent did not document a psychiatric referral. Respondent started Patient 1 on valproic acid[4] for impulse control.

14. In August 2013, Respondent documented in Patient 1's chart that Patient 1 was seeing a therapist for counseling. There are no therapy notes in the chart and no subsequent references to psychiatry referrals or follow up.

15. In December 2013, Respondent replaced Patient 1's hydrocodone 10/325 with oxycodone[5] 10/325.

16. In February 2014, Respondent ordered an MRI of Patient 1's cervical, thoracic, and lumbar spine after noting that Patient 1 had some motor vehicle accidents and falls in 2013.

17. On March 26, 2014, Respondent noted in Patient 1's chart that her psychiatrist had increased her Klonopin[6] to 4 times a day. This note gives the impression that at this point, Patient 1 was under the care of a psychiatrist and that the psychiatrist was managing her benzodiazepine prescriptions. However, a Controlled Substance Utilization Review and Evaluation System (CURES) report indicated that there was only one single clonazepam prescription issued from a different doctor other than Respondent. The rest of the prescriptions to Patient 1 were issued by Respondent. Respondent did not document a treatment plan from a psychiatrist or reference any ongoing psychiatric care.

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[3] Hydrocodone/acetaminophen is an opioid and Schedule II controlled substance. Common trade name is Norco or Vicodin. It is similar in strength to morphine.

[4] Valproic acid is used to treat certain types of seizures.

[5] Oxycodone is an opioid and Schedule II controlled substance. Common trade name is OxyContin. Oxycodone is somewhat more powerful than morphine.

[6] Klonopin is a trade name for clonazepam.

18. On April 9, 2014, Respondent documented in Patient 1's medical records that Patient 1 felt like jumping off a building.

19. On August 6, 2014, Respondent documented in Patient 1's medical records that Patient 1 reported having lost her purse with her medications in it and that she subsequently suffered seizures. At this visit, without explanation as to why, Respondent prescribed oxycodone immediate release 10 mg #120 and Valium 2 mg #120 (a benzodiazepine) to Patient 1. There is no mention of an electroencephalogram (EEG)[7] or neurology referral after any of Patient 1's seizures.

20. On September 22, 2014, Respondent ordered a urine drug screen for Patient 1 after he gave Patient 1 an early Klonopin refill. Respondent documented that Patient 1 had reported that she had lost her medications due to a fight with her boyfriend. There were no urine drug screen results in Patient 1's medical chart.

21. On October 8, 2014, Respondent noted in Patient 1's chart that she was drinking a pint of liquor a day. Respondent gave Patient 1 an alcohol taper schedule and a prescription for Librium (a benzodiazepine frequently used for alcohol withdrawal) to use in place of the Klonopin at the end of the alcohol taper.

22. In November 2014, one of Respondent's staff members noted in Patient 1's chart that Patient 1 was out of Klonopin. A handwritten note in the chart also stated that Patient 1 took too many Klonopin.

23. On November 24, 2014, Respondent documented in Patient 1's medical records that Patient 1 went into "complete liver failure" and was hospitalized.

24. On December 23, 2014, Respondent prescribed Ativan. It is unclear why Respondent prescribed the Ativan.

25. On January 19, 2015, Respondent increased Patient 1's oxycodone 10 mg to 3 times a day due to Patient 1 reporting severe pain. Respondent did not document a physical exam for Patient 1 before increasing her oxycodone.

[7] An EEG is a test that detects abnormalities in the brain waves.

26. On March 16, 2015, Respondent prescribed Roxanol (morphine suspension, immediate relief) to Patient 1. On July 2, 2015, Respondent switched Patient 1's Roxanol prescription to Percocet (trade name for oxycodone/acetaminophen) due to Patient 1's nausea from the Roxanol.

27. On August 4, 2015, Respondent documented that Patient 1 presented "drunk" and had "alcohol on breath." Despite being acutely intoxicated, Respondent refilled Patient 1's prescriptions for Percocet and Ativan. Respondent did not taper Patient 1's opioids or benzodiazepines, or refer Patient 1 to another provider for tapering.

28. On November 11, 2015, Respondent prescribed trazodone 300 mg at night. This dose of trazodone had the potential to cause sedation when combined with the benzodiazepines and opiates that Respondent was prescribing to Patient 1. Like many other prior visits, Respondent did not document a physical exam for Patient 1 other than vital signs.

29. On January 12, 2016, Respondent stopped Patient 1's Percocet and prescribed morphine contin[8] (long-acting) 30 mg daily and oxycodone 10 mg four times a day (total of 120 morphine milligram equivalent (MME)). Respondent had Patient 1 sign an opioid contract.

30. On March 2, 2016, Respondent documented that Patient 1 had gone on an alcohol binge and took "all of her medication." Respondent also documented that he prescribed a lower dose of MS Contin and OxyContin to Patient 1. However, a CURES report showed that Patient 1 filled prescriptions for oxycodone, morphine, and lorazepam.

31. On March 31, 2016, Respondent refilled Patient 1's controlled substances despite smelling alcohol on her breath.

32. On August 3, 2017, Respondent documented in the records that Patient 1 had reported that her prescriptions were stolen. Respondent noted that he told Patient 1 that without a police report, he would not refill her medications but in his treatment plan, Respondent documented "oxycontin 20 mg #90. However, a CURES report did not show a corresponding OxyContin prescription. On August 17, 2017, Respondent noted that after Patient 1 provided a police report,

[8] Morphine contin is an opioid and Schedule II controlled substance. Trade name is MS Contin.

he prescribed Norco (trade name for hydrocodone/acetaminophen). On August 23, 2017, Respondent prescribed MS Contin, oxycodone, and Ativan.

33. On January 17, 2018, Respondent documented in the medical records that Patient 1 was referred to a pain management specialist.

34. On November 7, 2018, Respondent miscalculated the MME that he was prescribing to Patient 1 when he attributed 1.0 MME to oxycodone when it should have been 1.5. Respondent reduced Patient 1's dose of oxycodone and MS contin.

35. On February 7, 2019, Respondent again miscalculated the MME but decreased Patient 1's MS contin while increasing her oxycodone.

36. In Patient 1's medical records, there was a July 15, 2019 urine drug screen from an emergency room visit, which showed no opiates in Patient 1's system. This raised the issue of diversion since Respondent prescribed opiates to Patient 1 for many years, including just prior to the emergency room visit. Respondent did not document a discussion between Respondent and Patient 1 about this controlled substance inconsistency and possible diversion of drugs.

37. On December 17, 2019, Respondent documented that he ran a CURES report for Patient 1 and discovered that another physician had prescribed buprenorphine[9] to Patient 1 on December 10, 2019 and that Patient 1 had not disclosed that prescription to him. Nevertheless, Respondent refilled Patient 1's oxycodone and morphine prescriptions and did not document an adequate rationale for refilling Patient 1's controlled substances in the face of what appeared to be the initiation of opioid addiction treatment for Patient 1.

38. On September 23, 2020, Respondent prescribed alprazolam (benzodiazepine) to Patient 1.

39. On November 2, 2020 and June 14, 2021, Respondent documented that Patient 1 had urine drug tests that were negative for benzodiazepines and positive for opiates when Patient 1 was being prescribed both benzodiazepines and opiates at those times.

[9]Buprenorphine is generally used to treat opioid-dependent patients and is intended to completely replace other opioids.

40. On April 7, 2021, after Respondent had decreased Patient 1's Ativan to 1 mg for the prior several months, Respondent inexplicably increased Patient 1's Ativan to 2 mg for seizure control despite Patient 1 denying any seizure activity.

41. In August 2021, Patient 1 presented to Respondent for a follow-up after a hospitalization for sepsis and/or rhabdomyolysis (breakdown of muscle tissue) related to alcohol overdose, and with acute renal failure on dialysis. Despite the fact that Patient 1 did not receive any benzodiazepines while in the hospital, Respondent resumed prescribing benzodiazepines for Patient 1. Respondent also prescribed oxycodone 10 mg.

42. On March 9, 2022, Respondent documented that he was refusing to fill Patient 1's benzodiazepine prescriptions.

43. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 1, and is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) of the Code in that Respondent committed gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent prescribed controlled substances for many years to Patient 1 without ongoing psychiatric consultation despite Patient 1's documented suicide attempts and bipolar diagnosis;

B. Respondent prescribed controlled substances for many years to Patient 1 without documenting a pain management consultant's treatment plan;

C. On August 3, 2017, Respondent prescribed controlled substances to Patient 1 when Patient 1 reported that her controlled substances had been stolen despite Respondent having previously documented that Patient 1 had reported losing her controlled substances on two prior occasions;

D. Respondent prescribed multiple benzodiazepines to Patient 1 contemporaneously;

E. On March 31, 2016, Respondent refilled controlled substances for Patient 1 when Patient 1 presented with alcohol on her breath and had previously shown up acutely intoxicated to an office visit with Respondent on at least one prior occasion;

F. Respondent failed to calculate an accurate MME dosing for Patient 1 on at least two occasions;

G. In December 2019, Respondent refilled Patient 1's controlled substances even though Patient 1 appeared to have initiated opioid addiction treatment;

H. Respondent failed to address the inconsistencies in Patient 1's urine drug testing results;

I. Respondent continued prescribing benzodiazepines to Patient 1 even after the benzodiazepines had been stopped while Patient 1 was hospitalized in 2021;

J. Respondent failed to obtain a neurologic consultation for Patient 1 to help determine the validity of her seizure history and to outline a treatment plan; and

K. Respondent continued to prescribe benzodiazepines to Patient 1 for long-term seizure control.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

Patient 1

44. Respondent prescribed controlled substances to Patient 1 for many years without documenting a relevant and adequate physical exam and neurologic exam.

45. Respondent prescribed numerous controlled substances to Patient 1 for many years without documenting a relevant history, relevant review of system items, and regular assessment of the effectiveness of the medications on Patient 1's daily function.

46. Respondent regularly prescribed controlled substances to Patient 1 without documenting a treatment plan from a psychiatrist.

47. On March 2, 2016, Respondent incorrectly documented that he prescribed a lower dose of MS Contin and OxyContin to Patient 1 when CURES indicated that Patient 1 actually filled prescriptions for oxycodone, morphine, and lorazepam.

48. On July 28, 2016, Respondent incorrectly documented in the progress notes that he refilled OxyContin for Patient 1 when CURES indicated that Patient 1 actually refilled a prescription for oxycodone.

49. Respondent is guilty of unprofessional conduct and subject to discipline for violation of Section 2266 of the Code for failing to keep adequate and accurate medical records as alleged above.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts and/or Failure to Maintain Accurate and Adequate Medical Records)

Patient 2

50. On December 1, 2021, Patient 2, a then 27-year-old female, presented to Respondent for a Q fever test[10] and for chronic back pain. Respondent conducted an inadequate physical examination to evaluate Patient 2's back pain in that he did not palpate Patient 2's spine and paraspinal muscles, did not conduct back and leg flexibility testing or a focused neurologic exam to assess motor weakness, sensory deficits, and/or abnormal deep tendon reflexes. Respondent seemed to focus on telling Patient 2 that simply improving abdominal muscle tone (getting a "six pack") would resolve her back pain.

51. Respondent did not adequately document Patient 2's back pain, such as what her past diagnosis was, how severe it was, its duration, what made it better or worse, or any red flag symptoms (i.e. incontinence, sudden weakness) or what treatment she was currently taking (if any). Respondent's medical recordkeeping for Patient 2 was disorganized and had various pieces of information randomly scattered throughout his notes. Respondent did not document a review of Patient 2's old imaging or imaging reports that he referenced in his Board interview.

52. Respondent is guilty of unprofessional conduct in his care and treatment of Patient 2, and is subject to disciplinary action under sections 2234 and/or 2234(c) and/or 2266 of the Code in that Respondent committed repeated negligent acts and failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to document an adequate history of low back pain for Patient 2, maintained disorganized records, and failed to document reviewing Patient 2's older imaging and imaging reports; and

B. Respondent performed an inadequate physical exam for Patient 2's low back pain.

[10] Q fever is a disease caused by the bacteria Coximella burnetti.

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 G 47055, issued to Robert Bruce Rushton, M.D.;

2. Revoking, suspending or denying approval of Robert Bruce Rushton, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Robert Bruce Rushton, 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; and

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

DATED: FEB 27 2023

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