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

In the Matter of the Accusation Against: **J Duc Ngoc Nguyen, M.D.** Physician's and Surgeon's Certificate No. A 62436 Respondent.	MBC File # 800-2022-086223

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 *A 62436*.

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: J Duc Ngoc Nguyen, M.D. Physician's and Surgeon's Certificate No. G 62436 Respondent.	Case No.: 800-2022-086223

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 June 21, 2024.

IT IS SO ORDERED: May 24, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

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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: **J Duc Ngoc Nguyen, M.D.** **8110 Mango Avenue** **Fontana, CA 92335** **Physician's and Surgeon's Certificate No. A 62436,** Respondent.	Case No. 800-2022-086223 OAH No. 2023110918 **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 Rosemary F. Luzon, Deputy Attorney General.

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2. Respondent J Duc Ngoc Nguyen, M.D. (Respondent) is represented in this proceeding by attorney Steven B. Goldstein, Esq., whose address is: Davis, Grass, Goldstein & Finlay, 901 Via Piemonte, Suite 350, Ontario, CA 91764.

3. On or about May 23, 1997, the Board issued Physician's and Surgeon's Certificate No. A 62436 to 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. 800-2022-086223, and will expire on March 31, 2025, unless renewed.

JURISDICTION

4. On or about August 22, 2023, Accusation No. 800-2022-086223 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 or about August 22, 2023, at his address of record. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2022-086223 is attached as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2022-086223. 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, having been fully advised of same by his attorney, Steven B. Goldstein, Esq.

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

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2022-086223, and Respondent hereby gives up his rights to contest those charges. Respondent further agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action.

10. 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. 800-2022-086223 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.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 62436 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

12. 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.

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

14. The parties 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 62436 issued to Respondent J Duc Ngoc Nguyen, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years from the effective date of the Decision on the following terms and conditions:

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

2. 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.

3. 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.

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4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

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

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

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

calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to

Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

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

10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $42,658.74 (forty-two thousand six hundred fifty-eight dollars and seventy-four cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

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

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

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than

30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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

Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2022-086223 shall be deemed to be true, correct, and admitted by

Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Steven B. Goldstein, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 62436. 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: 04/01/2024

J DUC NGOC NGUYEN, M.D.
Respondent

I have read and fully discussed with Respondent J Duc Ngoc Nguyen, 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: 4-3-24

STEVEN B. GOLDSTEIN, ESQ.
Attorney for Respondent

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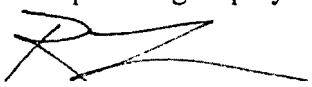
ENDORSEMENT

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

DATED: 4/3/24

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General



ROSEMARY F. LUZON
Deputy Attorney General
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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: **J Duc Ngoc Nguyen, M.D.** **8110 Mango Avenue** **Fontana, CA 92335** **Physician's and Surgeon's Certificate No. A 62436,** Respondent.	Case No. 800-2022-086223 **ACCUSATION**

PARTIES

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

2. On or about May 23, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. A 62436 to J Duc Ngoc Nguyen, 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, 2025, 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 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> . . .

6. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

. . .

7. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . .

8. 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.

9. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

10. Section 2228.1 of the Code states:

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

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

. . .

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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COST RECOVERY

11. Section 125.3 of the Code states:

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

administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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

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

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

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

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

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

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

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

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

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent has subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:[1]

Patient A

13. On or about December 3, 2014, Patient A first presented to Respondent for chronic lower back pain.[2] Respondent started Patient A on oxycodone[3] 30 mg, at a quantity of 90 tablets and frequency of every 4-6 hours daily as needed.

14. Between in or about April 2015, and June 2016, Patient A had five encounters with Respondent, including on or about April 9, 2015, October 16, 2015, April 15, 2016, June 8, 2016, and June 9, 2016. During the April 9, 2015, encounter, Respondent started Patient A on hydroxyzine[4] for itching. Except for the June 8, 2016, encounter, Respondent continued to prescribe oxycodone 30 mg to Patient A at the same quantity (90 tablets) and frequency (every 4-6 hours daily as needed) on each of these encounters. On or about June 8, 2016, Respondent also started Patient A on paroxetine[5] 20 mg for depression. During the June 9, 2016, visit, Respondent noted in his Assessment and Plan that he wanted to send Patient A to Pain Management and that Patient A told him she was not abusing her pain medication. Respondent referred Patient A to a pain management specialist for follow-up and treatment.

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[1] References to "Patient A," "Patient B," and "Patient C" herein are used to protect patient privacy.

[2] Any medical care or treatment rendered by Respondent more than seven years prior to the filing of the instant Accusation is described for informational and contextual purposes only and not pleaded as a basis for disciplinary action.

[3] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022.

[4] Hydroxyzine is an antihistamine used to treat itching caused by allergies.

[5] Paroxetine is an antidepressant medication.

15. On or about June 22, 2016, pursuant to a referral from Respondent, Patient A was seen by a neurologist for headache, dizziness, and disorientation.

16. Beginning on or about August 26, 2016, Patient A continued to be treated by Respondent for approximately two and a half years. During the August 26, 2016, visit, Respondent noted the presence of back pain, joint pain, joint stiffness, and muscle pain in his Review of Systems. He also noted the presence of anxiety and depression. Patient A's active medications continued to include oxycodone for pain and paroxetine for depression, as well as hydroxyzine for itching. In his Assessment and Plan, Respondent noted that Patient A was stable on her current regimen for her chronic lower back pain and depression, respectively, and he would continue to monitor her. The progress notes for this visit, and all subsequent visits, lacked any follow-up on the status of the pain specialist referral from June 9, 2016, including whether an appointment was made or took place.

17. On or about December 1, 2016, Respondent had a follow-up visit with Patient A. Respondent again noted the presence of back and muscle pain in his Review of Systems, but no joint pain or swelling. He also noted the presence of depression, but no anxiety. Patient A's active medications continued to include oxycodone, paroxetine, and hydroxyzine. In his Assessment and Plan, Respondent noted that Patient A was stable on her current regimen for her chronic lower back pain and he would continue to monitor her. With respect to Patient A's depression, Respondent noted that she was seeing a therapist and had an appointment with a psychiatrist on December 19. Respondent increased Patient A's paroxetine dosage from 20 mg to 40 mg, and educated her on depression, including its symptoms and treatment. During this visit, and all subsequent visits, Respondent made no attempts to coordinate care with Patient A's psychiatric provider, including by communicating with the provider and/or requesting treatment records from them.

18. On or about March 10, 2017, during a prescription only encounter, Respondent started Patient A on diphenhydramine[6] for allergy symptoms.

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[6] Diphenhydramine (Banophen) is an antihistamine used to relieve allergy symptoms.

19. On or about April 4, 2017, Patient A's active medications continued to include oxycodone, paroxetine, hydroxyzine, and diphenhydramine. In his Assessment and Plan, Respondent addressed the subject of opioid dependence with Patient A, specifically, ways to avoid side effects from long-term use. He offered to slowly wean Patient A off of oxycodone, but she declined. Respondent noted that Patient A was stable with respect to opioid dependence and he would continue to monitor her.

20. On or about July 5, 2017, Respondent referred Patient A to a pain management specialist for follow-up and treatment of her chronic lower back pain. The progress notes for all subsequent visits, however, lacked any follow-up on the status of this pain specialist referral, including whether an appointment was made or took place.

21. On or about September 1, 2017, Patient A's active medications continued to include oxycodone, paroxetine, hydroxyzine, and diphenhydramine. In his Assessment and Plan, Respondent noted that he was continuing Patient A on oxycodone for right ankle sprain issues. He again noted addressing the subject of opioid dependence with Patient A and offering to slowly wean her off of oxycodone, which she declined. Respondent also noted educating Patient A on the symptoms and treatment of depression. Lastly, Respondent noted that Patient A was stable with respect to opioid dependence and depression, respectively, and he would continue to monitor her.

22. During prescription only encounters that took place on or about February 28, 2018, and March 8, 2018, respectively, Respondent prescribed naloxone[7] to Patient A. However, in the progress notes for these visits, and all subsequent visits, Respondent failed to document any discussion educating Patient A about the use of naloxone.

23. On or about May 15, 2018, Patient A's active medications continued to include oxycodone, paroxetine, hydroxyzine, and diphenhydramine, as well as naloxone. The progress notes for this visit reflected an adjustment of Patient's A oxycodone regimen from every 4-6 hours to every 6-8 hours daily as needed, beginning on or about April 30, 2018. However, Respondent failed to document the rationale for this adjustment. Respondent again noted

[7] Naloxone (Narcan) is a medication that rapidly reverses an opioid overdose.

addressing the subject of opioid dependence with Patient A and offering to slowly wean her off of oxycodone, which she declined. A urine drug screen (UDS) was ordered for fentanyl, but not oxycodone. Respondent again noted educating Patient A on the symptoms and treatment of depression, and that she had a follow-up appointment with her psychiatrist in a month.

24. On or about August 6, 2018, Patient A's active medications continued to include oxycodone, paroxetine, hydroxyzine, diphenhydramine, and naloxone. The progress notes for this visit reflected a further adjustment of Patient A's oxycodone regimen from 90 tablets to 60 tablets per month, beginning on or about July 5, 2018. Respondent noted that the reason for this decrease was Patient A's report that she was only taking the medication twice a day. In his Assessment and Plan, Respondent noted that Patient A denied abusing her pain medication or experiencing any side effects. He again noted educating Patient A on the symptoms and treatment of depression. He further noted that Patient A was stable with respect to opioid dependence, chronic lower back pain, and depression, respectively, and he would continue to monitor her. Respondent continued Patient A on oxycodone, but at the higher quantity of 90 tablets per month, not 60 tablets. Despite increasing Patient A's oxycodone regimen, Respondent failed to document the rationale for this further adjustment.

25. On or about October 3, 2018, Patient A's active medications continued to include oxycodone, paroxetine, hydroxyzine, diphenhydramine, and naloxone. In his Assessment and Plan for this visit, Respondent noted that Patient A was mostly depressed, with occasional good days. He performed a depression screening and planned to continue educating Patient A on the symptoms and treatment of depression. Respondent again noted that Patient A denied abusing her pain medication or experiencing any significant side effects, but she told Respondent that she cannot function without it. Respondent noted that Patient A was stable with respect to opioid dependence and he would continue to monitor her. Although Respondent noted ordering a UDS, no corresponding test results are included in Patient A's chart.

26. According to the Controlled Substance Utilization Review and Evaluation System (CURES) report for Patient A, between in or about November 2016, and January 2019, Patient A continuously filled prescriptions of oxycodone, which Respondent prescribed as follows:

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
11-16-2016	Oxycodone HCL	30 mg	90	15	270	4050
12-14-2016	Oxycodone HCL	30 mg	90	15	270	4050
1-12-2017	Oxycodone HCL	30 mg	90	15	270	4050
2-13-2017	Oxycodone HCL	30 mg	90	15	270	4050
3-13-2017	Oxycodone HCL	30 mg	90	15	270	4050
4-13-2017	Oxycodone HCL	30 mg	90	15	270	4050
5-12-2017	Oxycodone HCL	30 mg	90	15	270	4050
6-9-2017	Oxycodone HCL	30 mg	90	15	270	4050
7-8-2017	Oxycodone HCL	30 mg	90	15	270	4050
8-5-2017	Oxycodone HCL	30 mg	90	15	270	4050
9-6-2017	Oxycodone HCL	30 mg	90	15	270	4050
10-6-2017	Oxycodone HCL	30 mg	90	15	270	4050
11-8-2017	Oxycodone HCL	30 mg	90	15	270	4050
12-7-2017	Oxycodone HCL	30 mg	90	15	270	4050
1-4-2018	Oxycodone HCL	30 mg	90	22	184	4048
2-2-2018	Oxycodone HCL	30 mg	90	22	184	4048
2-28-2018	Oxycodone HCL	30 mg	90	22	184	4048
3-28-2018	Oxycodone HCL	30 mg	90	22	184	4048
5-3-2018	Oxycodone HCL	30 mg	90	22	184	4048
6-1-2018	Oxycodone HCL	30 mg	90	22	184	4048
7-5-2018	Oxycodone HCL	30 mg	60	15	180	2700
8-6-2018	Oxycodone HCL	30 mg	90	22	184	4048
9-4-2018	Oxycodone HCL	30 mg	90	22	184	4048
10-3-2018	Oxycodone HCL	30 mg	90	22	184	4048
11-5-2018	Oxycodone HCL	30 mg	90	22	184	4048
12-4-2018	Oxycodone HCL	30 mg	90	22	184	4048
1-4-2019	Oxycodone HCL	30 mg	90	22	184	4048

27. In addition to oxycodone, Patient A filled multiple prescriptions of benzodiazepine medications, which other providers prescribed as follows:

Date Filled	Drug Name	Strength	Quantity	Days Supplied
1-24-2017	Clonazepam	0.5 mg	60	30
8-22-2017	Temazepam	30 mg	30	30

Date Filled	Drug Name	Strength	Quantity	Days Supplied
8-22-2017	Clonazepam	1 mg	90	30
9-27-2017	Temazepam	30 mg	30	30
9-27-2017	Clonazepam	1 mg	90	30
10-26-2017	Temazepam	30 mg	30	30
1-3-2018	Temazepam	30 mg	30	30
1-3-2018	Clonazepam	1 mg	90	30
2-1-2018	Temazepam	30 mg	30	30
2-1-2018	Clonazepam	1 mg	90	30
4-5-2018	Clonazepam	1 mg	90	30
4-5-2018	Temazepam	30 mg	30	30
5-3-2018	Clonazepam	1 mg	90	30
5-3-2018	Temazepam	30 mg	30	30
6-5-2018	Alprazolam	1 mg	90	30
10-18-2018	Alprazolam	1 mg	90	30
11-26-2018	Alprazolam	1 mg	90	30

28. On or about January 22, 2019, Patient A passed away at her home. The cause of death was accidental acute fentanyl intoxication and the mechanism of death involved respiratory depression. Several medications were found at Patient A's home, including Narcan, hydroxyzine, banophen, and paroxetine, as well as benozodiazepines.

29. Between in or about August 2016, and January 2019, Respondent continuously prescribed oxycodone to Patient A, but did not attempt to try a long-acting opioid medication for better pain control.

30. Between in or about August 2016, and January 2019, Respondent continuously prescribed oxycodone to Patient A, but did not attempt to wean the dosage.

31. Between in or about August 2016, and January 2019, Respondent continuously prescribed oxycodone to Patient A, but did not review the CURES database to check Patient A's use of other controlled substances prescribed by other providers.

32. Between in or about August 2016, and January 2019, Respondent did not document any discussion with Patient A regarding the risks and benefits of high-dose opioids, whether taken alone or with benzodiazepines.

33. Between in or about August 2016, and January 2019, Respondent did not order a UDS for oxycodone.

34. Between in or about August 2016, and January 2019, except for the pain management referral on or about July 5, 2017, Respondent did not provide any other referrals to Patient A for the diagnosis and management of her chronic lower back pain.

35. Between in or about August 2016, and January 2019, Respondent did not attempt any non-opioid modalities to assist with controlling Patient A's pain.

36. Between in or about August 2016, and January 2019, Respondent prescribed two antihistamines, hydroxyzine and diphenhydramine, to Patient A on a concurrent basis, but did not document any discussion with Patient A regarding the effects of antihistamines on the central nervous system when used in combination with opioids.

37. Between in or about August 2016, and January 2019, Respondent did not document any discussion with Patient A about the potential side effects of her medication regimen, such as dizziness.

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

A. Between in or about August 2016, and January 2019, Respondent failed to properly prescribe controlled substances for pain to Patient A, to wit:

(1) Respondent continuously prescribed oxycodone without attempting to try a long-acting opioid medication for better pain control;

(2) Respondent continuously prescribed oxycodone without attempting to wean the dosage;

(3) Respondent failed to document the rationale for adjustments to Patient A's oxycodone regimen;

(4) Respondent continuously prescribed oxycodone without reviewing the CURES database to check Patient A's use of other controlled substances prescribed by other providers;

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(5) Respondent failed to coordinate care with Patient A's psychiatric provider, including by communicating with the provider and/or requesting their treatment records;

(6) Respondent failed to document any discussion with Patient A regarding the risks and benefits of high-dose opioids, whether taken alone or with benzodiazepines;

(7) Respondent failed to document any discussion educating Patient A about the use of naloxone;

(8) Respondent failed to order a UDS for oxycodone;

(9) Respondent failed to ascertain and document whether Patient A followed through with referrals for pain management, including whether an appointment was made or took place;

(10) With the exception of the July 5, 2017, pain management referral, Respondent failed to provide any other referrals for the diagnosis and management of Patient A's chronic lower back pain;

(11) Respondent failed to attempt any non-opioid pain control modalities;

(12) Respondent prescribed two antihistamines, hydroxyzine and diphenhydramine, concurrently without documenting any discussion with Patient A regarding the effects of antihistamines on the central nervous system when used in combination with opioids; and

(13) Respondent did not document any discussion with Patient A about the potential side effects of her medication regimen, such as dizziness.

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Patient B

39. On or about September 20, 2016, Patient B had his first office visit with Respondent. He presented for evaluation and management of his hypertension. Patient B was noted to have chronic right shoulder pain and surgery in 2012, as well as attention deficit hyperactivity disorder (ADHD). In addition, his alcohol use history included drinking two beers a night. In his Assessment and Plan, Respondent referred Patient B to physical therapy for follow-up and treatment of his right shoulder pain. He also started Respondent on tramadol[8] 50 mg, at a quantity of 120 tablets and frequency of 4-6 hours daily. In addition to tramadol, Patient B was noted to actively be on Norco[9] 5-325 mg, at a frequency of one tablet as needed. Despite prescribing tramadol concurrently with Norco, Respondent did not provide a rationale for doing so, nor did he establish a plan going forward, including scheduling a timely follow-up visit with Patient B to assess the progress of his opioid regimen. Respondent also started Patient B on amphetamine-dextroamphetamine[10] 15mg for ADHD, at a quantity of 60 tablets and frequency of two times daily.

40. On or about October 11, 2016, during a prescription only encounter, Respondent prescribed Norco 5-325 mg to Patient B, at a quantity of 90 tablets and frequency of every 4-6 hours as needed. He also started Patient B on Soma[11] 350 mg, at a quantity of 30 tablets and frequency of three times daily as needed with two refills. Other than noting "CHRONIC RIGHT SHOULDER PAIN" and "surgery 2012," Respondent did not document any other history or information about the diagnosis or the rationale for prescribing Norco and Soma.

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[8] Tramadol is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c), and a dangerous drug pursuant to Code section 4022.

[9] Hydrocodone and acetaminophen (Norco) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022.

[10] Amphetamine-dextroamphetamine (Adderall) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Code section 4022.

[11] Soma (carisoprodol) is a Schedule IV controlled substance pursuant to 21 Code of Federal Regulations, part 1308.14, subdivision (c), and a dangerous drug pursuant to Code section 4022.

41. On or about October 24, 2016, during a prescription only encounter, Respondent started Patient B on Percocet[12] 10-325 mg, at a quantity of 90 tablets and frequency of every 4-6 hours as needed. Other than noting that the switch from Norco to Percocet was "for better pain control," Respondent did not document any other history or information justifying the medication adjustment.

42. On or about March 9, 2017, Respondent prepared and signed a progress report. The only note appearing in the Historical Summary and Assessment and Plan sections was "OPIOID DEPENDENCE." No other information about this issue was documented, including any discussions with Patient B about the risk of developing a tolerance to his pain medications.

43. On or about October 6, 2017, Patient B had his second office visit with Respondent. He presented with a complaint of lower back pain. Patient B's active medication list included tramadol, amphetamine-dextroamphetamine, Soma, and Percocet. His alcohol use history continued to include drinking two beers a night. Respondent noted a reduction in his Percocet regimen from a quantity of 120 tablets to 90 tablets pursuant to the patient's request, starting on or about October 5, 2017. However, Respondent did not document the prior adjustment from 90 tablets to 120 tablets or the rationale for the adjustment, nor did Respondent document the rationale for the subsequent adjustment back to 90 tablets other than that Patient B had requested it. In his Assessment and Plan, Respondent referred Patient B to physical therapy to address the recent flare-up of his chronic lower back pain. Regarding the subject of opioid dependence, Respondent noted that he discussed ways to avoid side effects from long-term use with Patient B. Respondent offered to slowly wean Patient B off of his pain medications, but he declined. Respondent noted that Patient B was stable with respect to opioid dependence and he would continue to monitor him. In addition, Respondent noted that Patient B was better overall with respect to his chronic right shoulder pain, "though he still needs to take analgesics." He noted that Patient B was stable regarding this issue as well and would continue to monitor him.

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[12] Oxycodone and acetaminophen (Percocet) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022.

44. On or about October 9, 2017, Patient B presented to Respondent for a physical. Respondent's notes regarding Patient B's active medication list and alcohol use history were the same as the prior visit on or about October 6, 2017. So, too, were the notes in his Assessment and Plan regarding Patient B's chronic shoulder pain and opioid dependence. In addition, Respondent noted that Patient B's ADHD and chronic lower back pain, respectively, were stable and he would continue to monitor him. Respondent performed an alcoholism screening. In response to the question as to whether he ever felt the need to cut down on his drinking, Patient B responded, "Yes."

45. On or about August 23, 2018, during a prescription only encounter, Respondent started Patient B on Ambien[13] 10 mg, at a quantity of 30 tablets and frequency of 1 tablet at bedtime with two refills. Other than noting "INSOMNIA," Respondent did not document any other history or information about the diagnosis. Nor did Respondent provide the rationale for starting Ambien at the higher maximum dosage.

46. On or about June 3, 2019, Patient B presented to Respondent for evaluation and management of his hypertension. Patient B's active medication list continued to include tramadol, amphetamine-dextroamphetamine, Soma, and Percocet. The list did not include Ambien. Starting on or about May 28, 2019, the frequency of Patient B's Percocet regimen changed from every 4-6 hours to every 6-8 hours as needed. However, Respondent did not document the rationale for this medication adjustment. Respondent noted in the History of Present Illness section that Patient B had no alcohol use, however, his alcohol use history continued to state that he drank two beers a night. In his Assessment and Plan, Respondent noted that on the subject of opioid dependence, Patient B claimed he was not abusing his pain medications, had no significant side effects, but could not function without them. Respondent ordered an alcohol and drug screen, as well as fentanyl and tramadol drug screens. He noted that Patient B was stable with respect to his opioid dependence and ADHD, respectively, and he would continue to monitor him. Regarding Patient B's chronic lower back pain, Respondent

[13] Ambien (zolpidem tartrate) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022.

educated him on lower back exercises. Respondent also performed an alcoholism screening. In response to the question as to whether he ever felt the need to cut down on his drinking, Patient B's response changed to "No."

47. On or about June 26, 2019, Patient B had an alcohol and drug screen and tramadol screen performed, which Respondent ordered. The results were negative for opiates and positive for amphetamines and tramadol. The drug screen results included an annotation that Patient B had not been on Percocet for one week. In subsequent visits with Patient B, Respondent did not address the negative opiate result with him or document any such discussion.

48. During a visit that took place on or about October 24, 2019, Respondent noted in his Assessment and Plan regarding chronic right shoulder pain that Patient B was still stable on his current medication regimen and would continue to monitor him.

49. On or about October 26, 2019, Patient B had another alcohol and drug screen and tramadol screen performed. The results were negative for opiates and positive for amphetamines and tramadol. In subsequent visits with Patient B, Respondent did not address the negative opiate result with him or document any such discussion.

50. On or about December 12, 2019, Patient B presented to Respondent with a complaint of gradually worsening, moderate to severe shoulder pain. Patient B's active medication list continued to include tramadol, amphetamine-dextroamphetamine, Soma, and Percocet, as well as Ambien. He continued to drink two beers a night. In his Assessment and Plan, Respondent noted that the severe pain kept Patient B from sleeping. However, no other history or information about Patient B's sleep issues were documented, and Respondent did not consider his concurrent use of amphetamines as a possible factor. He ordered an x-ray and MRI, and he discussed and provided information to Patient B about pain and shoulder injuries and disorders.

51. On or about December 16, 2019, Patient B had an alcohol and drug screen and tramadol screen performed. The results were negative for opiates and positive for amphetamines and tramadol. In subsequent visits with Patient B, Respondent did not address the negative opiate result with him or document any such discussion.

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52. On or about January 9, 2020, and January 29, 2020, respectively, Respondent referred Patient B to an orthopedic specialist and pain management specialist for chronic right shoulder pain.

53. On or about September 21, 2020, Patient B had a visit with Respondent. Patient B's active medication list continued to include tramadol, amphetamine-dextroamphetamine, Soma, Percocet, and Ambien.

54. On or about June 17, 2021, Respondent was notified by Patient B's health plan that the prescription for Soma was being denied. The health plan advised that their protocol required the trial and failure of two safer muscle relaxers (cyclobenzaprine, methocarbamol, or tizanidine) before prescribing Soma. In addition, the health plan advised that they required documentation showing that Respondent discussed with Patient B the additional risks of taking Soma, Percocet, and tramadol concurrently in accordance with the FDA's Black Box warning. Lastly, the health plan advised that they required documentation of the treatment plan supporting Patient B's continued use of Soma. The health plan noted that the drug was limited to short-term use only and the FDA recommended against using Soma longer than three weeks. Respondent failed to heed these warnings, and he failed to document any discussion with Patient B about this information.

55. On or about November 3, 2021, Respondent referred Patient B to an orthopedic specialist for chronic right shoulder pain.

56. On or about November 11, 2021, Patient B presented to Respondent with recurring moderate shoulder pain. Patient B's active medication list continued to include tramadol, amphetamine-dextroamphetamine, Soma, Percocet, and Ambien. Patient B was still drinking two beers a night. In his Assessment and Plan, Respondent noted that Patient B was concerned about becoming tolerant to his pain medications. No other information about this concern was documented, including any discussion with Patient B educating him on the subject of tolerance. Respondent proceeded to note that Patient B was stable with respect to his opioid dependence and ADHD, respectively, and he would continue to monitor him. Regarding Patient B's chronic shoulder pain, Respondent noted that the pain was frequent with decreased range of motion and

"really affected his daily function." Patient B asked for a referral to an orthopedic specialist for possible shoulder replacement surgery, which Respondent provided. Respondent also performed an alcoholism screening. In response to the question as to whether he ever felt the need to cut down on his drinking, Patient B responded, "No."

57. On or about April 1, 2022, Patient B presented to Respondent with a complaint of disorientation. Patient B's active medication list continued to include tramadol, amphetamine-dextroamphetamine, Soma, Percocet, and Ambien. In his Assessment and Plan, Respondent noted that Patient B was seen in the emergency room six days earlier after experiencing disorientation and blurry vision without any unusual activities. Respondent noted that Patient B was stable and he would continue to monitor him. During this visit and all other visits with Patient B, Respondent did not document any discussion with Patient B about the potential side effects of his medication regimen, such as disorientation.

58. As of on or about May 19, 2022, Patient B's active medication list continued to include tramadol, amphetamine-dextroamphetamine, Soma, Percocet, and Ambien.

59. According to the CURES report for Patient B, between in or about September 2017, and May 2022, Patient B continuously filled the following prescriptions, which Respondent prescribed:

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
9-13-2017	Carisoprodol	350 mg	90	30	N/A	N/A
9-20-2017	Dextroamphetamine-Amphetamine	15 mg	60	30	N/A	N/A
9-26-2017	Tramadol	50 mg	120	20	30	600
10-6-2017	Oxycodone HCL-Acetaminophen	325-10 mg	90	15	90	1350
10-9-2017	Carisoprodol	350 mg	90	30	N/A	N/A
10-16-2017	Dextroamphetamine-Amphetamine	15 mg	60	30	N/A	N/A
10-23-2017	Tramadol	50 mg	120	20	30	600
11-3-2017	Oxycodone HCL-Acetaminophen	325-10 mg	90	15	90	1350
11-6-2017	Carisoprodol	350 mg	90	30	N/A	N/A

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
11-16-2017	Dextroamphetamine-Amphetamine	15 mg	60	30	N/A	N/A
11-17-2017	Tramadol	50 mg	120	20	30	600
12-2-2017	Carisoprodol	350 mg	90	30	N/A	N/A
12-3-2017	Tramadol	50 mg	120	20	30	600
12-4-2017	Oxycodone HCL-Acetaminophen	325-10 mg	90	15	90	1350
12-24-2017	Tramadol	50 mg	120	20	30	600
12-30-2017	Carisoprodol	350 mg	90	30	N/A	N/A
1-4-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
1-10-2018	Dextroamphetamine-Amphetamine	15 mg	60	30	N/A	N/A
1-17-2018	Tramadol	50 mg	120	20	30	600
1-23-2018	Carisoprodol	350 mg	90	30	N/A	N/A
2-1-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
2-9-2018	Tramadol	50 mg	120	20	30	600
2-16-2018	Dextroamphetamine-Amphetamine	15 mg	60	30	N/A	N/A
2-18-2018	Carisoprodol	350 mg	90	30	N/A	N/A
3-2-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
3-11-2018	Tramadol	50 mg	120	20	30	600
3-19-2018	Carisoprodol	350 mg	90	30	N/A	N/A
3-23-2018	Amphetamine	15 mg	60	30	N/A	N/A
3-30-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
4-9-2018	Tramadol	50 mg	120	20	30	600
4-15-2018	Carisoprodol	350 mg	90	30	N/A	N/A
4-24-2018	Amphetamine	15 mg	60	30	N/A	N/A
4-27-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
4-27-2018	Tramadol	50 mg	120	20	30	600
5-11-2018	Carisoprodol	350 mg	90	30	N/A	N/A
5-16-2018	Tramadol	50 mg	120	20	30	600
5-22-2018	Amphetamine	15 mg	60	30	N/A	N/A

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
5-24-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
6-8-2018	Carisoprodol	350 mg	90	30	N/A	N/A
6-19-2018	Tramadol	50 mg	120	20	30	600
6-22-2018	Oxycodone HCL-Acetaminophen	325-10 mg	120	20	90	1800
6-22-2018	Amphetamine	15 mg	60	30	N/A	N/A
7-6-2018	Carisoprodol	350 mg	90	30	N/A	N/A
7-7-2018	Tramadol	50 mg	120	20	30	600
7-17-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
7-23-2018	Amphetamine	15 mg	60	30	N/A	N/A
8-1-2018	Tramadol	50 mg	120	20	30	600
8-3-2018	Carisoprodol	350 mg	90	30	N/A	N/A
8-16-2018	Tramadol	50 mg	120	20	30	600
8-20-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
8-20-2018	Amphetamine	15 mg	60	30	N/A	N/A
8-23-2018	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
9-1-2018	Carisoprodol	350 mg	90	30	N/A	N/A
9-4-2018	Tramadol	50 mg	120	20	30	600
9-19-2018	Amphetamine	15 mg	60	30	N/A	N/A
9-21-2018	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
9-26-2018	Carisoprodol	350 mg	90	30	N/A	N/A
9-26-2018	Tramadol	50 mg	120	20	30	600
10-15-2018	Tramadol	50 mg	120	20	30	600
10-17-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
10-23-2018	Amphetamine	15 mg	60	30	N/A	N/A
10-25-2018	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
10-25-2018	Carisoprodol	350 mg	90	30	N/A	N/A
11-4-2018	Tramadol	50 mg	120	20	30	600
11-15-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
11-27-2018	Tramadol	50 mg	120	20	30	600
11-27-2018	Carisoprodol	350 mg	90	30	N/A	N/A

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
12-11-2018	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
12-19-2018	Tramadol	50 mg	120	20	30	600
12-27-2018	Carisoprodol	350 mg	90	30	N/A	N/A
12-28-2018	Amphetamine	15 mg	60	30	N/A	N/A
1-7-2019	Tramadol	50 mg	120	20	30	600
1-10-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
1-21-2019	Carisoprodol	350 mg	90	30	N/A	N/A
1-30-2019	Tramadol	50 mg	120	20	30	600
1-30-2019	Amphetamine	15 mg	60	30	N/A	N/A
2-7-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
2-17-2019	Tramadol	50 mg	120	20	30	600
2-19-2019	Carisoprodol	350 mg	90	30	N/A	N/A
2-27-2019	Amphetamine	15 mg	60	30	N/A	N/A
3-5-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
3-8-2019	Tramadol	50 mg	120	20	30	600
3-19-2019	Carisoprodol	350 mg	90	30	N/A	N/A
4-1-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
4-1-2019	Amphetamine	15 mg	60	30	N/A	N/A
4-4-2019	Tramadol	50 mg	120	20	30	600
4-19-2019	Carisoprodol	350 mg	90	30	N/A	N/A
4-23-2019	Tramadol	50 mg	120	20	30	600
4-30-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
5-7-2019	Amphetamine	15 mg	60	30	N/A	N/A
5-9-2019	Tramadol	50 mg	120	20	30	600
5-16-2019	Carisoprodol	350 mg	90	30	N/A	N/A
5-28-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
5-31-2019	Tramadol	50 mg	120	20	30	600
6-9-2019	Amphetamine	15 mg	60	30	N/A	N/A
6-10-2019	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
6-21-2019	Tramadol	50 mg	120	20	30	600

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
6-26-2019	Carisoprodol	350 mg	90	30	N/A	N/A
7-3-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
7-9-2019	Tramadol	50 mg	120	20	30	600
7-17-2019	Amphetamine	15 mg	60	30	N/A	N/A
7-22-2019	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
7-24-2019	Carisoprodol	350 mg	90	30	N/A	N/A
7-26-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	23	58	1334
8-3-2019	Tramadol	50 mg	120	20	30	600
8-15-2019	Amphetamine	15 mg	60	30	N/A	N/A
8-17-2019	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
8-20-2019	Tramadol	50 mg	120	20	30	600
8-20-2019	Carisoprodol	350 mg	90	30	N/A	N/A
8-23-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
9-10-2019	Tramadol	50 mg	120	20	30	600
9-17-2019	Carisoprodol	350 mg	90	30	N/A	N/A
9-20-2019	Amphetamine	15 mg	60	30	N/A	N/A
9-20-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
10-2-2019	Tramadol	50 mg	120	30	20	600
10-15-2019	Carisoprodol	350 mg	90	30	N/A	N/A
10-16-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
10-17-2019	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
10-18-2019	Amphetamine	15 mg	60	30	N/A	N/A
10-31-2019	Tramadol	50 mg	120	30	20	600
11-12-2019	Carisoprodol	350 mg	90	30	N/A	N/A
11-14-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
11-27-2019	Tramadol	50 mg	120	30	20	600
12-7-2019	Amphetamine	15 mg	60	30	N/A	N/A
12-9-2019	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
12-11-2019	Carisoprodol	350 mg	90	30	N/A	N/A
12-11-2019	Zolpidem Tartrate	10 mg	30	30	N/A	N/A

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
12-21-2019	Tramadol	50 mg	120	30	20	600
1-4-2020	Carisoprodol	350 mg	90	30	N/A	N/A
1-8-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
1-19-2020	Tramadol	50 mg	120	30	20	600
1-21-2020	Amphetamine	15 mg	60	30	N/A	N/A
1-24-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
2-3-2020	Carisoprodol	350 mg	90	30	N/A	N/A
2-6-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
2-14-2020	Tramadol	50 mg	120	30	20	600
3-3-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
3-6-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
3-10-2020	Carisoprodol	350 mg	90	30	N/A	N/A
3-17-2020	Tramadol	50 mg	120	30	20	600
3-31-2020	Amphetamine	15 mg	60	30	N/A	N/A
4-1-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
4-8-2020	Carisoprodol	350 mg	90	30	N/A	N/A
4-8-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
4-15-2020	Tramadol	50 mg	120	30	20	600
4-29-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
5-7-2020	Carisoprodol	350 mg	90	30	N/A	N/A
5-7-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
5-11-2020	Tramadol	50 mg	120	30	20	600
5-18-2020	Amphetamine	15 mg	60	30	N/A	N/A
5-27-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
6-5-2020	Carisoprodol	350 mg	90	30	N/A	N/A
6-8-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
6-11-2020	Tramadol	50 mg	120	30	20	600
6-26-2020	Amphetamine	15 mg	60	30	N/A	N/A
6-26-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
7-3-2020	Carisoprodol	350 mg	90	30	N/A	N/A
7-6-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
7-11-2020	Tramadol	50 mg	120	30	20	600
7-24-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
7-29-2020	Amphetamine	15 mg	60	30	N/A	N/A
8-1-2020	Carisoprodol	350 mg	90	30	N/A	N/A
8-9-2020	Tramadol	50 mg	120	30	20	600
8-9-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
8-21-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
8-30-2020	Carisoprodol	350 mg	90	30	N/A	N/A
9-8-2020	Tramadol	50 mg	120	30	20	600
9-8-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
9-11-2020	Amphetamine	15 mg	60	30	N/A	N/A
9-18-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
9-29-2020	Carisoprodol	350 mg	90	30	N/A	N/A
10-7-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
10-7-2020	Tramadol	50 mg	120	30	20	600
10-17-2020	Amphetamine	15 mg	60	30	N/A	N/A
10-21-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
10-28-2020	Carisoprodol	350 mg	90	30	N/A	N/A
11-5-2020	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
11-5-2020	Tramadol	50 mg	120	30	20	600
11-17-2020	Amphetamine	15 mg	60	30	N/A	N/A
11-19-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
12-1-2020	Carisoprodol	350 mg	90	30	N/A	N/A
12-4-2020	Tramadol	50 mg	120	30	20	600
12-18-2020	Amphetamine	15 mg	60	30	N/A	N/A
12-19-2020	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
12-30-2020	Carisoprodol	350 mg	90	30	N/A	N/A
1-2-2021	Tramadol	50 mg	120	30	20	600

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
1-17-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
1-19-2021	Amphetamine	15 mg	60	30	N/A	N/A
1-31-2021	Carisoprodol	350 mg	90	30	N/A	N/A
1-31-2021	Tramadol	50 mg	120	30	20	600
2-4-2021	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
2-16-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
2-27-2021	Amphetamine	15 mg	60	30	N/A	N/A
3-1-2021	Carisoprodol	350 mg	90	30	N/A	N/A
3-1-2021	Tramadol	50 mg	120	30	20	600
3-8-2021	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
3-17-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
3-31-2021	Carisoprodol	350 mg	90	30	N/A	N/A
3-31-2021	Tramadol	50 mg	120	30	20	600
4-2-2021	Amphetamine	15 mg	60	30	N/A	N/A
4-16-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
4-29-2021	Carisoprodol	350 mg	90	30	N/A	N/A
4-29-2021	Tramadol	50 mg	120	30	20	600
5-3-2021	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
5-6-2021	Amphetamine	15 mg	60	30	N/A	N/A
5-15-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
5-24-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
5-29-2021	Tramadol	50 mg	120	30	20	600
6-11-2021	Amphetamine	15 mg	60	30	N/A	N/A
6-13-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
6-21-2021	Carisoprodol	350 mg	90	30	N/A	N/A
6-22-2021	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
6-27-2021	Tramadol	50 mg	120	30	20	600
7-12-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
7-19-2021	Amphetamine	15 mg	60	30	N/A	N/A

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
7-22-2021	Carisoprodol	350 mg	90	30	N/A	N/A
7-26-2021	Tramadol	50 mg	120	30	20	600
8-10-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
8-22-2021	Carisoprodol	350 mg	90	30	N/A	N/A
8-26-2021	Amphetamine	15 mg	60	30	N/A	N/A
8-28-2021	Tramadol	50 mg	120	30	20	600
9-9-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
9-26-2021	Tramadol	50 mg	120	30	20	600
9-28-2021	Amphetamine	15 mg	60	30	N/A	N/A
10-8-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
10-27-2021	Tramadol	50 mg	120	30	20	600
10-27-2021	Carisoprodol	350 mg	90	30	N/A	N/A
10-28-2021	Amphetamine	15 mg	60	30	N/A	N/A
11-6-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
11-23-2021	Carisoprodol	350 mg	90	30	N/A	N/A
11-29-2021	Tramadol	50 mg	120	30	20	600
12-3-2021	Amphetamine	15 mg	10	5	N/A	N/A
12-6-2021	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
12-6-2021	Amphetamine	15 mg	50	25	N/A	N/A
12-26-2021	Carisoprodol	350 mg	90	30	N/A	N/A
12-28-2021	Tramadol	50 mg	120	30	20	600
12-29-2021	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
1-5-2022	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
1-7-2022	Amphetamine	15 mg	60	30	N/A	N/A
1-28-2022	Carisoprodol	350 mg	90	30	N/A	N/A
1-28-2022	Tramadol	50 mg	120	30	20	600
2-3-2022	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
2-8-2022	Amphetamine	15 mg	60	30	N/A	N/A
2-25-2022	Zolpidem Tartrate	10 mg	30	30	N/A	N/A

Date Filled	Drug Name	Strength	Quantity	Days Supplied	MME Daily	MME Total
2-25-2022	Carisoprodol	350 mg	90	30	N/A	N/A
2-26-2022	Tramadol	50 mg	120	30	20	600
3-5-2022	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
3-15-2022	Amphetamine	15 mg	60	30	N/A	N/A
3-28-2022	Tramadol	50 mg	120	30	20	600
4-3-2022	Oxycodone HCL-Acetaminophen	325-10 mg	90	30	45	1350
4-14-2022	Carisoprodol	350 mg	90	30	N/A	N/A
4-19-2022	Amphetamine	15 mg	60	30	N/A	N/A
4-23-2022	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
5-2-2022	Oxycodone HCL-Acetaminophen	325-10 mg	90	22	61	1342
5-12-2022	Tramadol	50 mg	120	30	20	600
5-22-2022	Zolpidem Tartrate	10 mg	30	30	N/A	N/A
5-23-2022	Carisoprodol	350 mg	90	30	N/A	N/A
5-23-2022	Amphetamine	15 mg	60	30	N/A	N/A
5-28-2022	Hydrocodone Bitartrate-Acetaminophen	325-10 mg	90	30	30	900

60. Between in or about September 2016, and May 2022, Respondent regularly prescribed oxycodone and tramadol to Patient B over a prolonged period without appropriate justification.

61. Between in or about September 2016, and May 2022, Respondent did not attempt to try a long-acting opioid medication for better pain control.

62. Between in or about September 2016, and May 2022, Respondent did not attempt to wean the baselines dosages for the opioids he prescribed.

63. Between in or about September 2016, and May 2022, Respondent failed to properly document any discussion with Patient B regarding the issue of developing a tolerance to his controlled substance medications.

64. Between in or about September 2016, and May 2022, Respondent failed to educate Patient B about the risks of alcohol use in combination with his medications.

65. Between in or about September 2016, and May 2022, Respondent regularly prescribed Ambien to Patient B, but he failed to include insomnia in his Assessment and Plans and failed to consider Patient B's concurrent use of amphetamines in relation to his sleep issues.

66. Between in or about September 2016, and May 2022, Respondent failed to review the CURES database despite continuously prescribing multiple controlled substances to Patient B over a prolonged period.

67. Between in or about September 2016, and May 2022, Respondent failed to offer naloxone to Patient B and/or document any discussion educating Patient B about the use of naloxone.

68. Between in or about September 2016, and May 2022, Respondent failed to ascertain and document whether Patient B followed through with referrals for orthopedics, pain management, and physical therapy, including whether an appointment was made or took place.

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

A. Between in or about September 2016, and May 2022, Respondent failed to properly prescribe controlled substances for pain to Patient B, to wit:

(1) Respondent regularly prescribed multiple short-acting opioids, including oxycodone and tramadol, over a prolonged period without appropriate justification;

(2) Respondent started tramadol concurrently with Norco without appropriate justification, without any plan, and without scheduling a timely follow-up visit;

(3) Respondent did not attempt to try a long-acting opioid medication for better pain control;

(4) Respondent did not attempt to wean the baselines dosages for the opioids he prescribed;

(5) Respondent prescribed three different short-acting opioids, together with Ambien, an amphetamine, and Soma in a single month, i.e., May 2022;

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(6) Notwithstanding Patient's B health plan protocol for the prescribing of Soma, Respondent continuously prescribed Soma without first attempting to try two other safer muscle relaxers;

(7) Notwithstanding the FDA's Black Box warning, Respondent continuously prescribed Soma concurrently with oxycodone and tramadol without documenting any discussion with Patient B regarding the risks of such concurrent use;

(8) Notwithstanding the FDA's guidance, Respondent continuously prescribed Soma for longer than three weeks without justification and without documenting any discussion with Patient B regarding the risks of such long-term use;

(9) Respondent failed to properly document any discussion with Patient B regarding the issue of developing a tolerance to his controlled substance medications;

(10) Respondent failed to address with Patient B the inconsistent drug screen results showing the absence of opiates despite Respondent's continuous prescriptions of Percocet;

(11) Respondent failed to educate Patient B about the risks of alcohol use in combination with his medications;

(12) Respondent did not document any discussion with Patient B about the potential side effects of his medication regimen, such as disorientation;

(13) Respondent started Ambien at the maximum dose without documenting the rationale for the higher dosage;

(14) Despite continuously prescribing Ambien on a monthly basis, Respondent did not include insomnia in his Assessment and Plans and he failed to consider Patient B's concurrent use of amphetamines in relation to Patient B's sleep issues;

(15) Respondent failed to review the CURES database despite continuously prescribing multiple controlled substances to Patient B over a prolonged period;

(16) Respondent failed to offer naloxone to Patient B and/or document any discussion educating Patient B about the use of naloxone; and

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(17) Respondent failed to ascertain and document whether Patient B followed through with referrals for orthopedics, pain management, and physical therapy, including whether an appointment was made or took place.

Patient C

70. Beginning on or about December 19, 2014, Patient C was seen by Respondent for multiple conditions, including chronic lower back and hip pain, type 2 diabetes, and diabetic chronic kidney disease.

71. On or about November 4, 2016, Patient C presented to Respondent with a complaint of worsening lower back pain. Patient C's active medication list included Norco 10-325 mg as needed. In his Assessment and Plan, Respondent noted that Patient C had been advised in the past to have surgery for her back issues and she wanted to revisit that option. Respondent administered Toradol[14] 60 mg (IM injection) to Patient C and referred her to an orthopedic specialist for follow-up and treatment of her lower back pain. Respondent continued Patient C on Norco 10-325 mg, at a quantity of 60 tablets and frequency of every 4-6 hours as needed.

72. On or about November 8, 2016, Respondent referred Patient C to a nephrologist for follow-up and treatment of stage 3 chronic kidney disease.

73. Between on or about December 7, 2016, and September 16, 2022, Patient C continued to be seen by Respondent. During this timeframe, according to the CURES report for Patient C, Patient C continuously filled near-monthly prescriptions of Percocet 10-325 mg, which Respondent prescribed. The quantity of each Percocet prescription was 90 tablets and the days supplied ranged between 15 and 30 days.

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[14] Toradol (ketorolac) is a nonsteroidal anti-inflammatory drug (NSAID) used for the short-term relief of moderately severe acute pain. It is contraindicated in patients with advanced renal impairment and in patients at risk for renal failure due to volume depletion. High quantities or prolonged use of ketorolac can lead to renal toxicity.

74. During a visit that took place on or about February 17, 2017, Respondent started Patient C on Linzess for chronic constipation. During this visit, and all subsequent visits, Respondent did not document any discussion with Patient C about constipation as a potential side effect of her opioid medications.

75. On or about March 29, 2017, Patient C had a renal function consultation pursuant to a referral from Respondent. The consultation note, which was faxed to Respondent and received on or about March 30, 2017, is included in Patient C's chart. In the Assessment section of the consultation note, the nephrologist noted as follows: "Chronic kidney disease, stage 3 (moderate): secondary to diabetic nephropathy. Her eGFR runs in the 30 to 40 ml/min. She has significant proteinuria which is a poor prognostic sign that her kidney disease will progress. She needs better management of her sugars and to keep her SBP in the 120 to 130 range." In the Plan section, the nephrologist then stated: "Avoid nephrotoxic drugs..."

76. Despite this warning, during multiple visits between on or about April 14, 2017, and June 13, 2022, Respondent continuously administered Toradol 60 mg to Patient C. This included the June 13, 2022, visit, when Patient C's creatinine level was 3.18 mg/dL and eGFR was 16 mL/min.[15] On this day, Respondent noted that Patient C had stage 5 chronic kidney disease and was close to requiring dialysis, but he nevertheless administered 60 mg of Toradol to Patient C.

77. During a visit that took place on or about June 14, 2019, Respondent noted in his Assessment and Plan that Patient C was being followed by pain management for her back pain and planning for the implantation of a spinal cord stimulator. For this visit, and multiple visits between 2017 and 2022, Respondent repeatedly documented that Patient C was on Soma, tramadol, and voltaren gel. However, except for a single fill of tramadol in or about October 2019, Soma and tramadol were not listed in the CURES report for Patient C during this timeframe.

[15] Creatinine levels and eGFRs (or estimated glomerular filtration rates) measure a patient's level of kidney function and stage of kidney disease. As a patient's chronic kidney disease worsens, the eGFR number will go down.

78. On or about July 25, 2019, Patient C had a renal function consultation. The consultation note, which was faxed to Respondent and received on or about the same day, is included in Patient C's chart. In the consultation note, the nephrologist included the following precaution: "If GFR < 30 ml/min[,] cannot stay on metformin."[16] Despite this warning, Respondent continued Patient C on metformin notwithstanding multiple eGFR results that were below 30 mL/min.

79. During a visit that took place on or about April 21, 2020, Respondent noted that Patient C would be undergoing a psychotherapist evaluation to determine if she was a candidate for an implantable device for her lower back pain.

80. On or about April 22, 2020, Patient C had a renal function consultation. The consultation note, which was faxed to Respondent and received on or about April 27, 2020, is included in Patient C's chart. In the consultation note, the nephrologist stated that lansoprazole[17] should be discontinued in light of Patient C's chronic kidney disease and end-stage renal disease. Despite this order, Respondent continued Patient C on lansoprazole for daily use. In doing so, Respondent failed to discuss the potential risks of such use and alternative medications with Patient C.

81. On or about November 5, 2020, Patient C had another renal function consultation. The consultation note, which was faxed to Respondent and received on or about the same day, is included in Patient C's chart. In the consultation note, the nephrologist stated that the dosage of Lyrica[18] should be reduced to 100 mg daily. Despite this order, Respondent continued Patient C on Lyrica 100 mg at frequency of two times per day, for a total daily dosage of 200 mg.

82. According to a pain management note from on or about February 22, 2021, Patient C had an implant placed for her lower back pain on or about December 3, 2020.

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[16] Metformin is used to treat high blood sugar levels in patients with type 2 diabetes.

[17] Lansoprazole is a proton pump inhibitor medication used to reduce the amount of acid in the stomach.

[18] Lyrica (pregabalin) is used for diabetic nerve pain and other types of pain.

The implant provided 90% relief of pain, resulting in a decrease of Patient C's Percocet use to approximately 25% of her prior amount.

83. Patient C's next visit with Respondent took place on or about March 10, 2021, during which she reported suffering from withdrawal symptoms without her opioid medication. In his Assessment and Plan regarding opioid dependence, Respondent noted that Patient C was concerned about becoming tolerant to Percocet. He also noted that Patient C was stable and he would continue to monitor her. However, Respondent failed to acknowledge and note Patient C's successful implant or the resulting decrease of her Percocet use. Moreover, Respondent failed to assist with weaning Patient C's Percocet use. Instead, during this visit, and in all subsequent visits, Patient C's active medications continued to include Percocet 10-325 mg as needed, which Respondent regularly prescribed at a frequency of three times per day.

84. On or about March 21, 2022, similar to the March 10, 2021, visit, Respondent noted that Patient C was suffering from withdrawal symptoms without her opioid medication, but was also concerned about becoming tolerant to opioids. On or about September 16, 2022, Respondent again noted Patient C's concern about opioid tolerance. During these visits, Respondent did not document any details or information about these issues.

85. During a visit that took place on or about June 13, 2022, Patient C completed a health assessment form in which she responded that she recently had a car accident. Respondent signed the form and indicated that he counseled the patient on safety. However, Respondent did not obtain any additional details or information about the car accident to assess whether it was related to Patient C's opioid use.

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86. As of on or about September 16, 2022, Patient C's active medications continued to include Percocet and lansoprazole, as well as fenofibrate.[19] At the time, Patient C's eGFR result was 13 mL/min. Respondent continuously prescribed fenofibrate to Patient C for daily use notwithstanding multiple eGFR results that were less than 30 mL/min, including results ranging between 15 to 19 mL/min.

87. Between in or about November 2016, and September 2022, except for one occasion on or about August 19, 2022, Respondent continuously prescribed Percocet to Patient C without reviewing the CURES database.

88. Between in or about November 2016, and September 2022, Respondent continuously prescribed Percocet to Patient C without ordering any UDS tests.

89. Between in or about November 2016, and September 2022, Respondent continuously prescribed Percocet without having any pain agreements in place.

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

A. Between in or about November 2016, and September 2022, Respondent failed to properly prescribe controlled substances for pain to Patient C, to wit:

(1) Respondent continuously prescribed Percocet over a prolonged period without attempting to coordinate care with Patient C's pain management care, including after Patient C's successful device implant in or about December 2020 and resulting decrease in her use of Percocet;

(2) Respondent failed to appropriately document the opioid withdrawal and tolerance issues raised by Patient C;

(3) Respondent failed to appropriately document Patient C's active medications, including Soma and tramadol;

(4) Respondent did not document any discussion with Patient C about constipation as a potential side effect of her opioid medications;

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[19] Fenofibrate is used to treat high cholesterol and high triglyceride levels in the blood.

(5) Respondent failed to obtain any additional details or information about Patient C's car accident in or about 2022 to assess whether it was related to Patient C's opioid use;

(6) Respondent continuously prescribed Percocet without reviewing the CURES database;

(7) Respondent continuously prescribed Percocet without ordering any UDS tests; and

(8) Respondent continuously prescribed Percocet without having any pain agreements in place.

B. Between in or about November 2016, and September 2022, Respondent inappropriately prescribed and administered medications to Patient C without consideration of Patient C's renal function, to wit:

(1) Despite a Renal Function consultation note from in or about March 2017 stating that nephrotoxic drugs should be avoided, Respondent continuously administered Toradol to Patient C at nearly every visit;

(2) Despite a Renal Function consultation note from in or about July 2019 stating that metformin should be stopped, Respondent continuously prescribed metformin to Patient C;

(3) Despite a Renal Function consultation note from in or about April 2020 stating that the use of lansoprazole should be stopped, Respondent continuously prescribed lansoprazole to Patient C for daily use without any discussion with Patient C about the potential risks of such use and alternative medications;

(4) Despite a Renal Function consultation note from in or about November 2020 stating that the dosage of Lyrica should be decreased to 100 mg daily, and despite Patient C's declining renal function, Respondent continued to prescribe Lyrica to Patient C at a dosage of 200 mg per day; and

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(5) Despite being contraindicated in patients with GFR results of less than 30 mL/min such as Patient C, Respondent continuously prescribed fenofibrate to Patient C for daily use.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

91. Respondent has subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

Patient A

92. Paragraphs 13 through 38, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

Patient B

93. Paragraphs 39 through 69, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

Patient C

94. Paragraphs 70 through 90, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing of Controlled Substances)

95. Respondent has subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code, in that he committed repeated acts of clearly excessive prescribing of controlled substances to Patients A, B, and C, as more particularly alleged in paragraphs 13 through 90, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

96. Respondent has subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 13 through 90, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Violating or Attempting to Violate Any Provision of the Medical Practice Act)

97. Respondent has subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action under sections 2227 and 2234, subdivision (a), of the Code, in that he has violated or attempted to violate, directly or indirectly, provisions or terms of the Medical Practice Act, as more particularly alleged in paragraphs 13 through 96, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

98. Respondent has subjected his Physician's and Surgeon's Certificate No. A 62436 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 13 through 97, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 62436, issued to Respondent J Duc Ngoc Nguyen, M.D.;

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2. Revoking, suspending or denying approval of Respondent J Duc Ngoc Nguyen, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent J Duc Ngoc Nguyen, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent J Duc Ngoc Nguyen, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: AUG 22 2023

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

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