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

In the Matter of the Accusation Against: Joseph Harng Park, M.D. Physician's & Surgeon's Certificate No. A 47815 Respondent.	Case No. 800-2020-066539

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 1, 2024.

IT IS SO ORDERED: October 4, 2024.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
BRIAN D. BILL
Deputy Attorney General
State Bar No. 239146
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6461
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: JOSEPH HARNG PARK, M.D. 212 South Muirfield Road Los Angeles, California 90004-3731 Physician's and Surgeon's Certificate No. A 47815 Respondent.	Case No. 800-2020-066539 OAH No. 2023080183 **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 Brian D. Bill, Deputy Attorney General.

2. Respondent Joseph Harng Park, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, Bonne, Bridges, Mueller, O'Keefe & Nichols, 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071-15622.1.

3. On December 4, 1989, the Board issued Physician's and Surgeon's Certificate No. A

47815 to Joseph Harng Park, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-066539, and will expire on June 30, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-066539 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 April 7, 2023. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2020-066539 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-066539. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2020-066539, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving Accusation No. 800-2020-066539 without the expense

and uncertain of further proceedings, 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. 800-2020-066539 and that he has thereby subjected his license to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

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 agreement of the parties in this 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

A. **PUBLIC REPRIMAND**.

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. A 47815 issued to Respondent Joseph Harng Park, M.D., shall be and hereby is publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a)(4). This public reprimand is issued for committing repeated negligent acts during the care and treatment of Patients 1 and 2 during the period January 1, 2017, through December 31, 2020. Specifically as to Patient 1, Respondent failed to maintain adequate medical records, failed to consult CURES before prescribing controlled substances, and failed to require that Patient 1 obtain a chest x-ray, before prescribing controlled substances to treat chronic cough; and as to Patient 2, Respondent failed to maintain adequate medical records, failed to consult CURES prior to prescribing controlled substances, and failed to require that Patient 2 obtain imaging of her back prior to continuing to prescribe controlled substances to treat back pain. This conduct is in violation of California Business and Professions Code section 2334, subdivision (c), as more fully described in Accusation No. 800-2020-066539, a copy of which is attached as Exhibit A and is incorporated by reference herein.

B. **CLINICAL COMPETENCE ASSESSMENT PROGRAM.** Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s),

Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation as determined by the program for the assessment and clinical education and evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent does not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation. Any violation of this condition or failure to complete the program and/or comply with the program recommendations shall be considered unprofessional conduct and grounds for further disciplinary action.

C. **INVESTIGATION/ENFORCEMENT COST RECOVERY.** Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $25,914.60 (twenty-five thousand nine-hundred fourteen dollars and sixty cents). Costs shall be payable to the Medical Board of California.

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

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

D. FAILURE TO COMPLY. Failure to comply with any of the terms of this Disciplinary Order shall constitute general unprofessional conduct and may serve as grounds for further disciplinary action. In such circumstances, the Complainant may reinstate Accusation No. 800-2020-066539 or file a supplemental accusation alleging any failure to comply with any provision of this order by Respondent as unprofessional conduct.

ACCEPTANCE

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

DATED: 06/28/2024

JOSEPH HARNG PARK, M.D.
Respondent

I have read and fully discussed with Respondent Joseph Harng Park, 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: 06/28/2024

Derek O'Reilly-Jones

DEREK F. O'REILLY-JONES
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: June 28, 2024

Respectfully submitted,

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

Brian D. Bill

BRIAN D. BILL
Deputy Attorney General
Attorneys for Complainant

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ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
BRIAN D. BILL
Deputy Attorney General
State Bar No. 239146
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6461
Facsimile: (916) 731-2117
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOSEPH HARNG PARK, M.D.** **677 South McCadden Place** **Los Angeles, California 90005** **Physician's and Surgeon's Certificate** **No. A 47815,** **Respondent.**	Case No. 800-2020-066539 **ACCUSATION**

PARTIES

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

2. On December 4, 1989, the Board issued Physician's and Surgeon's Certificate Number A 47815 to Joseph Harng Park, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2023, unless renewed.

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 2001.1 of the Code states:

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

5. 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. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. 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.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

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

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

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

STATUTORY PROVISIONS

8. 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:

...

(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.

...

COST RECOVERY

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

DEFINITIONS

10. Controlled Substances – A controlled substance is a drug which has been declared by federal or state law to be illegal for sale or use, but may be dispensed under a physician's prescription. The basis for control and regulation is the danger of addiction, abuse, physical or mental harm, and death. Controlled substances include:

a. Alprazolam (Xanax). A medication classified as a benzodiazepine, prescribed as a short-term treatment of anxiety. Benzodiazepines are habit-forming and have significant addiction potential when improperly prescribed and/or used over prolonged periods. Negative side effects include drowsiness, dizziness, increased saliva, mood changes, hallucinations, thoughts of suicide, slurred speech, loss of coordination, difficulty walking, coma, respiratory failure and death.

b. Amphetamine Salt Combo (Adderall and Adderall XR). A medication classified as a central nervous system (CNS) stimulant prescribed to treat attention deficit hyperactivity disorder and narcolepsy. CNS stimulants, including amphetamine-containing products, have a high potential for abuse and dependence. Taking either Adderall formulation incorrectly may lead to sudden death or serious heart problems.

These problems include increased blood pressure and heart rate, stroke, and heart attack. Side effects include insomnia, nervousness, dizziness, mood swings, bodily weakness, new or worsened mental health issues, and circulatory problems.

c. Carisoprodol (Soma). A medication classified as a muscle relaxant prescribed to treat muscle spasms. Negative side effects include extreme weakness, lack of coordination, lightheadedness, fainting, paralysis, fast heartbeat, seizures, vision loss, agitation, and confusion.

d. Hydrocodone bitartrate-acetaminophen (Vicodin). A medication classified as an opioid prescribed to treat severe pain. Opioids have a high potential for abuse, dependence, and addiction. Opioids can be lethal when used without proper indication. The dangers of using such drugs include, but are not limited to, drug abuse, psychic dependence, immunosuppression, hormonal changes, central nervous system depression, respiratory depression, coma, and death. Acetaminophen (Tylenol) is a common medicine used to relieve pain and lower body temperature in fever. Excessive and chronic use of acetaminophen can cause liver toxicity and possible liver failure.

e. Promethazine with codeine is prescribed to treat airway diseases like the common cold, influenza, and pneumonia. Like many opiates, codeine acts to suppress coughing sensors in the brain and thus provides symptomatic improvement in patients with coughing symptoms from airway irritations. Promethazine is an antihistamine that treats runny nose and sneezing associated with respiratory infections. It is a sedative, and by itself it is not addictive. The combination of these two chemicals in the cough syrup makes it potentially addictive due mainly to the codeine/opiate component of the syrup.

FACTUAL ALLEGATIONS

11. On April 8, 2020, a complaint was filed by the Pharmacy Board of California based upon its own investigation of St. Paul's Pharmacy in downtown Los Angeles, a location 17 miles distant from the Respondent's medical office. According to the complaint, Respondent's patients

presented prescriptions from Dr. Park for only three controlled substances: promethazine with codeine, alprazolam, and hydrocodone, all drugs with an abuse potential.

12. The Board initiated its investigation into Respondent's prescribing practices. Two patients were identified for further review.

Patient 1.

13. Patient 1[1] (also "Patient 1") treated with Respondent monthly between approximately 2017 through 2020 [2] ("Treatment Period"). Patient 1 was a 35-year-old male with a smoking history who was treated for chronic upper respiratory symptoms of sore throat with coughing and congestion and generalized anxiety disorder.

14. Chronic upper respiratory symptoms of sore throat with coughing and congestion. Respondent repeatedly diagnosed Patient 1 with acute respiratory infections during the Treatment Period. Respondent performed and documented appropriate sinus and lung examinations. The Respondent also appropriately recommended chest X-ray imaging. The Respondent failed to perform further evaluations to determine the underlying cause of Patient 1's chronic cough. Respondent attributed Patient 1's chronic coughing symptoms to smoking. Respondent also considered asthma or chronic obstructive lung disease to be the root cause. However, the Respondent ordered no further evaluations to confirm these diagnoses. The Respondent also noted wheezing, which is indicative of possible asthma or chronic obstructive lung disease (COPD).

15. Respondent regularly prescribed antibiotics during the Treatment Period as a treatment for the respiratory infection diagnoses. Additionally, Respondent prescribed an albuterol inhaler as needed and ordered a chest X-ray evaluation to address the wheezing symptoms. However, Patient 1 did not comply with the chest X-ray order. Finally, Respondent treated Patient 1's chronic cough symptoms by prescribing a narcotic cough syrup, promethazine

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

[2] These are approximate dates based on the records available for review. Patient No. 1 may have treated with Respondent before or after these dates.

with codeine; approximately 26 times during the Treatment Period. Additionally, other providers prescribed promethazine with codeine to Patient 1 an additional 13 times during the Treatment Period. Patient 1 filled the prescriptions at 10 different pharmacies.

16. Generalized anxiety disorder ("GAD"). Patient 1 also presented with complaints of anxiety, nervousness, and insomnia. Patient 1 scored high on GAD screening, but Respondent failed to obtain and/or document a history of precipitating and relieving factors, or functional limitations. Respondent also suspected that Patient 1 was suffering from depression in February 2018. Respondent did not prescribe further medication to treat the suspected depression. Respondent recommended Patient 1 seek mental health care, but Patient 1 never complied.

17. Respondent never performed a comprehensive and thorough evaluation of the Patient 1's anxiety disorder. There was no detailed history of the triggering and relieving factors of anxiety. There was no assessment of the functional limitations posed by the anxiety. Although depression is a common cause of anxiety, the Respondent never performed a thorough evaluation of major depression disorder.

18. Respondent's treatment of Patient 1 for GAD was limited to prescribing alprazolam (a medicine used to treat anxiety disorder, which carries a risk for abuse and addiction). During the Treatment Period, Respondent wrote 14 prescriptions for alprazolam 2 mg daily. Patient 1 also received 22 additional prescriptions of alprazolam from various other physicians during the Treatment Period. Patient 1 filled the alprazolam prescriptions at five different pharmacies.

19. A review of the Controlled Substance Utilization Review and Evaluation System (CURES)[3] report showed that other providers prescribed Patient 1 Adderall, a controlled substance stimulant to treat attention deficit hyperactivity disorder (ADHD), beginning in approximately July 2019. It is unclear whether Respondent was aware of Patient 1's use of the stimulant Adderall, as the record contains no information regarding the diagnosis or the prescription.

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

Medical Issues as to Patient 1

20. Evaluation and Management of Chronic Coughing. Chronic coughing is often defined as persisting for longer than 4-8 weeks. Chronic coughing is not a disease but is a symptom of an underlying illness. Diagnosis of chronic coughing begins with a detailed history and physical examination. Further testing may include chest X-rays to assess for pneumonia or lung cancer, tuberculosis testing, CT scans, pulmonary function testing, and bronchoscopy.

21. Treatment of chronic coughing symptoms is focused on treating the underlying cause, for example, using antibiotics for pneumonia, antacid therapy for acid reflux, inhalers for asthma, and surgery for lung cancer. Treating the symptom of chronic coughing with anti-tussive medications intended simply to suppress the symptoms without a thorough evaluation is not recommended nor the standard of care.

22. The Respondent's treatment consisted of prescriptions for antibiotics and promethazine with codeine cough syrup. Patient 1's history of chronic coughing was highly suggestive of COPD secondary to smoking. Despite that, Respondent did not obtain a chest CT scan and/or a pulmonary function test. Also, the Respondent failed to consider non-pulmonary causes of coughing, such as acid reflux disease and chronic sinusitis.

23. Respondent's treatment for presumptive monthly recurrent respiratory infections was limited to prescribing various antibiotics and narcotic cough syrup. It is highly improbable that a patient would suffer from monthly bacterial acute respiratory infections.

24. In addition, frequent antibiotic therapy, such as the course prescribed by Respondent, without proper justification can lead to antibiotic resistance over time.

25. The chronic usage of promethazine with codeine is not recommended due to its potential for abuse and addiction.

26. Respondent committed the following simple departures in the care and treatment of chronic cough:

a. Respondent failed to pursue pulmonary function testing or chest CT for COPD diagnosis.

b. Respondent's failure to obtain pulmonary consultation for assistance in

diagnosis was another simple departure of care, as was his failure to consider other non-pulmonary causes of chronic coughing.

c. Respondent conducted improper clinical assessments and prescribed long-term antibiotic treatment without proper indication.

d. Respondent's improper long-term prescribing of codeine cough syrup for symptomatic management was a departure from the standard of care.

e. Respondent's overall evaluation and management of Patient 1's chronic cough, as detailed above, constitutes an extreme departure of care.

27. Prescribing of promethazine with codeine cough syrup. The prescribing of the codeine/promethazine cough syrup should only be short-term use; to avoid abuse, it should never be prescribed long- term for more than 4 to 6 weeks. Other safer anti-tussive alternatives are available for long term use.

28. Respondent should not have prescribed this cough medication regularly during the Treatment Period. Based on the CURES report, Patient 1 received a total of 39 prescriptions of promethazine with codeine from seven different providers, which were filled at 10 different pharmacies, during the Treatment Period.

29. Respondent failed to recognize the indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion.[4] Respondent failed appropriately to intervene regarding Patient 1's possible abuse and/or addiction, as he should have.

30. Respondent committed the following simple departures in prescribing promethazine with codeine cough syrup:

a. Respondent inappropriately prescribed promethazine with codeine cough syrup on a long-term basis.

b. Respondent failed to identify Patient 1's signs and symptoms of abuse of and/or

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[4] Indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion includes, but is not limited to: obtaining controlled substances from multiple providers, filling prescriptions of controlled substances at multiple pharmacies, requiring chronic high doses, using controlled substances not prescribed to the Patient, resisting attempts to decrease or change medications, reporting lost or stolen medications, and negative interactions with law enforcement.

addiction to promethazine with codeine cough syrup.

c. Respondent failed to intervene regarding Patient 1's abuse of and/or addiction to promethazine with codeine cough syrup.

31. Management of Generalized Anxiety Disorder. GAD is a common disorder with an adult onset and requires long-term treatment. GAD can lead to significant impairment in role functioning and reduced quality of life; however, it can be effectively treated with cognitive behavior therapy, medications, or a combination of those two modalities.

32. To meet the standard of care, a physician must assess the patient's severity and extent of functional impairment caused by the anxiety disorder by conducting a detailed history and objective screening questionnaire. A complete review of a patient's over-the-counter and prescribed medication history is important, as certain medications can trigger anxiety symptoms. Once medical causes of anxiety are excluded, the physician, together with their patient must choose the appropriate course of treatment, generally, behavioral therapy and/or medication.

33. Initial treatment with medication typically involves prescribing a serotonergic antidepressant (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI). Patients often need to try several different medications over several months to find which SSRI or SNRI is most effective. If a patient does not respond to these medications, second line medications, including antipsychotic medications and other antidepressants, can be prescribed under care coordinated with mental health experts.

34. Benzodiazepines have important roles in managing generalized anxiety disorder, typically as a short-term adjunct therapy during initial SSRI or SNRI treatment. However, well-understood concerns regarding their potential abuse, dependency, tolerance, amnesia, and withdrawal symptoms have limited their use. Once a patient responds to the SSRI or SNRI, benzodiazepines should be tapered off quickly to avoid dependency.

35. The Respondent failed to perform a comprehensive and thorough evaluation of the patient's anxiety disorder. The Respondent failed to investigate the reasons for the Adderall prescription. Respondent should have strongly considered recommending stoping this medication to see if Patient 1's anxiety improved. The Respondent never considered prescribing safer

anxiolytic medications that could reduce the patient's dependency on benzodiazepines. Instead, Respondent continued benzodiazepine treatment despite Patient 1's noncompliance regarding mental health treatment.

36. Respondent committed the following simple departures in the care and treatment of GAD, which, when taken together, constitutes an extreme departure in the standard of care in the overall care and treatment of Patient 1's GAD diagnosis. The individual simple departures consist of the following:

a. Respondent's failure to perform a comprehensive anxiety evaluation was a simple departure of care.

b. Also, Respondent failed to fully evaluate the patient's depression.

c. Also, Respondent failed to coordinate close monitoring by mental health specialists in this complex patient on both benzodiazepine for anxiety and stimulant for hyperactive disorder.

d. Also, Respondent failed improperly prescribed benzodiazepines long term as monotherapy for anxiety management.

e. In addition, Respondent improperly started Patient 1's benzodiazepine therapy at high dosage of 2 mg daily.

f. In addition, Respondent failed to try safer anxiolytic medications like SSRI or SNRI was also a simple departure of care.

g. Respondent's overall evaluation and management of Patient 1's GAD diagnosis, as detailed above, constitutes an extreme departure of care.

37. Concurrent usage of benzodiazepines and opiates. Benzodiazepines and opiate medications both cause central nervous system depression and can decrease respiratory drive. Epidemiologic data demonstrates that their concurrent use is likely to put patients at greater risk for potentially fatal overdose. As a result, clinicians should avoid concomitant prescribing of narcotics and benzodiazepines, as the risks outweigh the benefits. When confronted with patients who are prescribed both medications, physicians should slowly taper the patient off one of the prescribed medications. If the benzodiazepines are prescribed for anxiety, the taper should be

slow and gradual. Other antidepressants and non-benzodiazepine medications approved for anxiety should be offered to the patient. Consultation with psychiatry staff for cognitive behavior therapy is also vital to the success of the tapering.

38. Patient 1 was clearly at higher risks of accidental drug overdose due to his long-term usage of alprazolam and codeine syrup from 2017-2020. There was no proper indication for long-term prescribing of benzodiazepine medication for this patient. There was also no strong indication for long-term codeine therapy in this patient, as safer anti-tussive drugs were available. The combination of these two medications from 2017- 2020 unnecessarily exposed Patient 1 to increased risks of accidental overdose and death. Naloxone antidote (a medicine used to treat an opioid overdose) should also have been prescribed to minimize these risks from the combination therapy.

39. Respondent committed the following simple departures from the standard of care regarding his prescribing of benzodiazepines and opiate.

a. The Respondent's long-term and unjustified prescribing of benzodiazepines and opiates was a simple departure of care.

b. Respondent failure to offer naloxone antidote therapy to a patient with higher risk of overdose was also a simple departure of care.

Patient 2

40. Patient 2 was treated by Respondent between August 2017 through July 2020 ("Treatment Period").[5] Patient 2 was a 53-year-old woman with a history of smoking and a back injury resulting from a 2015 car accident, which resulted in difficulty walking. Respondent treated Patient 2 for chronic low back pain and GAD.

41. Chronic Back Pain. According to Respondent, Patient 2's chronic low back pain was the result of her motor vehicle accident. Respondent's physical examinations were mostly cursory and lacking in details. Respondent's examinations often recorded a limited range of motion with muscle spasms. Degrees of flexion and extension of the spine were not recorded.

[5] These are approximate dates based on the records available for review. Patient 2 may have been treated by Respondent before or after these dates.

Despite Patient 2 experiencing pain shooting down her legs, the physician failed to perform straight leg testing, a nerve conduction study, or electromyography testing to assess for nerve damage.

42. Respondent did not obtain an MRI, CT scan, or X-ray imaging of Patient 2's spine and hips. It is unknown if Patient 2 had any post-accident evaluations of her back before treating with Respondent, or whether Respondent reviewed prior test results because such information does not appear in his medical record for Patient 2.

43. The Respondent prescribed hydrocodone 20 mg daily, 12 times in 2017, and eight times in 2018. Respondent stopped prescribing hydrocodone in January 2019, as he assumed that Patient 2's back pains had improved. At that time, Respondent believed Patient 2 was no longer taking prescription narcotics. However, Patient 2 obtained narcotic and benzodiazepine prescriptions from other providers.

44. Respondent repeatedly recommended that Patient 2 undergo an MRI, participate in physical therapy, obtain a pain management consultation, and submit to additional testing for further evaluation of her lower back pain. However, Patient 2 did not comply with Respondent's orders. Based on the medical records, Patient 2 seemed only interested in narcotic medication treatment.

45. During the Treatment Period, Patient 2 received 49 prescriptions for narcotics from 2017 - 2020 from 7 different physicians. The prescription narcotics were filled at five different pharmacies.

46. During the Treatment Period, Respondent and other providers regularly prescribed Patient 2 carisoprodol[6], for a total of 33 prescriptions. The Respondent wrote 12 prescriptions, and the remainder were written by other providers.

47. Generalized Anxiety Disorder. The Respondent never performed a comprehensive and thorough evaluation of Patient 2's anxiety disorder. Respondent failed to obtain a detailed history of the triggering and relieving factors of anxiety, the functional limitations posed by the

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[6] Carisoprodol (trade name Soma) is an oral prescription drug used to treat muscle pain.

anxiety, or a thorough evaluation of depression disorder. Although Respondent recommended that Patient 2 seek mental health treatment, the patient never complied.

48. Respondent treated Patient 2 with regular prescriptions of alprazolam. During the Treatment Period, Respondent and other providers wrote a total of 33 alprazolam prescriptions, 2 to 4 mg daily. Of those, Dr. Park wrote 29 of the 33 prescriptions. Respondent documented in the medical chart that Patient 2 failed to comply with his recommendations for mental health treatment. Respondent failed to consider safer anxiolytic medications that could reduce the potential for dependency on benzodiazepines.

Medical Issues as to Patient 2

49. Evaluation and non-opiate management of chronic pain. The initial evaluation of chronic pain requires a complete history and physical examination. Appropriate radiologic and laboratory testing should be ordered to determine if pains are caused by cancer. Appropriate subspecialty consultations are recommended if diagnosis is elusive. Tissue biopsies and further specialized nerve testing may be appropriate in certain situations. For non-cancer chronic pains, opiate therapy is not the first line of treatment due to its risks of addiction and drug overdose and respiratory depression.

50. Non-pharmacologic therapy and non-opiate therapy are often preferred, including physical therapy and cognitive therapy can often improve pains in osteoarthritis joints. Non-opiate medications can often significantly reduce pain and restore the patients' functionality. Finally, surgical consultations could also be considered. If opiate therapy is chosen, it is most beneficial when combined with non-pharmacologic therapy and non-opiate medications.

51. Respondent failed to conduct a complete examination of Patient 2's back. Additionally, Patient 2 failed to conduct an examination of Patient 2's hips and knees, as these joint problems can cause low back pain. Respondent failed to obtain orthopedic consultations.

52. Although Respondent appropriately recommended an MRI and a pain management specialty consultation, Patient 2 never complied and appeared only interested in taking narcotics. Respondent should have been more adamant in his demands for Patient 2 to comply with the additional diagnostic testing and consultations. Absent objective findings in Patient 2's

evaluation, long-term opiate therapy of Patient 2 was unjustified.

53. Respondent failed to prescribe other safer non-opiate medications that could be used concurrently to reduce Patient 2's opiate needs. Respondent failed to recommend non-medication therapy, such as physical therapy, chiropractic manipulation, or acupuncture.

54. Respondent committed the following simple departures from the standard of care in his evaluation and management of Patient 2's chronic back pain:

a. Respondent failed to appropriately evaluate Patient 2's chronic low back pain.

b. Respondent failed to offer safer non-opiate based therapies.

55. Initiation and monitoring[7] of chronic opiate pain medications. Opiate pain medications can be used for chronic pain management if the benefits outweigh the risks and if non-opiate therapy did not adequately control the patients' pains. Opiates with lowest potency and addiction potential should always be tried first for a defined period, typically between one and three months. During the prescribing period, the patient's progress will be monitored for both benefit and harm, including the patient's level of pains, function, and quality of life, and adverse events.

56. Opiate therapy should only continue long-term if it satisfies functional goals set by the physician. If both the patient and physician agreed to continue opiate therapy beyond 90 days, the titration of pain medication dosage should be slow. Ideally, the morphine equivalent dose (MED) of the patient's daily opiate therapy should not exceed 80-90 mg per day. Risks of drug overdose and death and adverse effects increase significantly beyond this dosage.

57. The patients' risk of drug addiction and aberrancy should also be assessed prior to starting long term opiate therapy.

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[7] Failure to properly monitor a patient taking controlled substances includes, but is not limited to: executing a detailed controlled substance agreement, failing to attempt safer treatment modalities prior to prescribing controlled substances; reducing the strength and/or quantity of the prescribed controlled substance(s); discussing the Patient's current substance abuse issues; refer the Patient for further evaluations or to specialists, including pain management, orthopedic surgery, psychiatry, or behavioral therapy; document discussions regarding the risks of using controlled substances, high doses of controlled substances, or polypharmacy; consult or obtain a CURES report; determine whether the Patient exhibited misuse, dependence, addiction, or diversion of controlled substances; and conducting urine toxicology screenings.

58. Once a patient's pain is adequately controlled on a safe dosage of opiate therapy, a patient needs to be monitored on a regular basis every 1 to 3 months. These periodic assessments allow physicians to determine if the pain medications are meeting the goals of improved pain and functional status. They also allow physicians to discontinue or taper patients off opiates if the harm outweigh the benefit.

59. The regular assessment in clinical visits focuses on analgesia, activities of daily living, adverse side effects of opiates, and aberrant behaviors. If drug abuse or diversion is confirmed, physicians should immediately arrange a face-to-face meeting with the patient to re-evaluate the treatment plan and, in some instances, to taper off opiate therapy, if appropriate.

60. In his care of Patient 2, Respondent failed to perform a proper opioid risk evaluation. Respondent also failed to employ multi-disciplinary management, including orthopedic consultation, pain management evaluation, cognitive behavioral therapy with mental health staff, and ancillary treatments to avoid opioid abuse.

61. In his care of Patient 2, Respondent committed the following simple departures from the standard of care in his initiation and monitoring of chronic opiate pain medications:

a. Respondent failed to perform proper opioid risk evaluation.

b. The Respondent failed to offer multi-disciplinary management of Patient 2's chronic back pain.

c. Respondent failed to properly manage chronic opioid use.

d. The Respondent failed to try the lowest potency opiate first.

e. Respondent failed to offer naloxone antidote.

f. Respondent failed to appropriately document the functional assessments of opiate therapy and its relevant physical examinations.

62. Respondent's overall initiation and opioid monitoring of long-term opioid prescriptions written to Patient 2, as detailed above, constitutes an extreme departure of care.

63. Management of generalized anxiety disorder by primary care physician. The standard of care for patients with generalized anxiety disorder was previously described for Patient 1, and is incorporated here by reference.

64. Respondent committed the following simple departures in the care and treatment of GAD:

a. Respondent failed to perform a comprehensive anxiety evaluation.

b. Respondent improperly prescribed long-term benzodiazepine therapy to treat anxiety.

c. Respondent improperly prescribed an initial high dose of benzodiazepines.

d. Respondent failed to try non-controlled substance treatment methodologies.

65. The standard of care with respect to the concurrent usage of benzodiazepines and opiates was previously set for in connection with Patient 1, and is incorporated by reference here.

66. In his care of Patient 2, Respondent committed the following simple departures:

a. Respondent improperly prescribed two dangerous medications from 2017 - 2018.

b. Respondent failed to offer naloxone antidote therapy.

67. Prescribing of carisoprodol. Carisoprodol is a skeletal muscle relaxant that has an abuse potential similar to that of benzodiazepine. Many clinical reports have shown that this medication has been abused for its sedative and relaxant effects.

68. Respondent did not attempt to treat Patient 2 with safer non-addictive muscle relaxants. Respondent should have realized that carisoprodol is a drug that can be abused and can result in addiction, particularly in patients who are prescribed concomitant long-term benzodiazepine and opiate therapy.

69. Respondent's prescribing of this medication to Patient 2 constitutes a simple departure.

70. Informed consent and pain care agreement. A physician should discuss with his patient the risks and benefits of long-term opioid treatment. Patient consent and pain management agreements are often combined into one document. Pain management agreements typically outline the joint responsibilities of the physician and the patient, specifically regarding requests for early refills, lost medications, and the patient's obligation to obtain prescription opiate medication from only one physician or practice.

71. The medical record for Patient 2 contained no signed copies of a pain care agreement and informed consent.

72. The absence of a signed pain care agreement and informed consent here was a simple departure of care.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

73. Respondent Joseph Harng Park, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence in the care and treatment of Patients 1 and 2, resulting in patient harm. The facts set forth in paragraphs 11 through 73, above, are incorporated by reference as if set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

74. Respondent Joseph Harng Park, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated acts of negligence in his care and treatment of Patients 1 and 2, resulting in patient harm. The facts set forth in paragraphs 11 through 74, above, are incorporated by reference as if set forth in full herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 47815, issued to Joseph Harng Park, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. Ordering him to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: APR 07 2023

Jenna Jones for
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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