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

In the Matter of the Accusation/Petition to Revoke Probation Against: John Xiao-Jiang Qian, M.D. Physician's and Surgeon's Certificate No. A 72430 Respondent.	Case No.: 800-2021-081788

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 October 30, 2024.

IT IS SO ORDERED: September 30, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **JOHN XIAO-JIANG QIAN, M.D.** **P.O. Box 675594** **Rancho Santa Fe, California 92067** **Physician's and Surgeon's Certificate No. A 72430,** Respondent.	Case No. 800-2021-081788 OAH No. 2024050834 **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, and by Joseph F. McKenna III, Deputy Attorney General.

2. Respondent John Xiao-Jiang Qian, M.D. (respondent) is represented in this proceeding by attorney David Rosenberg, Esq., whose address is: 10815 Rancho Bernardo Road, Suite 260, San Diego, California, 92127.

3. On or about July 1, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72430 to John Xiao-Jiang Qian, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation and Petition to Revoke Probation No. 800-2021-081788, and will expire on June 30, 2026, unless renewed.

DISCIPLINARY HISTORY

4. In a disciplinary action entitled *In the Matter of the First Amended Accusation Against John Xiao-Jiang Qian, M.D.*, Case No. 800-2014-009588, the Board issued a Decision and Order, effective February 10, 2020, in which respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed, and respondent's Physician's and Surgeon's Certificate was placed on probation for a period of five (5) years subject to various terms and conditions. A true and correct copy of the Board's Decision and Order in Case No. 800-2014-009588 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

JURISDICTION

5. On February 16, 2024, the Accusation and Petition to Revoke Probation No. 800-2021-081788 was filed before the Board and is currently pending against respondent. The Accusation and Petition to Revoke Probation and all other statutorily required documents were properly served on respondent on February 16, 2024. Respondent timely filed his Notice of Defense contesting the Accusation and Petition to Revoke Probation. A true copy of Accusation and Petition to Revoke Probation No. 800-2021-081788 is attached as exhibit B and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2021-081788. Respondent has also carefully read, discussed with his counsel, and fully 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 and Petition to Revoke Probation; 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. Having the benefit of counsel, 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 contained in Accusation and Petition to Revoke Probation No. 800-2021-081788, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. A 72430.

10. Respondent stipulates that, at a hearing Complainant could establish a *prima facie* case or factual basis for the charges and allegations contained in the Accusation and Petition to Revoke Probation; he gives up his right to contest those charges and allegations contained in the Accusation and Petition to Revoke Probation; he has subjected his Physician's and Surgeon's Certificate to disciplinary action; and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

12. Respondent agrees that if an accusation is ever filed against him before the Board, all the charges and allegations contained in Accusation and Petition to Revoke Probation No. 800-2021-081788 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.

ADDITIONAL PROVISIONS

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 72430 issued to Respondent John Xiao-Jiang Qian, M.D., is revoked. However, the revocation is stayed, and respondent is placed on one (1) year of probation. The period of probation imposed in this case is an independent term of probation, but it shall run concurrent with the existing term of probation previously ordered in Board Case No. 800-2014-009588, which notwithstanding any future tolling conditions, shall terminate on or about February 10, 2025, with the following additional terms and conditions.

1. 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 fifteen (15) calendar days.

2. 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.

3. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal review, and multiple investigations, in the amount of $25,000 (twenty-five thousand dollars). 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 thirty (30) calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

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

4. 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 ten (10) calendar days after the end of the preceding quarter.

5. 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 thirty (30) calendar days prior to the dates of departure and return.

6. 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.

7. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than 30 calendar days and within fifteen (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 forty (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 eighteen (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; and Quarterly Declarations.

8. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (i.e., cost recovery) not later than one hundred twenty (120) calendar days prior to the completion of probation. This term does not include cost recovery, which is due within thirty (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.

9. 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.

10. LICENSE SURRENDER. Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within fifteen (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.

11. 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.

12. 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 and Petition to Revoke Probation No. 800-2021-081788 shall be deemed to be true, correct, and admitted by respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David Rosenberg, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 72430. 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: 09 / 05 / 2024

JOHN XIAO-JIANG QIAN, M.D.
Respondent

I have read and fully discussed with Respondent John Xiao-Jiang Qian, 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: 9/5/24

DAVID ROSENBERG, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: September 5, 2024

Respectfully submitted,

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

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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EXHIBIT "A"
Medical Board of California Decision
Case Number 800-2014-009588

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

In the Matter of the First Amended Accusation Against:	)	
John Xiao-Jiang Qian, M.D.	)	Case No. 800-2014-009588
Physician's and Surgeon's Certificate No. A 72430	)	
Respondent	)	

DECISION

The attached Proposed Decision 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 January 31, 2020.

IT IS SO ORDERED: January 3, 2020.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the First Amended Accusation Against:

JOHN XIAO-JIANG QIAN, M.D., Respondent

Physician's and Surgeon's Certificate No. A72430,

Case No. 800-2014-009588

OAH No. 2018030914

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on May 23, May 24, May 28, 2019, June 4 to June 6, 2019, October 14 to 18, 2019, and October 21, 2019, in San Diego, California.

Joseph F. McKenna, III, Deputy Attorney General, represents complainant Christine Lally, Interim Executive Director of the Medical Board of California.[1]

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[1] Kimberly Kirchmeyer was the Executive Director of the Medical Board at the time this matter was filed.

David Rosenberg and Chad F. Edwards, Attorneys at Law, Rosenberg, Shpall & Zeigen, and David M. Balfour, Attorney at Law, Nossaman LLP, represent respondent John Xiao-Jing Qian, M.D., who was present.

The matter was submitted on October 21, 2019.

SUMMARY

Complainant asserts that respondent's license should be subject to discipline because he committed gross negligence and repeated negligence acts in his care and treatment of five opioid prescription pain management patients. Complainant also asserts that respondent demonstrated incompetency in his care of two of his patients, excessively prescribed drugs to four of them, failed to maintain adequate and accurate records, and engaged in unprofessional conduct. In addition, complainant asserts that respondent misrepresented on his medical practice website that he was board certified when he was not.

Complainant proved that respondent committed gross negligence regarding his care of all five patients, committed repeated negligent acts with regards to all five patients, failed to maintain adequate and accurate records with respect to all five patients, and misrepresented that he was board certified when he did not hold this certification. Complainant did not prove that respondent demonstrated incompetency in the practice of medicine or that he clearly and repeatedly excessively prescribed controlled substances. Those charges are dismissed.

Respondent presented sufficient evidence that he is rehabilitated that revocation of his license is not required to ensure public protection. Respondent submitted proof, in response to the concerns regarding his conduct, he has changed

his practice of prescribing opioids and controlled substances, improved his record keeping, and implemented procedures to better monitor patients and coordinate their care. However, considering the nature and severity of the conduct and that the conduct occurred over an extended time frame, a five-year period of probation with terms and conditions, including requirements that he successfully complete a clinical competency program and have a practice monitor, is needed to ensure public protection.

PROTECTIVE ORDER

A protective order has been issued on complainant's motion sealing Exhibits 6 through 20, 23 through 39, and 41 through 56. The confidential names list has also been placed under seal. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

FACTUAL FINDINGS

Jurisdiction

1. On January 29, 2019, Kimberly Kirchmeyer, who was then Executive Director of the Medical Board of California (Board), filed the First Amended Accusation. Respondent had previously timely filed a Notice of Defense on December 5, 2017, to

the initial accusation filed on November 17, 2017. Complainant did not order respondent to file another Notice of Defense.[2]

Complainant alleges six causes to impose discipline on respondent's license in the amended accusation: respondent committed gross negligence regarding his treatment of patients A, B, C, D and E (First Cause for Discipline) and repeated negligent acts regarding his treatment of patients A, B, C, D and E (Second Cause for Discipline), he demonstrated incompetence in his treatment of patients A, B, and C (Third Cause for Discipline), he repeatedly prescribed excessive drugs "or treatment" to patients A, B, C, and D (Fourth Cause for Discipline), he failed to maintain adequate and accurate medical records regarding patients A, B, C, D and E (Fifth Cause for Discipline), and he engaged in unprofessional conduct (Sixth Cause for Discipline).

During the hearing, complainant moved to add a seventh cause for discipline, misrepresentation of qualifications, to conform with evidence submitted at the hearing. The motion was granted.[3]

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[2] Government Code section 11507 permits the agency to file an amended accusation and it "shall afford the respondent a reasonable opportunity to prepare his or her defense to the new charges, but he or she shall not be entitled to file a further pleading unless the agency in its discretion so orders."

[3] At the start of the hearing on May 23, 2019, and on October 14, 2019, complainant asked that specific paragraphs be stricken in the first amended accusation and language added to reflect that the allegations were limited to conduct that occurred only within the seven year statute of limitations. These interlineations to the

License History

3. On July 1, 2000, the Board issued Physician's and Surgeon's Certificate Number A72430 to respondent. The certificate is current and will expire on June 30, 2020, unless renewed. Respondent has no history of discipline.

Prehearing Motion

4. Respondent filed a motion in limine to exclude introduction of evidence precluded by Business and Professions Code section 2230.5 outside the seven-year statute of limitations. With respect to Patients A, B, and C, this statute of limitations involves allegations before November 17, 2010, since the original accusation in his matter was filed on November 17, 2010, and named only these three patients. With respect to Patients D and C, this statute of limitations involves allegations before January 29, 2012, since the first amended accusation was filed on January 29, 2019, and identified both these patients. Oral argument was presented on the record the first day of hearing and respondent's motion was granted. With the parties' input, references to dates outside the applicable statute of limitations were redacted from the first accusations. Dates outside of these time periods are considered only as background and are not considered as a basis for any discipline that may be imposed.

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first amended accusations were made and are reflected in the pleading received as a jurisdictional document.

Summary of Respondent's Treatment of Patients A-E and Prescription of Controlled Substance

5. Respondent's care and treatment of Patients A, B, C, D and E are found in respondent's progress notes for these patients and are summarized, in pertinent part, as follows:

PATIENT A

6. Patient A ("Patient A" or "A") was 53 years when she began treating with respondent for pain management on August 15, 2009, due to chronic back problems she had suffered for three years before she saw respondent. Tim Gurtch, M.D., Patient A's primary doctor, referred her to respondent for pain management. Respondent identified A's medical condition in A's chart notes from her initial visits as follows: "Low back s/p [status post] discectomy with right radiculopathy," "(n)ewly developed left lumbar radiculopathy," and "(c)hronic Neck Pain S/P cervical decompression and fusion." Patient A reported moderate to severe back pain with shooting pain to both legs with the left worse than the right, she rated her pain level as 8/10 on average on a pain scale of 0 to10, she had moderate paresthesia symptoms in the left leg, she described the pain as aching, stabbing, numb and "miserable." Patient A also reported the pain was constant and it worsened in the morning and evening and with physical activities such as prolonged standing and sitting. Respondent noted that A has been on a Duragesic (Fentanyl) patch 75 mcg for pain control and she was on Lortab 10/325 mg as needed for breakthrough pain.[4]

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[4] Duragesic patches contain Fentanyl, an opioid pain medication and Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision

Patient A completed a confidential health history on August 15, 2009, and signed a Pain Management Agreement and Consent (PMA) form that date. In the PMA Patient A agreed to use a single pharmacy to obtain medications respondent prescribed to her, she understood medications were to last until her next appointment and there would not be extra medications if she ran out early, and respondent could require her to submit to a urine drug screen (UDS) at any time. Patient A identified she had a Duragesic patch 75 mcg and prescriptions for Lortab 10/325, Soma 350 mg, Cardizem, 120 mg, Dyazide, 37.5, and Ambien, 10 mg.[5] Patient A signed another Patient Agreement & Consent agreement for Using Opioid Pain Medications on January 2, 2014. Patient A designated a specific pharmacy to obtain medications respondent prescribed her, respondent advised her that refills of scheduled drugs could only be done through office visits, and she acknowledged that respondent was the only doctor authorizing pain meds for her.

Patient A also completed a three-page document captioned "Patient Comfort Assessment Guide" on this date in which she detailed where she experienced pain, where the pain was located, the duration of the pain, the levels of pain she experienced on average in the past month and at the time of her appointment, the treatments and medications she received for the pain and the relief she obtained. In a pain diagram she also marked the areas on the body where she experienced pain, and

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(c), and a dangerous drug pursuant to Business and Professions Code section 4022. Lortab is another brand name for Norco, a Schedule II controlled substance and dangerous drug. Its generic name is Hydrocodone Bitartrate and Acetaminophen.

[5] Ambien is a sedative medication for sleep. It is a controlled substance and dangerous drug. Cardizem and Dyazide are medications to treat high blood pressure.

the nature of the pain. Next to the diagram respondent made specific notations. At the time she completed the pain diagram Patient A stated that her pain was 8 on the 10-point pain scale. Further, A identified that the pain she experienced interfered with her "General Activity" at an 8 point level on the 10 point scale, and interfered with her Mood, Normal Work, Enjoyment of Life, Ability to Concentrate and Relations with Other People and Sleep on levels which ranged from 6 to 8. In his hearing testimony, respondent stated that this diagram and other information he obtained from Patient A at this initial visit served as a "baseline" for his subsequent pain management of Patient A.

In addition, respondent obtained medical records from A that documented the procedures she underwent and the pain management treatments she received between September 24, 2004, and October 5, 2006. She received these treatments in New York State. In a note dated July 27, 2007, Russell Zelman, M.D. stated that Patient A "is fully disabled due to back and neck disorders." Patient A worked as a nurse practitioner.

After November 17, 2010, the relevant period of time at issue in this matter, respondent treated Patient A's chronic pain with opioid-based pain meds and administered L3-L4 epidural steroid injections (LESI) to her and other non-opioid based therapies, as detailed below. During the course of A's treatment with respondent, respondent employed physician extenders, a nurse practitioner (NP) and physician assistant (PA), who examined A, recorded her visits and wrote prescriptions

for A with respondent's consent. Respondent reviewed all of the notes documenting her care and signed them. The parties raised no issue at the hearing to the contrary.[6]

At her first visit after November 17, 2010, respondent saw A on December 1, 2010. Before this visit, it was noted, on November 3, 2010, respondent had her submit to a UDS per the PMA she had signed. Respondent documented A's "4 As," or Analgesia, Activities of Daily Living ("ADLs"), Adverse Effects and Aberrant Behavior, but the handwritten notes were difficult to read and largely not decipherable. Her pain scale and medications were not specifically documented. A report dated November 10, 2010, showed no irregularities and was "consistent" with Patient A taking the medications as prescribed.

At A's December 1, 2010, appointment respondent reported in a note from this date that A's activity level was at "baseline" for ADLs. He noted that she was "retired," her gait was steady and there were no signs of depression. Respondent documented that Patient A was feeling well, she was a little more comfortable and she cooked for Thanksgiving. She said the cold weather exacerbated her pain and she had an appointment with her primary for neuropathy. She rated her pain with medication as moderate to severe. For his plan, respondent continued A on her current medication regimen, refilled the Fentanyl patch, 180 pills of Norco 10/325 mg to be taken four times a day or as needed, 90 pills of Soma 350 to be taken as needed, and he

[6] Respondent did not dispute that respondent was responsible for the prescriptions of medications written by NPs and PAs to the patients in this matter.

scheduled her for an appointment in a month for a refill.[7] He wrote a prescription script for her that day.

Patient A returned to see respondent on December 29, 2010. Patient A reported the same information she had reported to respondent on December 1, 2010, regarding her ADLs and the results of her physical examination. She noted that she was in the "donut hole" which referred to the costs of medications she was required to pay under her Medicare drug plan. As a result, A was unable to obtain the Fentanyl patch. But she said she had enough patches to last her until January 2011. She said her "worst" time, in terms of pain, was at 1:00 p.m. and the cold weather worsened her pain.

Respondent gave A "some Flector patch samples," refilled the Norco and advised her to return in a month for follow-up.[8] Patient A received a prescription for the Norco that day.

Respondent next saw A on January 21, 2011. The same information was reported for A's ADLs and the Physical Examination. Respondent reported the following:

> States that b/c she couldn't afford her patches last month
> bc she was in her donut hole, she has had increased pain

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[7] Soma, a brand name for Carisoprodol, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug.

[8] A "Flector patch" is a nonsteroidal anti-inflammatory patch that treats acute pain due to minor strains, sprains, and bruises.

and has been having difficulty w/o the patches. States she has been taking a little more Norco and Soma to get her through. Will be happy to have the patches back. Otherwise no new medical issues.

Respondent continued A on her current medication regimen and wrote a prescription for the Fentanyl patch. He also wrote a prescription for Soma 350 mg with 120 pills, which was an increase from the 90 pills he prescribed on December 1, 2010. In his note respondent did not explain why he increased the number of Soma pills, but it appears to be related to A's increased use of Soma when she did not have the Fentanyl patch. He also wrote a prescription for Norco 10/325 for 180 pills. Respondent stated that he "will reduce back down" the Soma at A's next monthly visit. He gave Patient A script for these medications.

In his plan respondent noted that A would undergo a UDS at her next visit.

At A's February 22, 2011, visit, A reported that she had been doing much better now that she was out of the "donut hole" and she obtained the Fentanyl patches. She stated that the pain was much better managed with these patches. She then told respondent her pain was unchanged. The information regarding A's ADLs and her physical examination was the same as the prior visits.

On March 14, 2011, to approve the medications respondent prescribed, A's health plan asked respondent for A's progress notes documenting A's condition and current treatment. As the medical justification for the Soma, respondent stated that respondent "has been taking it for years for persistent pain and has been successful." The plan authorized all three medications respondent was prescribing A.

Patient A reported at her March 22, 2011, visit that she was very busy the last month and she was taking care of her son's 80-pound dog. As a result, she was experiencing more spasms. She said her activity level would return to normal in two weeks. Otherwise, she stated her pain was at baseline. In the margin, respondent notated that A had "more spasms-doing more (and) feeling it . . . 2wks will be back to (illegible)."

Respondent reported A's "baseline" ADL was "increased," she was able to drive and her physical examination showed her gait was steady. Respondent continued her on her current medication regimen and he refilled her prescription. He wrote that the Soma was to be "back(ed) down" "once weather warms up." Unlike the two prior notes, however, A did not address that she was having pain problems specifically due to the weather, as she reported previously. Respondent provided A with the script for the same three medications. He scheduled A for an appointment in a month and, in a note he underlined, he advised at the next visit A was to undergo a UDS. Respondent did not order this UDS until over a year later on May 15, 2012.

At the April 19, 2011, visit A reported that she "fell/tripped" over a small dog she was walking, fell on her left arm and scraped her knees. She stated her left arm was still painful with decreased range of motion. A note in the margin repeated this and also noted that she had a "root canal" that week. Her ADL was noted at "baseline," though this does not appear correct due to the decreased range of motion A described. The physical examination noted that she had pain with internal and external rotation of her left shoulder. At this visit respondent administered an injection of Toradol, a non-opioid medication, due to her increased pain. He further maintained her on her current medication regimen and scheduled her to return for a cortisone injection of her left shoulder. He did not comment regarding lowering the Soma as he

indicated in his previous notes. Respondent provided A with a script for the medications in the amounts previously prescribed.

Patient A returned on May 17, 2011, and reported that the past week "was bad" and she had to spend a couple of days in bed. She said she had a lower back flare-up over the weekend and had pain into her left foot with numbness and tingling. She said that the symptoms improved since the weekend and her pain pattern was almost back to baseline. Respondent recorded her ADL at baseline with a normal physical exam. He continued her on her current medication regimen and refilled her medications in the same amounts and doses as previously ordered including 120 pills of Soma.

He gave her a script for the drugs and he noted he would like her scheduled for a LESI. He advised her to return in a month for follow-up and refills. On May 24, 2011, he ordered the LESI.

She returned on June 14, 2011, and stated she was going to a family reunion for a week. She said her pain pattern was the same but she felt "some more breakthrough pain" because she was waiting for the LESI. Respondent noted there was an insurance approval issue. Respondent increased the Norco to 195 pills for breakthrough pain and stated he would decrease it after the LESI. He otherwise kept her medications the same. He asked her to return in a month. Patient A was again provided a script to refill the meds.

At her next visit on August 9, 2011, A reported that she had a lot of dental work, a root canal and two teeth extractions. She otherwise stated that her pain pattern was baseline. She asked to wait for a month for the LESI due to the dental work. Respondent noted her ADL as baselines with normal results for her physical examination. He continued A on the same medication regimen with a monthly follow-

up visit. He provided her a script with the Norco lowered to 180 pills from 195 as ordered previously.

The next record in A's chart is a script respondent's Physician Assistant Shehzaana Kureshi, signed dated August 29, 2011, for 30 pills of Dilaudid 2mg.[9] There is no accompanying note or record documenting why PA Kureshi issued A this script at this time, or if respondent even approved it.

The next note in the chart documents that A saw respondent on September 6, 2011. Patient A reported that she had a lower back pain flare-up a week and a half before her visit and had a "left foot drag." She stated that the "Dilaudid [*sic*] given in the office really helped." Again, there was no note in A's chart contemporaneous to the August 29, 2011, script that recorded A's visit and respondent's issuance of the script for Dilaudid. Respondent otherwise continued A on the same medication regimen and stated that as soon as possible the LESI would be scheduled. Patient A was scheduled to return in a month for follow-up and refills. Respondent signed a prescription script for these medications on September 8, 2011.

After the record of this visit, the chart contains another health care authorization form respondent completed. In this request respondent was asked by A's health plan to justify A's Fentanyl prescription. In a form dated September 9, 2011, respondent wrote the following as the medical justification for this prescription: "Has been taking it for years for persistent pain and has been successful."

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[9] Dilaudid, a brand name for Hydromorphone, is a Schedule II controlled substance and dangerous drug.

On September 12, 2011, respondent signed another script for the Norco, Fentanyl patch and Soma. There was no accompanying note for this prescription. The parties did not address this prescription in their respective cases.

The next recorded visit was October 4, 2011. At this visit A reported that she was visiting her brother in Los Angeles for the last week and a half for a medical procedure he was having. She stated that her "sciatica" was worse since her last visit and she wanted the LESI. Her ADLs and physical exam results were reported as normal. Respondent maintained her on her current medication regimen and indicated he would schedule her for an in office LESI. She was advised to return in a month. Respondent gave Patient A script for the medications dated October 4, 2011.

On October 25, 2011, respondent performed the LESI on A in his office and documented the procedure in an operative report. On this same date, Physician Assistant Kureshi issued her a prescription for 45 pills of Norco 10/325 and 30 pills of Robaxin, a muscle relaxant. There was no accompanying documentation in the chart regarding the decision to prescribe the Norco and Robaxin to A on October 25, 2011. The chart note, dated October 25, 2011, was blank.

Patient A returned on November 1, 2011, and stated that since she had the LESI her leg pain was better and she was almost "100 percent." She said her low back was better by about 50 percent. She stated that she still had some low back pain but felt she was almost at "baseline." Patient A reported that she had a "kidney (illegible)" scheduled and she would inform respondent of the results. Her ADLs were reported as normal at baseline and the results of her physical exam were normal. Respondent continued A on the same medication regimen and issued a prescription for Norco, Soma and Fentanyl patch that date.

At her November 29, 2011, visit, A reported that she was still having a lot of back pain but was able to function independently at home with pain meds. She noted increased pain in the morning and she was able to cook and clean. On this visit A was reported having pain at a level 7/10 scale on a good day with pain meds; 9/10 on bad days with meds. Her ADLs were reported to be at baseline again and the results of her physical exam were normal. Respondent continued her on her current medication regimen and A was to return in a month for follow-up and medication refill. She was given a prescription that date.

Patient A returned on December 27, 2011, and reported that she was still having moderate to severe back pain with the meds. The pain increased during the Christmas holiday with cooking and moving chairs. She reported she was doing better the last month and able to do chores at home with pain meds. No new medical issues were noted. Her pain level was reported at 6-7 out of 10 with meds. Her ADLs were listed at baseline and her physical exam results were normal. Respondent continued her on the same medication regimen and she was scheduled to return in a month for follow-up and refills. She was given a script for the medication that date.

On January 24, 2012, A reported moderate back pain with pain meds and said she was able to do housework with the pain meds. She noted the LESI helped 100 percent with back pain, but the back pain had increased a week ago and she wanted another LESI. Her ACLs were reported at baseline and her physical exam results were normal. Respondent continued her on the same medication pain regimen, her medications were refilled, she was advised to return in a month and told that an LESI would be scheduled. Patient A received a prescription for the medications that day.

At her next appointment on February 21, 2012, A stated that she had moderate pain with pain meds and her LESI was pending. She stated that she had been taking

Cymbalta, which her primary doctor prescribed, for three weeks which helped her with pain and depression. She reported her pain at 5 on the 10-point scale and she was able to do chores with her pain meds. Her ADLs were identified at baselines and the results of her physical exam were normal. Respondent continued A on her current pain med regimen with follow-up in one month. Her LESI was set to be scheduled. Patient A received a prescription that date for 180 pills of Norco 10/325, 120 pills of Soma and a Duragesic patch.

Patient A saw respondent next on March 20, 2012. She told respondent she continued to have moderate and sometimes severe lower back pain with radiculopathy and otherwise did not have a change in her pain pattern. Respondent wrote that A was "functioning @ baseline." He added that the medications "really help to manage her pain." He further added that "pain w/meds is moderate." Per the documented physical exam he performed on A, he stated that her activity level was at baseline, she was able to drive and was independent for ADLs. He described her gait as steady and noted no signs of depression. He continued A on the same medications previously ordered in the same dosages. Respondent wrote a script for these medications.

On March 20, 2012, respondent completed a medication prior authorization form for A's health plan, at the health plan's request. Respondent wrote, as "medical justification" for prescribing A Norco, Soma and the Duragesic patch, that A "has been taking it for years for persistent pain and has been successful."

At A's April 17, 2012, appointment, respondent recorded that A "continues to have moderate LBP w/ rad and muscle spasms." She told respondent that the LESI she had a few months ago had really helped her manage her pain and had minimized her "sciatica." She told respondent, however, that she had not been able to exercise because there was too much crime in her neighborhood. Respondent notated that

there was no change in A's pain pattern and she continued to function at "baseline" and "pain w/ meds is moderate." He recorded the same physical examination and ADL findings he previously made. Respondent continued her on the same medications in the same dosages he had previously prescribed and A was provided a script that day.

That day, in response to A's pharmacy's inquiry, respondent authorized two refills of 120 pills of Soma. Per a handwritten note next to the request for refill authorization, respondent wrote, "was given RX per this @ visit on 4/17/12- please just add on these refills." Respondent did not document why he was adding these refills.

At her May 15, 2012, Patient A reported that while she continued to have moderate lower back pain with radiculopathy she had a good week and had no aggravating leg pain. Respondent again documented that there was no change to her pain pattern and she was functioning at baseline. He also again recorded that "pain w/ meds is moderate." He recorded the same ADLs he previously recorded and the same physical examination results. Respondent continued A on the same mediations in the same amounts and dosages previously ordered and provided her a script for these meds that day.

At this May 15, 2012, visit, respondent had A submit to a UDT to test for hydrocodone APAP, Duragesic, Restoril, Soma and Xanax. The lab results from Alcala Testing and Analysis Services were negative for Hydrocodone, Alprazolam and Temazepam. Next to the Hydrocodone negative result, respondent drew an unhappy face and wrote "will need to retest." He also placed his initial. Respondent did not discuss these results with A, and he did not have A retested for hydrocodone.

A reported to respondent at her June 12, 2012, visit that she had a "flare up" of her sciatica with "terrible" radiating pain down her left leg. She said she was in bed for

several days, but she felt better at the appointment. Respondent wrote that A had the same pain pattern and was "back @ baseline" and was functioning at baseline. Patient A's ADLs and physical exam findings were the same as previously recorded. Respondent continued A on the same medication regimen. He wrote, however, a prescription for "medial dose pak10."

At her July 10, 2012, visit with respondent, A reported that she had more good days than bad days, and she still had moderate to severe back pain with radiculopathy. Respondent wrote that there was no change to her pain pattern and she was functioning at baseline. Patient A's ADLs and physical exam findings were the same. Respondent continued her on the same medication regiment in the same amounts and dosages. Respondent noted that A did not have to use the "medial dose pak." He gave her a script for the meds that day.

The pharmacy sent respondent a request for fill authorization for the Norco and Soma he prescribed A. Next to the requests, he asked "Did pt get Rx written on 7/10 filled?" for both meds.

At A's next visit with respondent on August 7, 2012, A reported that she continued to have moderate to severe back pain with "some flare ups." She advised respondent that she had not needed to use the Medrol Dosepak and was saving it for a "'really bad'" flare up. Respondent documented that there was no change to A's pain

[10] This appears to be a reference to Medrol Dosepak, a medication used, among other uses, to reduce swelling and pain.

pattern and she was functioning at baseline. Her ADLs and physical exam findings remained unchanged. Respondent continued her on the same medication regimen.[11]

In a communication log dated August 8, 2012, respondent (or possibly someone from his office) noted that he tried to "get CURES report" on A but the pharmacist told him that he was not able to do run the report because the "system is getting upgraded."12 He also "doesn't know when it will done [and] available." In a note dated that same day, respondent had asked to get a CURES report on A.

Patient A visited respondent on September 4, 2012, for her appointment. Respondent recorded that A was doing "fine" with pain management for back pain, she was functioning at baseline and was managing her meds "fine." Her ADLs were unchanged and respondent recorded that there were no significant changes noted in her physical exam findings. For his plan for A he continued her on the same medication regimen in the same amounts. He wrote a script for Norco and Soma in the same amounts and dosages previously prescribed. He did not issue a script for the Duragesic patch however. A subsequent note indicated that A's insurance would not cover the patch.

On October 2, 2012, A left respondent a message that appeared to anticipate A's concern that her son was going to call respondent to advise him that she was

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[11] The note stated that A's meds were refilled with respondent's "consent." PA Kureshi wrote the script for the meds.

[12] CURES is the acronym for The Controlled Substance Utilization Review and Evaluation System. Since 2011, CURES reports have been available to doctors to ensure the appropriate prescribing of controlled substances.

"abusing" drugs respondent was prescribing her. Patient A advised respondent that she was "ready to call lawyer its not the first [sic]."

On this same date, A saw respondent, but respondent did not reference the message she left for him. A told respondent that she had "overused her meds one time due to mistake," but she was now using a medication organizer. Respondent documented that A was doing "fine with pain management for back pain." She reported more back pain returned and she "'can use one L-ESI,'" but her insurance did not cover it. Respondent recorded that A was functioning at baseline. Her ADLs remained unchanged and he noted "no significant changes" in her physical exam. Respondent continued her on the same medication regimen and provided her with a script for Norco and Soma in the same amounts and dosages previously ordered.

On October 30, 2012, A saw PA Kureshi. At this visit she stated she had a rough few days because her insurance was not[?] covering the Duragesic patches. As a result, she was using patches she obtained from a friend. The note documents that A's son called to advise respondent that he "thinks she is over using her medication and that he wants her off the medication." Patient A told PA Kureshi that her son was exaggerating she was overusing her meds. At the same time, she admitted she did overuse her meds when she took "more than one dose and was a little loopy from that." For some reason, PA Kureshi documented that A was not engaging in aberrant drug-taking behaviors when in fact, by her own admission, she was. PA Kureshi found A to be functioning at baseline. He documented that her average pain was "6/10" and she described her pain at the visit as "8/10." PA Kureshi found her ADLs to be the same as previously recorded, and "no significant changes" were noted in her physical exam. Patient A responded that she was obtaining from her current pain relievers enough pain relief "to make a real difference in her life." With respondent's consent, for her

plan, the Duragesic patch was replaced with a prescription for 60 pills of MS Contin[13], and A was continued on Soma and Norco in the same amounts and dosages previously ordered. In an addendum to the note, A was advised to take her medications as directed and not to take all her pills at once. Further, the note stated that "Will slowly try to reduce her medications in next visits and try to go back to her Duragesic patch once her insurance issues are resolved." The note recorded that prescriptions for Soma and Norco were issued to A in the same amounts and dosages previously ordered. A prescription for 60 MS Contin pills, to be taken one tablet every 12 hours, was also issued.

Patient A saw respondent after this visit on November 27, 2012. At this visit respondent "confront[ed]" her about calls from her son. The note stated that A returned for the visit but did not come with her son "as planned." She said she did not want her son involved in her personal health care issues and her son "has mental problems." A told respondent she had been taking MS Contin but wanted to switch back to the Duragesic patch when her insurance authorized it. She said she did not have much change from her chronic pain; she was having good and bad days but overall she was doing "fine" with pain management. Respondent recorded that she was functioning at baseline. A reported that her average pain was 7/10 and her pain at the visit was 6/10. A stated that she was obtaining pain relief from the pain meds she was taking to make a real difference in her life; her "4 A's" were the same as previously reported. She was functioning at her baseline, she was having side effects from the pain relievers, and her analgesia was reported as noted above with the pain meds

[13] MS Contin is a Schedule II controlled substance and dangerous drug. Its generic name is morphine.

making a real difference in her life. Respondent continued her on the same meds including the MS Contin, in the same amounts and dosages previously ordered.

At A's December 24, 2012, visit, she reported that her pain the day of her visit was 6/10 and her average pain on the scale was 7/10. She told PA Kureshi she had been taking MS Contin but wanted to switch back to the Duragesic patch when her insurance covered it. PA Kureshi noted that she was functioning at baseline; she was having good and bad days, and she was managing her meds "fine." He reported that A had the same "4As" he previously recorded with her physical exam findings unchanged. He issued her prescriptions for the same amounts of meds in the same dosages he previously ordered.

Patient A next saw PA Kureshi on January 21, 2013. A reported her average pain was 9/10 with her pain level 6/10 at time of the visit. A reported she had neck pain with stiffness. A reported she was having good and bad days, was doing "fine" with pain management and was functioning at baseline. PA Kureshi stated that A was managing her pain meds "fine." She recorded the same "4As" he previously recorded with A's physical exam findings unchanged. This date, PA Kureshi wrote prescriptions for a Duragesic patch, and Norco and Soma in the same amounts and dosages previously ordered with respondent's consent. He discontinued the MS Contin.

At A's February 19, 2013, appointment, A reported, essentially, that the pain condition was the same as recorded at her previous visit with the exception that she was having tingling in her two fingers. PA Kureshi documented that A was functioning and managing her pain meds "fine." Her "4 A's" were recorded the same, as were her physical exam findings. For her plan, it was noted that A would benefit from a C-ESI and she may need an MRI or further imaging. With respondent's consent, prescriptions for Norco, Soma and the Duragesic patch were issued to A in the same amounts and

dosages previously ordered. On this date, A submitted to a point of care UDT. The test was negative for, among other drugs, opiates. PA Kureshi noted that the specimen was sent to an outside lab for confirmation. According to the Alcala lab report (Exhibit 25, AGO 1679), the specimen was positive for Hydrocodone which was consistent with the meds respondent was prescribing her.

A's pain condition remained mostly the same as previously recorded at her March 19, 2013, visit, with her average pain level at 9/10 and her pain at the visit reported as 5/10. She was reported to be functioning at baseline and was managing her meds "fine." A told PA Kureshi she wanted to find insurance that would cover both her office visits and her medications but was having trouble finding such coverage due to her "'pre-existing condition.'" A's "4 A's" and physical exam findings were noted to be unchanged from her prior visit. With respondent's consent, A was provided prescriptions for the same meds for the same amounts and dosages previously ordered.

A's pain condition, "4 A's" and physical exam findings were reported the same at her April 16, 2013, visit. At this visit, however, A again told PA Kureshi that she did not want her son involved in her medical care. She stated she was taking her meds as prescribed and her son did not understand her pain or the need to treat it. A said she would put something in writing, which she did. She wrote the following:

> I [patient's name] am writing this letter to dismiss any or all information my son [name of son] has relayed to office [*sic*]. I am a responsible person and take my medications as needed and prescribed. I ask that no further information is ever given to him in regards to my health or treatment.

As discussed later in this decision, A's statement about her medication use was incorrect as she later admitted in another letter to respondent on June 30, 2015. In this letter, which is detailed below, A discharged respondent as her doctor and advised him that she was, in fact, misusing the Norco that respondent prescribed her. (Exhibit 9, AGO 0429.)

With respondent's consent, PA Kureshi issued A prescriptions for the Duragesic patch, and Norco and Soma in the same amount and dosages previously ordered.

At A's May 14, 2013, visit, her pain level remained at 9/10 on average and was 8/10 on the visit date. PA Kureshi reported that she was functioning at baseline, she was managing her medications "fine," "but is really hurting today." Her "4As" and physical exam findings remained unchanged. For follow up the following was noted: "Medical necessity and goals for pain management: [¶] 1. Reducing pain. [¶] 2. Management of opioid pain medications and other potential habit forming medications. [¶] Improving/maintaining current function level. [¶] 4. Improving/maintaining the quality of his/her life." With respondent's consent, for A's plan, A's meds were refilled in the same amounts and dosages previously ordered. She was advised she could use the Medrol Dosepak, which was ordered previously.

At A's next visit on June 12, 2013, with PA Kureshi, A's son was reported as having sent an email to respondent in which he stated, as characterized, "he is very upset about the medication the patient takes and does not know why it is prescribed when she abuses it." (The email was not made part of A's chart.) A denied "all the claims since her son has been containing our office with phone calls and emails." Her prior statement was noted that she did not want her son involved in her medical care and she was "not on good terms with him." A reported that she "understands the situation and for now is ok with her friend managing her medication." It was unclear

what A meant when she referred to "the situation." Later in the note, under respondent's plan for A, her friend was identified by name and it was noted that this person was providing A with A's "daily allotment of pills." A was reported as managing her medications "fine," though this entry was incorrect considering that A's friend needed to help her manage her meds. Her pain level remained the same, for the most part, with slight improvement in her reported pain level at the visit at 7/10, and "4As" remained the same with no aberrant drug taking behavior noted. Her physical exam findings were unchanged. Follow-up was noted as recorded at her April 2013 visit and the plan involved refilling her meds in the same amounts and dosages previously ordered. Under the plan, A's discussions regarding her son were noted and was the fact that her friend was giving A her meds on a daily basis. In addition, the note added: "Everyone is in agreement." There was no further discussion regarding why A felt she needed to have her friend give her the opioid meds respondent was prescribing. Nevertheless, it substantiated her son's concerns that A was abusing the opioid pain meds respondent was prescribing her.

At A's August 7, 2013, her pain levels, "4 A's, and physical exam findings were unchanged. She stated she was experiencing back spasms and she would like to use "Relafen" for the back inflammation.[14] She noted she took some recently from her roommate. A was noted to be able to do chores at home with pain meds. The follow-up, as noted previously, was included in the note and for her plan A was to continue with respondent's consent on the same medication regimen previously ordered. PA Kureshi also ordered 60 pills of Relafen 500 mg with two refills.

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[14] Relafen is a nonsteroidal anti-inflammatory drug. Its generic name is Nabumetone.

At A's September 4, 2013, visit with PA Kureshi, A's pain levels, her "4 A's," and physical exam findings remained unchanged. She said she was able to do chores at home with the same medications. A told PA Kureshi that she was on better terms with her son but decided to stop talking to him because he was adding stress to her life. She expressed fear about finding another pain doctor. As described in respondent's plan for A, there was a lengthy conversation regarding "threatening" emails from her son to the office and she was made aware that a risk assessment would need to be done of the situation to assess whether she was able to continue as respondent's patient.15 She assured PA Kureshi that she was taking her meds as prescribed. In the meantime, her medication regimen was continued with the meds previously ordered. It was highly recommended to her that she see an addictionologist regarding whether she was able to remain a candidate for chronic opioid pain medication therapy in the future. In addition to Norco, Soma and the Duragesic patch, Zyban, a medication for smoking cessation, was prescribed.

At A's next appointment on October 2, 2013, A's pain levels, "4 A's," physical exam findings, and follow-up remained unchanged. A's physical exam findings remained unchanged except for A's mood. She was described as very upset and tearful because a random UDS tested positive for cocaine while the second spot test was negative. The specimen was sent to Alcala lab for confirmatory testing. The test result was negative for cocaine. Otherwise, according to the note for this visit, A reported she tore the ligament in her right foot while she was walking her dog and was seeing a neurologist regarding her left wrist and breast surgery she was scheduled to have was postponed.

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[15] The emails from her son were not made of A's records.

For respondent's plan for A, the record noted that respondent was waiting for a response to an inquiry he made to the Medical Board regarding the course of action to take with respect to A's son because "her son has been threatening her medical providers."16

A was maintained on the same medication regimen previously ordered and prescriptions were issued that day. Follow-up with A's primary doctor was noted for A's right foot and left wrist issues.

A's next visit with PA Kureshi was on October 30, 2013. At this visit her condition remained unchanged. Her pain level was notated as 9/10 on average, and her pain at the visit of 7/10. Her physical exam findings and "4 A's" remained unchanged. She was described as mostly recovered from the incident noted at her early October visit and was back at baseline. She was reported able to do chores with pain meds. Her pain remained the same with the same medication regimen and follow-up with A's primary doctor for her right foot. Prescriptions were issued for her meds that day.

At A's December 4, 2013, visit, she reported that she was under emotional stress because she ended a personal relationship with her boyfriend and, also, she hurt her tailbone when she fell taking out the trash. She was reported able to do chores with pain meds. Her pain levels of 9/10 on average and 7/10 on the day of the visit and her

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[16] It is again noted that these "threatening" emails from A's sons were not part of A's chart. It is thus not clear why respondent felt these emails from A's son were "threatening" if her son was expressing concerns about his mother's possible abuse of pain meds respondent was prescribing her.

"4 A's," were reported to be at baseline, and her physical exam findings remained unchanged from her prior visits. Follow-up for A was described in the same language previously recorded. For A's plan her meds were refilled and she was to be monitored for her status after her fall. Prescriptions were issued that date.

A next saw PA Kureshi on January 22, 2014. A's reporting of her pain level, 4 A's, and other information were the same as in prior notes. She stated she was doing "ok." Her medication regimen remained unchanged and her meds were refilled.

At A's February 19, 2014 visit, A again stated she "does not want her son know [sic] about her medial [sic] issues and care." A added that "her son mania [sic]." A's reporting of her pain level, 4 A's, and other information were the same as in prior notes. Her medication regimen remained unchanged and her meds were refilled.

Records of A's March 19, 2014, through May 14, 2014, visits contained substantially the same language as the February 19, 2014, note, including typos, with regards to A's desire that her son not know about her medical care. These visits were with respondent and not a PA. A's medication regimen remained unchanged and her meds were refilled. Respondent added as part of his plan for Patient A an LESI and right superscapular nerve injection.

At A's May 14, 2014, visit, A's pain levels were not documented. A reported that she was having more overall pain since her last visit and that the Norco was not "holding back her breakthrough pain." Her 4 As and physical exam findings remained unchanged. For his plan for A respondent noted that because A could not afford injections at the time he gave her a Toradol 60 mg IM (intramuscular) injection. He otherwise maintained A on the same medication regimen and issued prescriptions for her that day.

A saw another provider, PA Clark, on June18, 2014, and her pain levels were recorded as 5/10 on average and 7/10 the day of the visit. A said she was having more overall pain since her last visit. The note continued to populate the prior notes regarding her son. Her 4 A's and physical exam findings remained unchanged. Her medication regimen remained unchanged and prescriptions were issued. A point of care urine screen tested positive for THC and benzodiazepines. In November 2011, respondent's office asked A to be screened in UCTs for Xanax, a benzodiazepine, in addition to opioids and other meds. The specimen was sent for confirmatory testing. However, the lab test results are not part of the record.

At A's July 16, 2014, visit, A was reported to have the same pain levels recorded at her June 18, 2018, visit. The language regarding the son's involvement in her care was repopulated. Her 4 As, physical exam findings, and follow-up remained unchanged. For A's plan, it was noted that lab results were pending. The lab results however were never documented. A's medication regimen remained unchanged and prescriptions were issued for the meds.

At Patient A's August 13, 2014, visit A was reported to be "going through a vertiginous episode where she vomits multiple times a day." The note, otherwise, contained the same language as the prior note including language in the plan regarding waiting for the lab results. Prescriptions were issued that day in the same amount and dosages previously ordered.

A's September 12, 2014, visit note documented that A reported her average pain scale at 5/10 and her pain at the visit as 7/10. Her 4As, physical exam results remained unchanged and her mood was documented as displaying "no signs of depression." The plan for A remained the same including waiting or the lab results. At this visit, along with the prescriptions for Soma, Norco and the Duragesic patch,

respondent issued a prescription for 90 pills of Wellbutrin. He did not document why he prescribed this medication, however.

A's October 10, 2014, visit note recorded that A's condition, including her pain levels, remained unchanged, including "no signs of depression." PA Clark at this visit discontinued the Wellbutrin but issued a prescription, according to the note, for 60 pills of Seroquel with three refills. The note did not document why he prescribed this med. Otherwise, respondent issued prescriptions for Norco, Soma and the Duragesic patch in the same amounts and dosages previously ordered and a prescription signed by PA Clark was issued for these meds this date. However, a copy of prescription for Seroquel was not included in the record.

Patient A's November 7, 2014, visit note reported that A's condition remained the same and no depression was noted. With respondent's approval, A's meds were refilled and it was noted that A was to continue taking the Seroquel as previously ordered. A prescription signed by "PA Smith" was issued that day for the Norco, Soma and Duragesic patch in the amounts and dosages previously ordered.

On November 18, 2014, respondent ran a CURES report on A for the November 2013 to November 2014 period and the report was made part of A's medical record. It showed that Dr. Gurtch was prescribing A the benzodiazepines Temazepam and Alprazolam during this time.

At A's December 5, 2014, visit respondent noted that he discussed with her another email he received from A's son "to complain about her using pain medications." The note added that "My office- Dr. Luu has called Medical board [*sic*] to get a letter from the patient." Respondent noted in his plan that A "read the email from her son and said her son has mental illness. She stated she does not want her son

get involved [sic] her medical care. She said she will write a letter to re-instate that [sic]." Respondent told her he wanted the letter as soon as possible to send to the Medical Board.

Otherwise, A's pain levels of 5/10 and 7/10 at the time of visit remained unchanged, her 4 A's and physical exam findings remained unchanged. A prescription was issued that day. Respondent noted that A was to continue with Seroquel though there was no documentation regarding why he was prescribing this med.

A brought a note with her at her next visit on January 2, 2015, stating that she did not want her son involved in her health care. A's letter dated December 18, 2014, stated this. In this letter she stated she did not want respondent to give her son "any information" regarding her heath and she had been taking the same meds for 21 years and would not be able to live without them due to her herniated discs. She gave respondent permission to discard the email her son sent to him. As a post script, she said her son did not know about "HIPPA Laws."[17]

In this visit note, under "Current Medication" respondent did not list the benzodiazepines that Dr. Gurtch was prescribing A although the November 2014

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[17] It is pointed out here that complainant's expert, Sanford Helm, M.D., noted in his testimony that there would have been no breach of A's privacy rights under HIPAA for respondent to talk to A's son without divulging her private medical information or for that matter considering his emails to him in the context of possible misuse of the prescribed meds he was prescribing her. Considering, as discussed below, in just a few months, A admitted that she was misusing her meds and there was some indication of aberrant behavior, A's son concerns for his mother's welfare were justified.

CURES report identified these medications. In a "Patient Information Update" document, respondent recorded her meds as Lortab, Duragesic Patch, Soma, Diazide, Restoril, and Xanax.[18]

Respondent's plan for A included sending the letter A wrote to the Medical Board, though it was not clear why he felt this was appropriate. He continued A on her current meds and a prescription was issued that date for the meds as previously ordered.

At this visit, respondent had A sign another pain management agreement. The agreement did not contain an advisement regarding the risk of using benzodiazepines with opiates. In fact, there was no documentation in A's medical records that respondent advised her of the risks of using the combination of these meds.

A's condition remained unchanged as documented in her January 30, 2015, visit note, and she was noted to be "doing fine with pain management" and "functions better with pain management." Respondent continued A on the same medications, including Seroquel. PA Smith wrote a prescription for Norco, Duragesic patch and Soma.

A's February 26, 2015, visit note contained identical language as the January 30, 2015, note including that A brought in the December 18, 2014, letter regarding her

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[18] Restoril is the brand name for Temazepam and is a benzodiazepine. Xanax is the brand name for Alprazolam and is also a benzodiazepine. Both meds are identified in the November 2014 CURES report. Diazide is medication used to treat high blood pressure. Respondent did not document these meds in A's January 2015 note, or for that matter in any notes, as A's "Current Medication."

son. Respondent continued A on the same medications, including Seroquel and a prescription was issued that appeared to have been signed by respondent. At this visit respondent administered a therapeutic injection to A of "ketorolac."[19]

At A's March 25, 2015, appointment, A reported that she fell on her left leg/hip the previous day and had increased pain. The note repopulated the note that she brought in the hand-written letter about her son. A's 4 As and physical exam findings remained unchanged, her current medications did not identify the benzodiazepines she was taking and the plan repeated language about the email her son sent to respondent. Respondent authorized refills of all of A's medications and added Duexis, a medication for the treatment of arthritis, though this was not discussed in the note. PA Smith wrote the prescription for Norco, Duragesic patch and Soma.

The documentation for A's April 22 and May 18, 2015, visits contained identical language to the March 25, 2015, note. Prescriptions were issued by PA Smith on April 22, 2015, for Norco, Duragesic patch and Soma. PA Clark issued a prescription on May 18, 2015, for these same meds.

A's last visit with respondent occurred on June 15, 2015. The note for that visit again contained identical language to the notes from A's prior visits and A's pain levels, 4As, and physical findings remained unchanged. A was continued on the Duragesic patch and Soma, with respondent noting in his plan that he was discontinuing Norco as noted: "D/C Norco 10/325. (decrease from 5/d)." Respondent did not explain in the note why he was doing this. He issued a prescription for Soma and the Duragesic patch that date in the same amounts and dosages previously

[19] Ketorolac is a nonsteroidal anti-inflammatory drug.

ordered. Her medications were not updated to include the benzodiazepines and other meds she was taking.

7. On June 30, 2015, A wrote a letter to respondent in which she discharged him as her doctor. She wrote the following:

> I am writing this letter to inform you that I will no longer be a patient at your office. I received very good care by you however my family situation is such that I am no longer able to take any medication. I misused the prescription for pain (Norco) in searching for pain relief. I will have to learn to deal with the pain and move forward.
>
> This isn't a reflection on your care and therefore I am sorry about any negative outcome. I don't really know how to respond other than to apologize for this occurrence.
>
> I have NOT and never would report you to the Medical board. However my son, in his frustration did. I also apologize for this. I will stand by you if you ever need me to speak on your behalf.

8. Apparently in response to A's son complaint to the board, respondent wrote a summary dated July 30, 2015, of his care of A. In this summary, he described the treatment he provided A and noted that he had A submit to UDTs on September 29, 2009, November 3, 2010, May 5, 2012, February 19, 2013, October 2, 2013, and June 18, 2014. He said the lab results were consistent with the meds he was prescribing her. Respondent was mostly correct here. However, it is noted that a confirmatory lab result from June 18, 2014, was not included in the record, which

included other lab results. (Exhibit 25.) The other results were consistent. Respondent also noted that he monitored her use of meds with CURES on August 8, 2012, and November 8, 2014, although he noted he was unable to access CURES on August 8, 2012, because the system was down.

Respondent then noted the "increasingly threatening phone calls and emails" he received from A's son. At the same time, he stated that A's son "was concerned the patient was overusing her medications." He wrote that he addressed her son's concerns directly with A and A blamed her son's "mental illness, his lack of understanding of pain and his distrust of doctors" and she did not give respondent permission to talk to her son. Respondent added that he sought advice from the board and the board "instructed" him that A was the sole person who could authorize discussion of her condition and/or care with family members. However, respondent did not, in A's medical notes, document the discussion he had with the board, or who at the board told him this. His characterization of his discussion with board is, thus, looked at with suspicion. At any rate, as complainant's expert, Dr. Helm stated, respondent was not barred from listening to A's son's concerns. Respondent, in addition, in his summary said he "highly" recommended A seek consultation with an addictionologist and discussed the possibility of terminating her from his care. Respondent made this recommendation on September 14, 2013, but the record did not document that he referred A to such a provider. Further, respondent stated that the daily management of A's meds, "by the agreement of everyone," was handled by her friend and roommate.

Respondent added, as part of his analysis regarding whether A was misusing the meds, that A was a trained Nurse Practitioner and she knew the difference

between misuse and abuse and in her letter she must have selected the word "misuse" knowingly.

PATIENT B

9. On August 24, 2005, Patient B ("Patient B" or "B"), a then-49-year-old female, began treating with respondent. Patient B's primary doctor referred her to respondent for pain management due to failed back surgery syndrome and chronic low back pain. At this first visit, respondent documented Patient B's current medications, which included high doses of opioids that Patient B had been taking for several years. Patient B signed a Pain Treatment Agreement on August 24, 2005. After this initial consultation, respondent began seeing Patient B on a routine basis for pain management. As noted earlier, the relevant period of time at issue is respondent's treatment of B after November 17, 2010, seven years before the filing of the initial accusation in this matter. Respondent treated Patient B, according to records received into evidence through at least 2015.

At this initial visit respondent completed an intake of Patient B in which she identified the areas on her body where she was experiencing pain and that her pain level was 4/10 at the visit. Per her pain agreement B identified a specific pharmacy to receive pain medications and acknowledged that she may be subject to a UDT at any time and that the goals of her treatment were to reduce her pain and suffering, maintain her ability to function and to use the minimum amount of pain medication to control her pain.

Respondent wrote a consultation report for B's referring doctor dated September 1, 2005, based on B's August 24, 2005, intake and exam. His impression of B was "Chronic pain status post laminectomy and discectomy in 1993" and "Long-term

hydrocodone dependent for pain control." He recommended that B be treated with a combination of long-acting and short-acting opioids. He expressed concern about the 10 pills of Norco B was taking daily because he wanted her acetaminophen dosages below 3,000 mg. B was receptive to trying MS Contin. On August 24, 2005, he wrote a prescription for MS Contin for 15 mg every 12 hours and 120 pills of Norco 10/325.

At some point before November 17, 2010, respondent discontinued Norco and, according to the prescription dated November 19, 2010, respondent prescribed 150 pills of Kadian 100 mg, 240 pills of Percocet 10/325 and 60 pills of Dilaudid. Respondent also, on this date, issued a prescription for 60 pills of Roxicodone 30 mg and Levaquin Respondent's handwritten note from this date was not decipherable. It appeared A's pain scale was reported as 5/10 and B's "4 As" were documented.

According to a CURES report (Exhibit 15) dated April 30, 2019, for the period from January 1, 2011, to December 31, 2015, respondent prescribed B the Kadian, Percocet, Dilaudid and Roxicodone in these amounts and dosages, more or less. He also was prescribing B the following benzodiazepines: 30 pills of Valium and/or Diazepam on a monthly basis. However, respondent did not document in his visit notes with B that he was prescribing B these benzodiazepines.[20, 21]

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[20] Percocet, Kadian and Roxicodone are Schedule II controlled substances and dangerous drugs. Percocet is the brand name for Oxycodone and Acetaminophen. Kadian is the brand name for Morphine Sulfate.

[21] Benzodiazepines include Temazepam, Diazepam, and Alprazolam and are Schedule IV controlled substances and dangerous drugs. Valium is the brand name for

On March 1, 2011, B reported that her oncologist had died and she needed a new oncologist, she reported she was very fatigued and she had chronically low hematocrit. Respondent recorded that B's pain pattern remained the same and her pain with meds was moderate. No specific numerical pain level was documented. Her 4As were documented with B at baseline with no signs of depression but she was taking Cymbalta. For her pain, B's meds were continued and respondent refilled 60 pills of Cymbalta 60 mg. He advised her to follow-up with hematology/oncology as soon as possible. Prescriptions for the meds were issued that date.

On June 15, 2011, respondent noted that he lowered the dose of Kadian "if possible" and reduced the amount of Dilaudid pills he was prescribing from 80 to 60. He wrote prescriptions for 180 pills of Kadian, 60 pills of Dilaudid, 240 pills of Percocet, and 90 pills of Roxicodone this date. He also wrote a prescription for Cymbalta.

Respondent continued B on the same medication regimen through October 2011. On October 10, 2011, B reported that she fell at her home and fractured two of her ribs and she had "22 x-rays taken to confirm." She stated her left elbow was still bruised and swollen and hurt as much as it did right after she fell. B stated she took extra medications due to her fall but she felt she could go back to her prior medication regimen as directed. Respondent reported B as functioning at "baseline" with no adverse effects, aberrant behavior or signs of depression. His plan for B involved refilling her meds and ordering an x-ray of her left elbow.

Diazepam. Xanax is the brand name for Alprazolam. Restoril is the brand name for Temazepam.

Per the CURES report that was run for this period (Exhibit 15, AGO 3877), B had obtained a prescription from another provider of 24 pills of Percocet 5/325 on September 24, 2011.

At B's next visit on November 2, 2011, respondent recorded that B had no fractures but she was not functioning well. Per his physical exam of B, she appeared according to the handwritten note to have left elbow pain and he noted that B "[l]ooked pale." His plan for her consisted of refilling her as previously ordered.

On November 23, 2011, respondent had B submit to a UDS. According to the December 2, 2011, lab report from Ethos Laboratories, B tested negative for Oxycodone and Oxymorphone even though respondent routinely prescribed Oxycodone to her. At Patient B's next documented visit, on December 15, 2011, respondent did not document any discussion with her regarding the negative UDS results. In fact, respondent indicated the absence of aberrant drug taking behaviors. At this visit respondent refilled B's medications without documenting whether he discussed with her the inconsistent lab results and whether she was taking the meds as prescribed by respondent.

In his November 23, 2011, note documenting B's visit for this date, respondent documented that his plan for her included administration of a LESI. He did not, however, document that he was refilling B's meds or list the medications he was prescribing her. He issued prescriptions for the Roxicodone, Dilaudid, Kadian and Percocet that date.

At B's next visit on December 15, 2011, B reported she was having severe shoulder pain. She said she was able to function at home with the pain meds but had decreased mobility. Respondent recorded B as functioning at baseline without adverse

effects or aberrant behavior. He recorded that she displayed no signs of depression. Respondent continued B on her medication regimen, ordered a CT Scan of her shoulder and scheduled a cortisone injection for her shoulder. He issued prescriptions for her meds that day.

Two weeks later, according to CURES (Exhibit 15, AGO 3877), on December 28, 2011, without an accompanying note explaining why he was providing B with this prescription, B filled a prescription for 30 pills of Diazepam 10 mg based on respondent's prescriptions. This prescription appeared to be from a prescription respondent wrote on September 2, 2011, for B with two refills. (Exhibit 14, AGO 3505.) At any rate, respondent's notes did not identify this benzodiazepine among the meds he was prescribing B, the reason he was prescribing it, or any advisement to B regarding the risks of taking this med in combination with the high dose opioids he was also prescribing her.

According to a review of B's medical records, which were consistent with the CURES report, respondent was issuing prescriptions for Valium and Diazepam without documenting in B's medical records that he was issuing these prescriptions or listing the benzodiazepines he was prescribing as among the meds he was prescribing. As an example of this practice, he issued prescriptions for 30 pills of Valium 10 mg with two refills on December 23, 2010 (Exhibit 14, AGO 3431) and March 10, 2011 (Exhibit 14, AGO 3457), a prescription for Diazepam on June 8, 2011 (Exhibit 14, AGO 3477) with two refills, and another prescription for Diazepam on September 2, 2011 (Exhibit 14, AGO 3505.)

On January 21, 2012, B's health plan sent respondent a letter that identified the medications respondent was prescribing B between October 23, 2011, and January 21, 2012. This list included Diazepam among the other meds respondent had been

prescribing B. B's health plan provided respondent this advisement because of the number of controlled substances B was obtaining during this period. B's medical records did not document that respondent responded to the health plan's letter.

Per the note documenting B's January 27, 2012, visit with respondent, B reported she was having moderate to severe low back pain and the injection respondent administered to her right shoulder did not help her. Respondent noted that there was no change in B's pain pattern, and B was functioning at baseline. Her 4As remained unchanged. Respondent continued B on the medication regimen previously ordered and wrote prescriptions that date. Despite her health plan's concerns regarding the number of controlled substances she was taking, respondent did not record whether he discussed with B the medications she was taking or the inconsistent lab results from December 2, 2011.

Respondent continued B on the same medication regimen, including prescriptions for Valium and Diazepam, from this date through April 2012.[22] About March 30, 2012, respondent underwent right shoulder joint aspiration surgery. On April 13, 2012, respondent wrote a prescription for 45 pills of 30 mg Roxicodone. There was no accompanying note to document the reason he issued this prescription at this time. According to CURES, B filled this prescription on April 13, 2012, and a week later, on April 20, 2012, filled another prescription for 90 pills of Roxicodone. The April 20, 2012, prescription had an accompanying note with prescriptions for Roxicodone, Dilaudid, Percocet and Kadian written by respondent that date.

[22] Respondent was also issuing B prescriptions for Cymbalta during this time.

Previously, on March 30, 2012, respondent had also written prescriptions for Roxicodone, Dilaudid, Percocet and Kadian in the same amounts and dosages.

B, thus, during a less than 30-day time period between March 30, 2012, and April 20, 2012, obtained more than 30-day supplies of Roxicodone, Dilaudid and Percocet without documented medical justification.

Through July 2, 2012, as she was recovering from shoulder surgery, B was maintained on the same medication regimen. In a note dated June 1, 2012, respondent recorded that B was recovering from surgery. The note was largely illegible except for language regarding continuing B on her then current medications. The note did not identify the medications she was taking. On this date, respondent wrote prescriptions for 90 pills of Roxicodone, 75 pills of Dilaudid, 90 pills of Percocet and 180 pills of Kadian. On June 12, 2012, respondent wrote a prescription for 75 pills of Dilaudid and on June 20, 2012, respondent wrote a prescription for 45 Roxicodone pills and 30 pills of Dilaudid. There were no accompany notes for these prescriptions.

In a note dated June 22, 2012, respondent documented that B continued to have moderate severe lower back and shoulder pain status post-surgery. She noted that she planned to begin physical therapy the following week. Respondent wrote that there was no change to her pain pattern and she was functioning at baseline. Per her 4As, she was not independent for ADL and required assistance. Otherwise her condition remained unchanged. For her plan, B was to be administered a Toradol injection. B's medications were refilled and that day, with respondent's consent, PA Kureshi wrote prescriptions for the medications in the same amounts and dosages previously ordered.

On July 2, 2012, B left a message for respondent "requesting pain med 2 wks was discharge [*sic*] from hospital for shoulder replacement surgery!!" That day, without documenting why he did this, respondent wrote a prescription for 30 pills of Dilaudid. A week later, on July 9, 2012, again without an accompanying note to document why he was prescribing the med, respondent wrote another prescription for 30 pills of Dilaudid.

According to the note documenting B's July 13, 2012, visit, B continued to report that she was not doing well after her shoulder surgery. Her activity level was identified as "poor" but she did not need help with ADLs. It was difficult to decipher respondent's plan for B but her Kadian was continued, Roxicodone and Percocet were to be continued on an as needed basis and the Dilaudid was to be decreased. Prescriptions for these meds were issued in the same amounts and dosages previously ordered according to the CURES report.

On July 20, 2012, respondent wrote a prescription for Cymbalta for B without an accompanying note or identifying this med among the meds he was prescribing her in her visit records. On July 24, 2012, a prescription for 30 pills of Valium with one refill was authorized by PA Kureshi. There was no accompanying note for this prescription.

On July 27, 2012, B's health plan sent a second letter to respondent regarding controlled substances B was obtaining through May 2012. The letter consisted of five pages but only two were in respondent's records. On the cover sheet, respondent acknowledged on July 31, 2012, the health plan's concerns, noted he reviewed the letter and the letter could be filed in B's records

From this date, respondent employed an electronic medical record keeping (EMR) system that made it easier to follow his treatment of B. On August 3, 2012, B

described her pain as constant with her average pain as 8/10. B's 4 As were recorded, with her ADLs described as poor with B needing help for her upper extremities. Respondent continued B on the same medication regimen and added a vitamin B12 injection to address B's anemia. He documented that he discussed her right shoulder with her and possible referral to the Mayo Clinic. He wrote prescriptions for the meds that date. Notwithstanding the new EMR system, respondent did not identify in his note recording B's visit the meds respondent was prescribing B, including Valium or Diazepam or Cymbalta.

Respondent next saw B on August 24, 2012. At this visit, B described her average foot pain as 8/10. Regarding her shoulder pain, B said she was having a lot of pain and '"lost more range of motion and more pain"' since the total shoulder replacement. She said she was to start Occupational Therapy for the right shoulder. Respondent stated that she was functioning at baseline and she needed "a lot of assistance." Under her 4As, she said she was getting relief from the meds but not enough and she was functioning at baseline. Respondent did not note aberrant drug-taking behaviors. He noted under this category, that she was struggling with pain management and "it seems the surgery has failed." In his diagnosis of B he stated that B had "Failed back surgery syndrome," a diagnosis he continued to record in B's notes. His other diagnoses of B were as follows: "S/P right shoulder total replacement one month ago," "Tough post-surgical course," "Low back pain s/p laminectomy," "Failed back surgery syndrome," "Left foot fracture s/p ORIF," "Chronic left foot pain causing Altered gait," and "Chronic anemia." It was unclear from the record why respondent reached the conclusion that B was suffering from failed back surgery syndrome. It is noted that his initial impression of B in 2005 did not identify this condition.

In his August 24, 2012, note, respondent also recorded that B's husband helped to manage her medications. He did not document why B's husband needed to do this for her. Respondent added B "Function [*sic*] poorly. She needs care now." He scheduled her for a follow-up appointment in one month and, as part of his plan, stated that he was to prescribe B 180 pills of Kadian 100 mg, 90 pills of Roxicodone 30 mg, 90 pills of Dilaudid 8 mg, and 240 pills of Percocet 10/325 mg. On August 24, 2012, respondent wrote prescriptions for 180 pills of Kadian, 90 pills of Roxicodone, and 240 pills of Percocet. He issued 75 pills of Dilaudid this date, not the 90 pills he stated in his note he was prescribing.

B's next visit with respondent was on September 14, 2012, about three weeks later, less than the month respondent scheduled B to see him. At this visit, her low back and leg pain levels were documented as 7/10. With respect to her shoulder pain, respondent wrote that B was "functioning at the baseline and needs a lot of assistance." The language for the 4As appears to have been repopulated from the August 24, 2012, visit and included the language "It seems the surgery has failed." Her overall functioning was rated as poor and she needed assistance for her upper extremities. For his plan respondent stated that he would follow-up with the orthopedic surgeon and the Occupational Therapist. There was, however, no documentation he did so in subsequent notes. For his follow-up he stated that he was going to have B undergo "aggressive pain management to improve function and quality of life." His plan involved issuing prescriptions for 180 pills of Kadian, increasing Roxicodone to 120, from 90 pills, and "(w)ean(ing B)off Dilaudid 8 mg tid x 35 (will reduce more next)." It was not clear from B's note why respondent felt the need to wean B off Dilaudid. Respondent scheduled B for an appointment to see him in a month. Respondent wrote prescriptions for the medications in the following amounts and dosages that day: 120 pills of 30 mg Roxicodone (which was to be taken

four times a day from twice a day as ordered previously), 35 pills of 8 mg Dilaudid, 240 pills of 10/325 mg Percocet, and 180 pills of 100 mg Kadian.

B's next visit, on October 5, 2012, was less than a month from the September 14, 2012, visit. No reason was documented regarding why B's visit was scheduled for less than a month from the September 14, 2012, visit. B presented at this visit with the same pain levels and stated she was having trouble sleeping. Respondent's plan for B called for respondent to follow-up with B's orthopedic surgeon and occupational therapist and respondent increased B's Dilaudid to 60 pills from 35 pills. Otherwise, he maintained B on the same medication regimen. PA Kureshi wrote prescriptions for these meds with respondent's consent.

At her October 26, 2012 visit, B described her low back and leg pain as 6/10 on average and 8/10 at the time of her visit. She stated that her foot pain was 8/10. B said she appeared to be getting better range of motion in her right shoulder but still had a lot of pain, especially with the physical therapy she was undergoing. Respondent reported that B was functioning fine at baselines but, paradoxically, needed a lot of assistance. Respondent documented B's 4As in the same terms as he had in previous notes and he again noted that B had shoulder surgery "a month ago" that seemed to have failed because she was experiencing more pain and had no improvement with range of motion. This note conflicted with B's report that she was experiencing improvement in her range of motion. Respondent further noted that B was struggling with pain management, was managing her meds fine, but was functioning poorly. For his plan for B, he noted he discussed with her pain management and she needed to be on time at her visits. In his hearing testimony, respondent stressed a patient's punctuality as evidence of a patient's compliance with the pain management regimen. He described her as a very difficult pain management patient in his note. His plan at

this time consisted of: follow-up with orthopedic surgeon and occupational therapy, and issue prescriptions for 120 pills of Roxicodone, 240 pills of Percocet, and increase Dilaudid to 60 pills. He identified Kadian as a continuing prescription but did not issue a Kadian prescription that day. Respondent noted that B was to return in a month for a follow up visit.

On this date, he had B submit to a point of care urine screen, which was consistent with current meds. But, a confirmatory lab screen showed Fentanyl, Soma and a clonazepam in B's system. Respondent signed the lab report and wrote "OK." In a subsequent note dated December 14, 2012, respondent wrote that he reviewed B's UDS and found it consistent with the medications prescribed. In his hearing testimony, respondent stated that he talked to B about the Fentanyl specifically and the Fentanyl was from a prescription written by PA Kureshi on July 11, 2011, but he did not document he had this discussion with B in the notes. The clonazepam did not appear in a CURES report, the source of this med was unclear and respondent did not document whether he clarified this with B. According to CURES (Exhibit 15, AGO 3878), B's primary doctor, Dr. Killeen, prescribed Soma to B on October 22, 2012, both respondent and Dr. Killeen prescribed valium, and respondent prescribed Diazepam to B (Exhibit 15, AGO 3878) during this time frame. The lab report, in addition, showed "traces" of Oxycodone in B's system when, per complainant's expert Dr. Helm, given the Roxicodone prescription, it would have been expected that more than traces of Oxycodone would have been found in B's system.

Respondent's November 19, 2012, progress note for B had the caption "Physical Medicine and Rehabilitation Consultation." Respondent recorded B's condition in similar terms as he documented in B's previous notes. He identified B with the same

diagnoses including "Failed back surgery syndrome" and he continued B on the same medication regimen.

On November 12, 2012, a pharmacy contacted respondent requesting approval to refill respondent's prescription of Cymbalta, an antidepressant medication, which respondent wrote on July 23, 2012. Respondent did not document in B's medical record that between July 23, 2012 and November 12, 2012, he was prescribing Cymbalta to her or the reason he was doing so. Further, he did not identify the medication among medications she was taking in B's notes.

On December 7, 2012, without an accompanying note, respondent issued prescriptions for 240 pills of Percocet, 180 pills of Kadian, 120 pills of Roxicodone, 90 pills of Dilaudid in additional to a Lidoderm patch. Per CURES (Exhibit 15, AGO 3878), B filled prescriptions for these meds on December 14, 2012, which corresponded with her appointment with respondent on December 14, 2012. But the documentation was confusing.

Parenthetically, as Dr. Helm noted in his testimony, per this CURES report, B filled a prescription from respondent for 45 Dilaudid pills on December 4, 2012. A review of B's notes did not indicate that respondent prescribed this amount of Dilaudid to B.

As noted, B saw respondent on December 14, 2012, and respondent continued her on the same medication regimen and issued prescriptions for her this date. He noted that her next appointment was to be set in one month.

On December 28, 2012, according to CURES, B filled a prescription for 30 pills of Diazepam from a prescription respondent wrote. There was also no accompanying note in B's records for this prescription.

Three weeks after her December 14, 2012, visit, on January 8, 2013, B saw respondent and presented, for the most part, with the same pain pattern. Respondent continued her on the same medication regimen he previously ordered. Without explanation, he excluded "failed back surgery syndrome" among B's diagnoses. He scheduled B to return for a follow up visit in four weeks.

A little over two weeks later, on February 1, 2013, B saw respondent. She presented with a similar pain pattern as documented in B's previous notes and respondent issued prescriptions to B for the meds as previously ordered. For some reason not documented, respondent added back the "failed back surgery syndrome diagnosis" with the same diagnoses he had noted in previous notes. He scheduled her to return in one month.

Less than one month later, on February 26, 2013, B returned to see respondent. She presented with the same pain patterns in her low back, leg, foot and shoulder. At this visit she noted that she wanted an early refill because her husband was going out of town for a meeting. Respondent's plan maintained B on the same medication regimen, added a possible LESI treatment and indicated that B was to follow-up with her orthopedic surgeon and physical therapist. There was no documentation that respondent did so. For his diagnoses of B, he removed the failed back surgery syndrome diagnosis from among the conditions he believed she had without explanation. Respondent issued prescriptions to B as early refills for the same meds in the same amounts and dosages he had previously ordered.

On March 18, 2013, without an accompanying note, respondent documented he issued a prescription for a 30-day supply of 60 pills of Cymbalta 60 mg.

According to B's March 22, 2013, note, B saw respondent on this date and again, according to the note, wanted an early refill because her husband was going out of town "tomorrow for a meeting." This was the exact language from the previous note and it appeared to be a repopulated note from the February 26, 2013, visit.

Under his plan for B, respondent wrote the following:

> She may need L-ESI soon. She has been on high dose of pain medications. Needs more monitoring.
>
> Again, as stated before, it is very difficult pain management case due to multiple catastrophic injuries in the past years, which has caused right total shoulder replacement (functionless) and left foot fracture casing [*sic*] gait changes and aggravates back pain. She has lost significant function level due to these new injuries. Unfortunately, the damages are not curable by surgery syndrome.

His plan for B remained the same, however, including following up with B's orthopedic surgeon and physical therapist and refilling her medications in the same amounts and dosages previously ordered. He did not explain in this note or subsequent note why he felt that B needed more monitoring. It is also noted that respondent continued to repopulate the same language in subsequent notes. Prescriptions for these meds were issued this date and he wanted B to return in one month for follow up and medication refill.

In B's May 10 and 24, 2013, notes, respondent issued prescriptions of B's meds for 15 days as follows: 30 pills of Dilaudid, 90 pills of Kadian, 120 pills of Percocet and 60 pills of Roxicodone. In both of these notes, he stated he wanted her to return in

two weeks for follow-up. Respondent did not document, however, his reason for wanting to see her on a two-week basis. In addition, at B's May 24, 2013 visit, respondent had B undergo a point of care UDC which was reported as consistent with B's medications although the test was negative for opiates. Respondent did not send the sample out for confirmatory lab testing and he did not document in B's June 7, 2013, visit note anything about the missing Kadian or Dilaudid per the point of care test.

As documented in B's July 3, 2013, visit note respondent wrote prescriptions for 90 pills of Kadian for a 15-day supply, 120 pills of Roxicodone, 60 pills of Dilaudid, and 240 pills of Percocet. Respondent scheduled B to return in one month. The prescriptions for Roxicodone, Dilaudid and Percocet were for 30-day supplies of these meds.

B saw respondent next on August 2, 2013. According to B's note respondent's plan for B was to issue her prescriptions for 180 pills of Kadian, 120 pills of Roxicodone, 60 pills of Dilaudid, and 240 pills of Percocet and B was to return in a month for follow up and medication refill. But, as documented in the same note on the same page, respondent prescribed 90 pills of Kadian for a 15-day supply. His prescriptions for the other meds were consistent with his plan. Notwithstanding the documentation of 15-day Kadian prescription as contained in the note, PA Kureshi wrote a prescription for 180 pills of Kadian, not the 90 that was documented to have been prescribed.

B saw respondent on August 30, 2013, which is again sooner than the 30-day period he wanted her to return for follow up and prescription refill. This record is notable because B told respondent that she was "able to maintain a month's supply of medication." In other words, B told respondent that she did not need the high dosages

of opiate meds respondent prescribed her. Respondent also noted that her pain pattern remained the same. Respondent prescribed B 90 pills of Kadian for a 30-day supply and 120 pills of Roxicodone, 60 pills of Dilaudid, and 240 pills of Percocet. B was to return in a month for follow up and medication refill. On this date he administered ketorolac.

According to CURES (Exhibit 15, AGO 3879) respondent's August 30, 2013, record that he prescribed 90 pills of Kadian for a 15-day supply was wrong. In fact, B filled a prescription for 180 pills of Kadian on August 30, 2013, from respondent's prescription, meaning he wrote a prescription for this amount of Kadian this date.

Starting in his November 18, 2013, note, respondent in his plan for B identified her as a "high risk patient due to high dosage of pain medications and multiple on-going chronic pain disorders and medical issues." In the note this date he wrote that it was difficult to reduce her pain meds due to these issues.

For the rest of 2013 respondent continued B on the same pain medication regimen, prescribed Cymbalta on October 28, 2013, administered B-12 injections to her, and administered a LESI treatment on November 21, 2013. B's reported pain levels remained largely unchanged with minimal variations of degree. Respondent's plan for B throughout 2013 remained unchanged. The plan continued B on the same medication regimen and added a LESI treatment. She remained on a daily 900 MED dose throughout this period.[23] Other than May 2013 B was scheduled for monthly visits with respondent, though B's appointments were often scheduled in less than one

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[23] Morphine Equivalent Doses (MED) is a measure used to equate different opioids under one value to compare doses.

month increments with prescriptions issued in greater than 30-day supplies. Notably, respondent commented in his plan for B in her November 18, 2013, note that it was "difficult to reduce her pain meds due to "B's on-going chronic pain disorders and medical issues."

On December 13, 2013, respondent wrote prescriptions for 60 pills of Dilaudid, 180 pills of Kadian, 240 pills of Percocet and 120 pills of Roxicodone. There was no accompanying note for these prescriptions. Three weeks before, on November 21, 2013, respondent wrote prescriptions for these meds.

In January and February 2014, respondent continued B on the same medication regimen with B reporting the same pain pattern and restrictions in the range of motion in her shoulder. In B's January 10, 2014, note, respondent recorded he discussed with B weaning her off her pain medications, but B stated she was not ready to do this. He continued her on the same medication regimen. In the February 7, 2014, note, respondent noted that he "can not [*sic*] taper off more pain meds due to the left issues."

B saw respondent on April 4, 2014, and was continued on the same medication regimen with prescriptions issued for the pain meds that day. She received a therapeutic injection in her left knee of Ketorolac for pain relief. Respondent scheduled B to return in one month for a follow up visit.

B saw respondent sooner than one month later on April 15, 2014. He obtained an MRI of B's left knee to rule out a fracture due to a fall she had had. At this visit he administered a Toradol injection in her knees and continued her on the same medication regimen. Prescriptions for her pain meds were issued that day. Respondent

did not document whether he discussed with her that she had used up the pain medications he prescribed to her on April 4, 2014.

According to CURES (Exhibit 15, AGO 3880), on April 4, 2014, respondent filled prescriptions from respondent for 60 Dilaudid pills, 120 Roxicodone pills, 240 Percocet pills and 180 Kadian pills. On April 15, 2014, she filled a prescription for Dilaudid from respondent and on April 18, 2014, she filled a prescription for Percocet from Dr. Killeen on April 18, 2014. She did not fill the prescriptions respondent wrote for Roxicodone and Kadian on April 15, 2014 during April 2014.

Also as revealed in the CURES report for April 2014, B had filled a prescription for Soma from Dr. Killeen on April 22, 2014, in addition to a prescription for 90 pills of Valium from Dr. Killeen on April 11, 2014.

Before B's next visit with respondent on April 25, 2014, on April 23, 2014, B's health plan sent another letter to respondent to advise him of the number of medications B obtained from respondent's prescriptions through March 2014 to ensure B was appropriately using the meds respondent was prescribing her. The health plan, in its letter, noted a concern about "Polypharmacy 10 drugs" (Exhibit 14, AGO 3791) and Hydromorphone. Respondent's response, if any, to the health plan was not included in B's records.

B next saw respondent on April 25, 2014, to obtain another refill of her pain medications. She said she saw her orthopedic doctor and was found to have "more non-displaced fracture in the right tibia." She also told respondent her left leg was so bad she had to use more of her medications and she was out of Percocet. That she would have been out of Percocet by this time is concerning, as Dr. Helm stated in his testimony, since she had just filled a prescription for 100 pills of Percocet from Dr.

Killeen on April 18, 2014, according to CURES. Respondent documented that she was one week early for her visit and he refused to issue her a prescription for the pain meds he had been prescribing. But, he wrote her a prescription for 120 pills of Oxycodone 10 mg to be taken eight times per day for the week before her next appointment. Aside from B's statement regarding the Percocet, respondent did not document whether B had run out of the other pain meds he prescribed her in April, and he did not run or obtain a CURES report to see if she had filled the prescriptions he wrote for her for pain meds in April. As noted, if respondent had run a CURES report for April, he would have seen that B was not candid with him. In fact, B had not filled all of the pain meds respondent had prescribed her and on April 18, she obtained 100 pills of Percocet from a prescription from Dr. Killeen. Thus, it appears she either did not need all of the pain meds, contrary to what she told respondent, or she was stockpiling her pain meds. As in all of B's notes, respondent wrote that B was not displaying aberrant behavior. This was not accurate. B's behavior regarding obtaining her meds this month can fairly be characterized as aberrant.

At her May 2, 2014, visit B reported the same pain pattern. For his plan respondent wrote that B's pain management was more of a "challenge" due to her recent knee fracture. He said he was trying to avoid escalating the dose of B's pain meds. He continued B on the same medication regimen and wrote prescriptions for her for these meds.

B's next visit on May 29, 2014, was scheduled for less than one month later, although at her May 2, 2014 appointment he wanted her to return in one month. He noted that B came with her husband and was in a wheelchair. He maintained her on the same medication regimen and prescribed her Cymbalta although in his exam

findings he noted that B displayed no signs of depression.[24] He scheduled her to return for follow up and medication refill though he did not note whether this was to be in one month. He wrote prescriptions for her on this date.

B's next appointment was on June 27, 2014. At this visit, he noted that B was walking without assistance and was two months out from her left tibia fracture. He noted her condition remained unchanged and he prescribed her the same meds in the same amounts and dosages previously ordered.

B's next visit of note was on October 10, 2014. At this visit B said that her husband would be out of town for two weeks and she wanted an early refill of her meds as a result. Her last visit with respondent was on September 17, 2014, at which time respondent administered a LESI treatment and wrote prescriptions for the opiates as previously prescribed. In this note, respondent wrote that B's various "traumas have limited her from significant recovery," she has lost significant function level due to these new injuries," and "the damages are not curable by surgery anymore." He added: "In terms of long term of pain management, I will see little chance for her to be off opioid pain medications." He said B should consider a pain pump and gave her information in this regard. He wrote prescriptions for B for the opiate meds previously ordered.

Shortly before this visit, on October 6, 2014, according to CURES, B filled a prescription for 120 pills of Percocet from Dr. Killeen. On October 1, 2014, according to

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[24] Respondent consistently documented that B displayed no signs of depression throughout B's notes despite prescribing her Cymbalta for depression.

this same CURES report, B filled a prescription for 53 pills of Soma. On October 9, 2014, B filled a prescription for 90 pills of Valium.

B saw respondent on November 5, 2014, and reported the same pain pattern she previously reported in her last visit. Respondent wrote prescriptions for the same opiate meds in the same amounts and dosages and scheduled her for follow up, as typical, in one month. On November 13, 2014, respondent administered a LESI treatment. Per a phone call respondent had with B, she told respondent she had significant back pain and was not able to walk. He did not provide her with prescriptions and scheduled her for follow up in two weeks.

B reported she had a good response to the November 13, 2014, LESI treatment, was doing fine with pain management, but at the same time her pain pattern remained the same. B's note contains repopulated language under respondent's plan for her and respondent wrote prescriptions for her opioid meds in the same amounts and dosages previously ordered. He administered a Ketorolac injection this date.

Thus, for November 2014 respondent prescribed to B two month supplies of Dilaudid, Roxicodone, Percocet and Kadian. B filled the prescription for Kadian on December 4, 2014, according to CURES. (Exhibit 15, AGO 3881.)

At B's next visit, on December 19, 2014, the language in the note again recited that B had a good response to the LESI and her pain pattern remained the same. The language was repopulated from the November 26, 2014, visit. On this visit, respondent wrote prescriptions for 240 pills of Percocet, 60 pills of Dilaudid, and 120 pills of Roxicodone. In his note he did not document why he was not prescribing Kadian this visit.

On January 7, 2015, respondent obtained a CURES report for the meds B had been obtaining between January 7, 2014, and January 7, 2015. In this report, as noted above from the CURES report complainant obtained, B filled prescription for 100 pills of Percocet from Dr. Killeen on April 18, 2014, and 120 pills of Percocet also from Dr. Killeen on October 6, 2014. As noted, B also obtained prescriptions for Soma and Valium from Dr. Killeen this month. At this point, because she obtained Percocet from another provider, B was in violation of the pain management agreement she signed.

At B's visit after respondent ran this report, on January 16, 2015, respondent did not document any discussion about what the CURES report revealed about the meds she obtained from Dr. Killeen. He issued B prescriptions for opioid medications in the same amounts and dosages he had previously ordered.

Per the CURES report complainant obtained on April 30, 2019, on January 27, 2015, B filled a prescription for 60 pills of Percocet from a prescription from Mark Stewart Austerlitz, M.D. (Exhibit 15, AGO 3881.)

B next saw respondent on February 6, 2015, for an urgent visit because she fell and injured her knee. Due to B's "emergency," he wrote B a prescription for 60 pills of Roxicodone, and 45 pills of Dilaudid. He ordered an x-ray to rule out a fracture. Respondent scheduled B for a follow-up appointment in two weeks.

At B's February 13, 2015, visit, B told respondent she "has been out of pain medications now." She was in a wheelchair and was with her husband. Respondent did not document he had given B a 10-day supply of meds on February 6, 2015. His note did not record that he took a critical assessment of B's use of pain meds during this time and he did not obtain an additional CURES report. He wrote prescriptions for 60

pills of Dilaudid, 120 pills of Roxicodone, 180 pills of Kadian, and 240 pills of Percocet. Respondent scheduled B to return in a month for follow up.

A little over two weeks later, on March 4, 2015, B returned for her follow up visit with respondent. This note contains repopulated language from the February 13, 2015, visit note including that she was out of pain meds. Respondent added, "She is out of short-acting pain meds now." Respondent did not issue prescriptions for Kadian or Dilaudid but wrote a prescription for 240 pills of Percocet and 120 pills of Roxicodone. He discussed with her use of a pain pump. He scheduled B to return in two weeks for follow up.

On March 13, 2015, B next saw respondent. She was still in a wheelchair. For his plan for B respondent repopulated language from earlier notes and added that she was a candidate for a pain pump and she has "fall tendency and d/w her to use support." He wrote a prescription for 120 pills of Roxicodone and 240 pills of Percocet. He did not write prescriptions for Dilaudid or Kadian. He scheduled her for a follow up visit in a month.

For a reason not documented, B's follow up visit with respondent was in a little over two weeks, on March 27, 2015. Respondent reported her pain pattern as the same and noted that she was still using a wheelchair. He again wrote a prescription for 120 pills of Roxicodone and 240 pills of Percocet. He did not write prescriptions for Dilaudid or Kadian. He noted she remained a candidate for a pain pump.

From this point through August 2015, respondent continued to prescribe 120 pills of Roxicodone and 240 pills of Percocet. He documented that she was a candidate for a pain pump. In her July 15, 2015 note, respondent wrote that he reviewed the CURES report he obtained on January 7, 2015, and deemed it "consistent," although it

showed that B obtained Percocet from Dr. Killeen on April 18, 2014. Subsequently, respondent pulled a CURES report on July 24, 2015, for the July 24, 2014, to July 25, 2015, period. He did not document in B's August 12, 2015, record that he reviewed this CURES report.

On July 15, 2015, respondent completed an Opioid Risk Tool (ORT) in which B's score was 5, which was deemed a "moderate" risk. He did not document in B's July or August notes why he initiated this test or what conclusions, if any, he made regarding it.

10. Respondent prescribed B opioids in greater than 30-day supplies between November 2, 2011, to Jan 3, 2012, two-month period, in which according to CURES, respondent prescribed 960 pills of Percocet, a four-month supply of the medication. During this same time, he also prescribed her 360 pills of Roxicodone, and a four and a half-month supply of Dilaudid, as documented in CURES on November 23, 2011 (75 pills), December 15 (75 pills), and January 3, 2012 (75 pills). As discussed below, respondent acknowledged in his testimony that he prescribed B this amount of meds. He explained he did so because B was in a pain crisis at the time, though in B's notes from this time he did not use the language "crisis."

PATIENT C

11. Patient C ("Patient C" or "C") first saw respondent on September 10, 2008, when he was 35 years old. Patient C was a workers' compensation patient whose spinal surgeon referred him to respondent for discography. Respondent soon assumed C's care for pain management and in this regard prescribed him opiate pain medication therapy. Between 2010 and 2015, among other controlled drugs respondent prescribed C he prescribed Norco and Soma. During this time, respondent prepared

reports for workers' compensation, in which he was identified as the secondary treating doctor, and documented his treatment of C in C's records as C's primary treating doctor. His prescription of opiates ranged from 485 to 650 MEDs.

For the period at issue in this matter, respondent recorded at C's December 15, 2010, visit that C reported pain as 9/10. C stated he wanted a Toradol injection for pain relief. C reported his pain to be at "baseline with moderate to severe pain." C said he did not sleep well and woke up due to back pain. Respondent identified the following diagnoses for C's condition: Low back pain due to work-related injury; L4-5 herniated nucleus pulposus (HNP) with significant weakness with the left leg; left shoulder trauma due to fall with A/C joint sprain, low back pain with sympathetically maintained pain, which is the etiology for the weakness in the left leg and intractable back pain. His treatment plan included the possibility of a pain pump, a LESI and the following meds: 90 pills of OxyContin,[25] 150 pills of Roxicodone, and Ambien and Soma. In prescriptions dated January 12, 2011, and February 9, 2011, he also prescribed 30 pills of Klonopin, though he did not document why he was prescribing this medication. Dr. Helm identified the MED as 585 at this point, which respondent maintained throughout his treatment of C as documented in this matter.

At this time, according to a CURES report obtained by complainant (Exhibit 19, AGO 5003) C filled a prescription for 150 pills of Norco based on a prescription from Carla Young, M.D.

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[25] OxyContin, a brand name for Oxycodone HCL, is a Schedule II controlled substance and dangerous drug.

According to C's July 29, 2011, note, C was reported to be seeing a psychiatrist. Respondent continued C on the same medication regimen and he documented C was to continue on the same medication regimen. He did not write C a prescription for these meds this date.

At C's August 26, 2011, visit, respondent wrote prescriptions for 90 pills of OxyContin, 150 pills of Roxicodone, 30 pills of Ambien, 90 pills of Soma, and 30 pills of Valium.

As documented in a letter dated December 12, 2011, C's workers' compensation insurance conducted a utilization review to "determine medical necessity and appropriateness" regarding respondent's treatment of C. Respondent's treatment of C was described as the prescription of 90 pills of OxyContin and 90 pills of Soma in addition to Toradol and Cortisone injections.

As part of the carrier's utilization review, Joel Mata, M.D., as documented in a letter he wrote dated December 12, 2011, questioned the medical necessity of prescribing 90 pills of OxyContin because his review of C's records failed to show C was improving functionally. Dr. Mata also questioned respondent's prescription of Soma to C because Soma "is not indicated for long term use." In his testimony, Dr. Helm agreed with Dr. Mata that Soma was not appropriate for long term use and he stressed that if this med is prescribed in conjunction with benzodiazepines and opiates a doctor must document that the benefits of this prescription are worth the risk. Dr. Helms testified that respondent failed to document such.

On December 28, 2011, in a handwritten record, as opposed to the typed workers' compensation reports respondent prepared, respondent documented that C was able to function independently at home with his pain meds and his pain was 5/10

with the pain meds. Respondent continued C on the same medication regimen and wrote prescriptions for 90 pills of Soma, 30 pills of Ambien, 90 pills of OxyContin, 150 pills of Roxicodone, and 30 pills of Valium.

C saw respondent next on January 28, 2012, when he reported that the pain was "eating away at his brain." Respondent documented that he continued to see a psychiatrist. Respondent wrote prescriptions for C for the same meds in the same amounts he previously ordered.

In a handwritten note dated May 23, 2012, respondent noted that C was having "vivid dreams" and "nightmares." He described his pain as worse in the back and said he fell three times. Respondent wrote prescriptions for him for the OxyContin, Roxicodone, Valium, Ambien, and Soma. For some reason not documented, respondent wrote two prescriptions for these meds for May 23, 2012. (Exhibit 19, AGO 4125 to 4127.)

On May 29, 2012, C called to state that he was going into "withdraw" and felt "suicidal." Respondent advised him to either call 911 or have someone take him to the hospital.

The next record of note was dated September 11, 2012. At this visit C stated that he was struggling to function and the only thing that kept him going was the pain medications respondent was prescribing him. That day, respondent wrote prescriptions for him for the OxyContin, Roxicodone, Ambien, Soma and Valium.

Respondent continued to prescribe C the same medications through July 12, 2013. C reported at his July 12, 2013, visit with respondent that his pain pattern remained the same but had been more manageable since his medications had been approved. He issued prescriptions that day for 180 pills of Roxicodone for break-

through pain, and 90 pills of OxyContin. He also issued a prescription for 30 pills of Valium.

The next record of note was dated January 20, 2014. At this visit, C was reported to have been crying "due to the pain and frustration of his pain condition." His subjective complaints, however, remained unchanged. Respondent wrote prescriptions for him for 30 pills of Valium, 180 pills of Roxicodone, and 90 pills of OxyContin. He noted that C had refills for Soma and Ambien.

In an electronic medical record (EMR) dated September 18, 2014, respondent documented that C's prescription for OxyContin was denied and a "weaning off plan has been suggested." Respondent was referring to a letter from C's insurance dated September 17, 2014, in which the insurer advised respondent that it did not authorize prescriptions for OxyContin or Roxicodone. Respondent sought prior authorization for OxyContin on September 4, 2014, and stated in his request that C never displayed any signs of abuse or diversion, he had no side effects, and was compliant with significant pain relief.

In this note respondent stated that C was placed on Oxycodone in place of the OxyContin. C reported that he had the same pain in his low back for five years and the pain, at its worst, was 10/10 without medications and 6/10 with medications. For his plan, respondent weaned down OxyContin with a prescription of 60 pills and he did not write a prescription for Roxicodone or a prescription for Valium and he did not refill the Soma and Ambien this visit.

On January 7, 2015, respondent ran a CURES report on C's prescriptions for the January 7, 2014, to January 7, 2015, period. It showed that C was compliant with his pain agreement and not obtaining meds from doctors other than respondent.

C's next notable record of his visits with respondent was dated February 11, 2015. At this visit, C stated that he was experiencing "significantly increased low back pain and left radicular pain." At the same time, C reported that his average pain was 6/10. C asked for a Toradol injection and he told respondent he was taking Oxycodone every eight hours. Respondent increased the OxyContin to 80 mg from 60 mg, and wrote a prescription for Roxicodone. Although he wrote in his note he was not refilling C's Valium prescription, he wrote a prescription for 30 pills of Valium plus 30 pills of Ambien. He also wrote prescriptions for 90 pills of Soma, 180 pills of Oxycodone and 90 pills of OxyContin on this date. This note, as was the case with C's other notes, did not contain respondent's rationale for prescribing Ambien and Soma with the opiates he has been prescribing.26

12. Respondent did not document in C's records that he advised C of the risks of taking Soma, benzodiazepines and opiates together. In C's notes, respondent did not acknowledge the risk of prescribing this combination of meds to C, as Dr. Helm stated in his testimony. In addition, in terms of monitoring C as a high-risk opioid pain management patient, respondent conducted only one UDS screen in July 2015. According to the lab report from Confirmatrix Laboratory, dated July 15, 2015, the screen was "positive" for Zolpidem, or Ambien, and was deemed "inconsistent."

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[26] It is worth repeating Dr. Helm's testimony that Soma's metabolite is meprobamate, a drug with known sedative and abuse potential. Respondent did not dispute this. Further, as was the case with Patient A, C was taking benzodiazepines. The combination of opioids, benzodiazepines and Soma is a well-known favorite triad of drug abusers, as Dr. Helm stated in his testimony.

Otherwise, the lab results were consistent with the meds respondent was prescribing C.

13. In C's records, respondent did not document his rationale for prescribing and continuing to prescribe Valium and Soma to C.

PATIENT D

14. Patient D ("Patient D" or "D") was a male patient who began treatment with respondent from December 2006, when he was 31 years old, until his death on September 12, 2015, from a combination of "mixed medication intoxication" due to toxic levels of morphine, oxycodone, and alprazolam, according to the Medical Examiner's report, plus other medications which respondent was prescribing D to manage his pain. D's pain was the result of a slip and fall accident he incurred on December 5, 2003, that caused a rupture in his right patellar tendon and a lumbar contusion. He had a surgical repair of the tendon on January 4, 2004, followed by physical therapy. D also suffered a motor vehicle accident which required D to undergo a second right knee surgery. He suffered a second motor vehicle accident in late November 2006.

At the time of his initial visit with respondent D reported that his pain was 10/10. The impressions were low back pain and right quadriceps tendon rupture status post surgery. Respondent's plan was a lumbar MRI, therapy to the knee and OxyContin 80 mg every 12 hours and Norco 10/325. The MEDs at the time were 320. The MEDS increased in 2012 to 485. D signed a pain agreement on January 22, 2008.

During the relevant period of time at issue in this matter, January 29, 2012, through D's death on September 12, 2015, respondent followed D roughly once a month. The pertinent records for this period show the following:

During this period respondent documented D's pain levels in general terms and his pain levels were not consistently documented until November 9, 2012, when respondent noted D's pain levels on a numeric scale. From November 9, 2012, through September 2015, D's reported average pain levels were consistently 7/10 to 8/10 and respondent also consistently documented he was functioning at "baseline." D's notes were in handwritten form from February 3, 2012, to August 3, 2012. The notes were difficult to read and, as noted, did not document D's pain levels except in the most general terms, with language such as "pain-no change." The notes also documented that D, in his 4As, was able to function independently. Respondent's plan for D involved prescriptions of 120 pills of Roxicodone, 60 pills of OxyContin, 45 pills of Soma, and 180 pills of Norco 10/325. In 2012, D saw respondent for follow-up and refills on March 2, March 30, April 27, May 23, June 15, July 10, August 3, August 24, September 14, October 12, November 9, and December 7, 2012. During each of these visits, respondent refilled D's opiate medications in 30-day supplies. According to these records, without an accompanying note, on January 3, 2012, respondent wrote a script for 120 pills of Oxycontin, 120 pills of Roxicodone, and 180 pills of Norco. He also wrote a script, dated January 3, 2013, for 90 pills of Soma. The date on this later script appeared to be incorrect.

D similarly, and frequently, saw respondent on a less than 30-day basis in 2013, 2014 and 2015. Often his visits were two to three days sooner than 30 days, but on occasion he saw respondent about two weeks after his last visit. This occurred notably on December 2, 2013, when D's previous visit with respondent was on November 15, 2013. Respondent had scheduled D to return in one month at his November 15, 2013, visit. No reason was given for D's early visit on December 2, 2013.

At D's November 15, 2013, visit respondent wrote prescriptions for D this date for 30 pills of Dilaudid, 90 pills of Soma, and 45 pills of Roxicodone. Notably, he wrote that he was providing D with Dilaudid and Oxycodone because D's mother had thrown out his medication because she was in a "bad mood" due to a typhoon that killed a family member in the Philippines. On its face, D's reason why his mom threw out his pain meds made no sense and suggested that his mother was concerned about his use of the pain medicine, if in fact D was truthful that his mom threw out his meds. (What his family's bad mood had to do with his mom going into his personal items, finding his oxycodone, and throwing the meds out made no sense.) It was clear from the note that D's explanation for losing his oxycodone suggested that his mother was concerned about his oxycodone use. Respondent did not record that he critically assessed D's stated reason for loss of his meds. At the hearing, respondent repeated that he had accepted D's explanation. By prescribing the Dilaudid and Oxycodone as replacement meds respondent took an uncritical view of D's stated reason. He, further, did not run a CURES report or require that D submit to a UDS to ensure compliance. He wrote that D was not engaging in aberrant behavior when this was not the case by D's own statement.

A little over two weeks later, on December 2, 2013, D returned to visit with respondent. Respondent noted, as his prior note documented, that D was having trouble walking and he walked with a cane. He described his pain as 8/10 and he said he lost his insurance because his job was terminated. Thus, at this point, D was not working.[27] Respondent noted, as he did in all of D's notes, that he was functioning at

[27] As noted below, hospital registration records for D (Exhibit 35, AGO 5010 and 5200) documented that D was not working and was unemployed.

baseline which suggested that his baseline functioning was for D to be in constant pain with the opiates and Soma respondent was prescribing D. Despite stating he lost his job, respondent recorded in D's 4As that he was working full time when he was not working. He also recorded D was not engaging in aberrant behavior. In fact, in every note reviewed, respondent noted that D was not engaging in aberrant behavior.

Respondent documented that he wrote prescriptions for 180 pills of Norco 10/325 mg, 120 pills of Roxicodone 30 mg, and 60 pills of MS Contin 100 mg.

At D's next visit on December 30, 2013, D stated that he was looking for a job and he wanted OxyContin, not MS Contin, to manage his pain because he said he was having trouble managing his pain without OxyContin. He said he wanted the OxyContin adjusted to help him with breakthrough pain. He continued to walk with the use of cane. Respondent again, and incorrectly, in D's 4As, noted that D was a full-time worker and he was functioning at baseline. Respondent increased the prescription of Roxicodone to 150 from 120 pills and wrote prescriptions for 60 pills of MS Contin, 180 pills of Norco, 150 pills of Roxicodone, and 90 pills of Soma. Respondent commented that he "will try to decrease (the Roxicodone) back down to #120." Notably, D remained on 150 pills of Roxicodone until his last appointment with respondent on September 11, 2015.

In 2014, D continued to see respondent on a less than 30-day basis where he obtained refills on MS Contin, Norco, Roxicodone, and Soma. In all of D's visits respondent repeated the same information, that D's pain was under control, there were no new medical conditions, no aberrant behavior, and no signs of depression. The one exception to this pattern of D's visits in less than one month increments with respondent was on April 30, 2014. This visit occurred well after D's March 24, 2014, visit with D. The reason D was unable to make his appointment with respondent, which

was scheduled for April 22, 2014, was that he was hospitalized at Paradise Valley Hospital with for severe cellulitis, a serious bacterial infection of the skin, where he presented with draining abscesses in his arms, and pop marks in his legs indicating he was injecting himself with illegal drugs or other substances. Upon his admission, D's UDS tested positive for opioids and cocaine. The hospital discharge summary documented that D had a long history of drug abuse, and shooting cocaine.

Not long before D's April 2014 hospitalization, at his January 27, 2014, office visit with respondent, D declined to have respondent's medical assistant check his blood pressure. The medical assistant wrote as follows in D's EMR for this date: "**PT DECLINED VITAL.**" [Boldened and capitalized in original.] It is noted that D's medical assistant felt that D's refusal to have his blood pressure taken was sufficiently unusual to warrant documenting it in bold and in caps for respondent to address with D when he examined D. Notably, Dr. Shurman, respondent's own expert, in his testimony, found D's refusal to have his blood pressure taken to be a "significant data point" that required respondent to ask D why he did not want his blood pressure checked. Yet, neither respondent nor his PA recorded whether D was asked why he did not want his blood pressure checked.

At D's February 24, 2014, visit with respondent, D reported that he "has had a lot of swelling in his legs" and he continued to struggle with his right knee and left shoulder pain. Respondent did not document that he examined D's legs or knee. D's blood pressure was also not taken at this visit.[28]

[28] D's weight was also not taken at this visit or the subsequent visit.

At D's March 24, 2014, visit with respondent, D reported "a lot of swelling in his right leg," which was more specific than his report at his February 24, 2014, visit when he referenced both legs. Respondent also noted D was having "trouble" walking and he walked with the assistance of a cane. He reported he had left shoulder pain. His blood pressure was again not taken at this visit. Respondent recorded he examined D in general terms at this visit and noted his left ankle was "tender and swelling." He did not record that he examined D's left shoulder. He diagnosed D with right knee pain due to trauma status post multiple surgeries.

As noted, D was hospitalized with a serious skin infection from April 16, 2014, to April 22, 2014. The admitting diagnoses were Acute Renal Failure, Severe anemia, Cellulitis, and Severe protein-calorie malnutrition. (Exhibit 35, AGO 5230.) D was on "Full Code" upon admission. D was noted to have come into the hospital with "right lower extremity pain and swelling" (Exhibit 35, AGO 5201), the same condition he reported to respondent at his March 24, 2014, visit. He was further noted to have "chronic infections in all 4 extremities that he reports have been healing." (Exhibit 35, AGO 5204.) Paradise Valley hospital records documented that upon admission he reported to have had "a significant history of drug abuse." He was reported to have "profound anemia." The differential diagnosis was "Necrotizing fasciitis, multisystem organ failure."

D told Adam Weissman, M.D., an ER doctor, that he was an intravenous drug user but had not injected himself for three months. However, his urine toxicology was "positive for opiates and cocaine." (Exhibit 35, AGO 5201.) In other hospital records, D admitted he used to inject drugs, but only in his extremities. He denied he was injecting himself in his leg. D was noted to be in "acute renal failure with a creatinine level of 4 and extremely anemic." [redacted]

numerous scars on all of his extremities with multiple draining abscesses on the right upper extremity. In his hospital registration records (Exhibit 35, AGO 5200), D was identified as "unemployed." The hospital also noted, relating to his subsequent hospitalization in November 2014, that he remained "unemployed." (Exhibit 25, AGO 5010.) Thus, respondent's documentation in D's records that he was working full time appears to have been wrong.

Photos taken of D's extremities showed alarming open wounds, track marks, and decomposing blackened charred skin. One color photo of D's skin taken at the hospital showed multiple "pop" marks or injection sites where D injected himself with cocaine, according to Dr. Helm, in D's right leg. The photo appeared to show small open reddened wounds. (Exhibit 35, AGO 5345.) Another color photo taken of D's left forearm showed black and flaking necrotized or drying skin over his entire upper arm with an over 4 cm open wound, according to a ruler set against his arm. In D's hospital record note (Exhibit 35, AGO 5230), Dorothy E. Hairson, M.D., an emergency room doctor, assessed that D's "upper extremities were "open wound(s)" from "drug abuse." D told Dr. Hairson that the healed wounds were from flea bites.

D was discharged on April 22, 2014, after receiving a blood transfusion and other treatment. His vital signs upon discharge were stable. His discharge diagnoses were Acute or chronic renal failure, Cellulitis, Anemia, Status post PRBC transfusion, Drug Abuse, and Chronic bilateral extremity wounds.

13. Oddly, while D was hospitalized, on April 21, 2014, respondent issued a prescription for D for 15-day supplies of 30 pills of MS Contin 100 mg, 90 pills of Norco, and 90 pills of Roxicodone. In D's treatment records from respondent, there was no accompanying record documenting that D, or a relative or friend, contacted respondent to obtain this 15-day supply of meds or why respondent wrote the

prescriptions for this duration. It is noted that D, while hospitalized, was prescribed and administered pain meds, including Dilaudid and MS Contin, according to nursing notes and medication administration records.

Per a CURES report obtained by complainant (Exhibit 37, AGO 5549), despite being hospitalized with a serious medical condition, D was able to fill a prescription for 90 pills of Soma on April 20, 2014, and prescriptions for 75 pills of Oxycodone, 30 pills of MS Contin, and 90 pills of Norco.[29] It was not clear from the record why the pharmacy filled a prescription for 75 pills of Roxicodone when the prescription was for 90 tablets. These prescriptions were filled at the CVS Pharmacy D typically used.

Eight days after D was discharged from the hospital, D saw respondent for a follow up visit for refills. Respondent recorded that D continued to have a lot of swelling in his right leg, and continued to struggle with his right knee and shoulder due to "left rotator cuff tear pain." He continued to have trouble walking and used a cane. Respondent stated D was functioning at baseline. For his 4As respondent continued to state that D was a full-time worker though there is no record that he returned to work after his job was terminated. Respondent did not document aberrant behaviors. He noted nothing significant in the physical exam he performed, which

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[29] This suggests the possibility, given the 15-day supply, that D or perhaps D's relative communicated with respondent and/or his office while he was in the hospital for the prescription, but there was no record of this communication for whatever reason. A review of hospital records, specifically nursing notes, indicated that D remained in the hospital during this time. Complainant suggested in closing this may show that respondent knew about D's hospitalization at the time, but a conclusion in this respect cannot be made based on the evidence of record.

suggested he examined D's knee and shoulder. Respondent referred D to an orthopedic doctor for knee surgery and maintained D on the same medication regimen, noting that D did not want to have the Roxicodone reduced to 120 pills from 150. Prescriptions were written for the meds in the same amounts and dosages previously ordered.

On November 15, 2014, D was again hospitalized. This date, he went to the ER due to vomiting and nausea and was diagnosed with stage 4 chronic kidney failure. The secondary impression was acute-on-chronic renal failure, nausea and vomiting, hyperkalemia, diminished renal excretion, and Hypocalcemia. He was febrile and tachycardiac. His lower extremity showed multiple hypopigmented scar lesions from probable skin popping.

As an indication of the degree of D's dependence on the opiates he was taking, a nurse documented that on November 15, 2014, a doctor "had to explain" to D that he was not able take his narcotic medications while admitted in the hospital. D did not want "to give his narcotics to staff." The "narcotic medications" appeared to be the meds respondent was prescribing him. The nurse stated that D had a history of "narcotic dependence." (Exhibit 35, AGO 5042.) D's BUN and creatinine levels were 74 and 5.0 upon admission on November 15, 2014, and 39 and 2.3 upon discharge.[30] Dr. Helm, complainant's expert, testified that at these levels before his admission D would not have looked healthy when D saw respondent on March 24, 2014.

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[30] The blood urine nitrogen (BUN) test measures how well an individual's kidneys and liver are functioning. Similarly, the creatinine test also measures how well a person's kidneys are functioning.

Respondent did not note anything unusual about D's physical condition at either D's November 12, 2014, visit with him, three days before his admission, or at his December 10, 2014, visit with respondent.

D saw respondent 10 times in 2015. The notes repeated the same language from D's notes in 2014 with pain levels remaining the same, no aberrant behavior reported, no signs of depression, no new medical conditions, and medications were noted to be controlling pain. D remained on the same medication regimen.

In D's records was a letter from a state agency relating to D's application for Social Security Disability benefits addressed to respondent dated July 28, 2015. (Exhibit 35, AGO 2540.) D alleged as bases for his Social Security disability claim the following conditions: ESRD (End Stage Renal Disease), Knee Torn Patellar Tendon, Sciatica, High Blood Pressure, Depression and Anxiety. (Exhibit 34, AGO 2540.)31 In this letter, respondent was asked by the agency processing D's disability claim to provide a history of D's impairments, tests and other objective information he obtained regarding D's medical condition, and respondent's diagnosis and prognosis for D. On August 4, 2015, respondent's office sent to the agency, it appears, D's medical records.

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[31] End Stage Renal Disease means that a person's kidneys have stopped functioning due to chronic kidney disease. A person with end stage renal disease requires dialysis or a kidney transplant to stay alive. <https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-20354532 > [Retrieved November 13, 2019.] Respondent in his HQIU interview on August 17, 2017 stated that he was not "aware of what happened to his kidney." (Exhibit 41, AGO 2642.) Given the letter regarding D's Social Security claim he should have been aware of D's kidney condition by late July 2015.

(Exhibit 34, AGO 2539.) However, respondent's August 14 and September 11, 2015, records did not document that respondent acknowledged this request or that he was aware D was alleging he had ESRD as a basis for his disability claim.[32] These notes documented that D was a "full time worker." (Exhibit 34, AGO 2549 and 2553.)

On August 13, 2015, for the first time, D ran a CURES report on D for the period August 13, 2014, to August 13, 2015. Respondent, in addition, on July 11, 2015, had D complete an Opioid Risk Tool on July 11, 2015. The ORT, as Dr. Helm explained in his testimony, is a self-assessment tool completed by the patient and is a component of the risk stratification identified in the 2014 Board Guidelines. The score was 1, which placed D in the lowest risk category for opioid abuse. D, however, did not complete the form. Notably, respondent did not answer whether his family had a history of substance abuse, whether he had a history of substance abuse, and whether he had a history of any psychological disease. He only provided his age, which led to the "1" rating. Based on D's history of illegal drug abuse the assessment did not accurately reflect the reality of D's risk of opioid abuse.

In D's August 14, 2015 note, respondent documented that D "continues with the anxiety and the Xanax is helping him fall asleep and dealing with family stressors." He noted that D was seeing a psychologist due to increasing agoraphobia and he was able to function independently. Respondent continued to note, as cited above, under

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[32] Respondent and respondent's expert, Dr. Shurman, repeatedly emphasized that D was functioning with the opioids and other meds respondent prescribed him because he was a full time worker. This letter, at the least, should have placed respondent on notice that D was not functioning well and he was not a full time worker.

the 4As that D was a full-time worker even though this was not accurate. Respondent recorded that D was functioning at baseline. He noted he reviewed the CURES report which he found consistent. He increased D's Xanax to 90 pills to be taken as needed. He instructed him not to take Xanax with Soma, but he continued to prescribe Soma. He wrote prescriptions for 60 pills of MS Contin, 180 pills of Norco, and 150 pills of Roxicodone. According to CURES he wrote a prescription for 60 pills of Xanax, not 90 pills as he wrote in his plan, on August 14, 2015.

D last saw respondent on September 11, 2015, three days before he died. The language from this visit was the same language from his August 2015 visit with respondent. At his September 11 visit, for some undocumented reason, respondent decided to reduce the 90 pills of Xanax to 60 pills and again instructed D not to take Soma and Xanax together. On September 11, 2015, respondent wrote a prescription for 90 pills of Soma, and 60 pills of Xanax. He also wrote a prescription for 60 pills of MS Contin, 180 pills of Norco, and 150 pills of Roxicodone. D filled the prescriptions for MS Contin and Roxicodone that date.

15. As noted, on September 14, 2015, D's mother found him dead in their home. Medical Examiner Investigator Lenore Aldridge, as documented in a report she prepared dated September 19, 2015, interviewed D's relatives to help identify D's cause of death. According to D's family D "was known to overuse and abuse his prescription medications," and family members believed he developed a tolerance to the opiate pain meds he was being prescribed and required higher and higher doses of the pain meds to relieve his pain. They did not believe he was using illicit drugs. Investigator Aldridge searched D's room as part of her investigation and found six bottles of prescription medications on D's bed and numerous empty medication bottles in the trash.

16. Othon J. Mena, M.D., Deputy Medical Examiner, conducted an autopsy of D and found D's cause of death as mixed medication intoxication and the manner of death an accident. He made the following conclusions: History of pain medication abuse, witnessed somnolent and drowsy behavior on evening prior to being found dead, toxic levels of morphine, oxycodone and alprazolam, therapeutic levels of hydrocodone and carisoprodol. Dr. Mena noted that D was known to overuse and abuse his prescription medications.

17. D's mother, T.D., testified regarding her son's medical condition and his personal circumstances the year before his death.

During this time, she said she took him to his appointments with respondent and paid for the visits and the medications respondent prescribed D because he was having financial problems. The day before he died she took him to a pharmacy to get his pain meds, which she again paid for. In the last years of his life he stopped doing martial arts or working out, activities he had engaged in throughout his life, and in the months before his death he appeared depressed to her.

D's mother testified that D did not appear "sickly" to her and she did not know whether he used illegal drugs. She did not go into his room to respect his privacy. After his April 2014 hospitalization she did not see his arms or notice whether they were bandaged.

After his death, she went to respondent's office to obtain his records to see what happened to her son. Respondent's office told her there were no records and she was never able to get his records. D's mother's request was documented in D's record. (Exhibit 24, AGO 2559.) A copy of D's mother's request for the medical records, dated

November 19, 2015, and signed by her, authorized D's brother to pick up D's records the following week.

D's mother said that respondent was a "good friend of his" and was helping D look for a place for his business. Respondent in an Health Quality Investigation Unit (HQIU) interview on August 17, 2017, appeared to substantiate D's mother understanding. He said that D talked to him about "funding" a business related to opening a Filipino restaurant and D presented him a plan to do this. Respondent stated he did not make any contribution to this proposed business. (Exhibit 41, AGO 2645-2646.)

18. During respondent's treatment of D for the period at issue in this matter, January 29, 2012, through September 14, 2015, as documented in D's records, respondent did not recognize the risks to D associated with D's concurrent use of high dose opiates, benzodiazepines, and Soma or advise D of the risks in concurrently taking these meds.

19. Respondent did not document his rationale for prescribing Soma to D or his rationale for prescribing Xanax (Alprazolam) to D.

PATIENT E

20. Patient E was a 44-year old female who treated with respondent from October 28, 2011, until her death on October 5, 2012, apparently from an accidental overdose of acute morphine, codeine, diazepam, doxepin, and hydroxyzine intoxication.

Patient E initially saw respondent on October 28, 2011, based on a referral from E's primary doctor, Donald Tecca, M.D. At this visit she signed a pain management agreement. Her chief complaint was rheumatoid arthritis and she had pain "all over."

During the relevant period of time at issue in this matter, January 27, 2012, through October 5, 2012, as documented in E's records, respondent prescribed to E high dosages of opioids, and benzodiazepines. E was also being prescribed Soma through, it appears, her primary doctor. E filled prescriptions from respondent, and other providers, over this time on a monthly basis for the following meds:

- For January 27, 2012: 75 pills of Percocet, 30 pills of Kadian.
- February 2, 2012: 90 pills of Soma.
- February 7, 2012: 170 pills of Percocet, 60 pills of Kadian,
- February 17, 2012: 30 pills of APAP/Hydrocodone Bitartrate 325/10 mg
- February 21, 2012: 30 pills of APAP/Hydrocodone Bitartrate 325/10 mg
- March 2, 2012: 7 pills of Butalbital, acetaminophen and caffeine[33]
- March 6, 2012: 60 pills of Kadian, 60 pills of Aspirin/Butalbital, Acetaminophen and Caffeine.
- March 7, 2012: 170 pills of Percocet.

[33] Butalbital/acetaminophen/caffeine is a medication used to relieve migraine headaches. It has the brand name Fioricet.

- March 19, 2012 (from Rylan Lee, D.P.M.) 60 pills of Norco.
- March 23, 2012 (from Amy Louise Magnusson, M.D.) 8 pills of Aspirin/Butalbital, acetaminophen and caffeine.
- March 24, 2012 (from Jeffrey Dysart, M.D.) 30 pills of APAP/Hydrocodone Bitartrate 325/10 mg.
- March 27, 2012 30 pills of Hydromorphone Hydrochloride.
- March 31, 2012 (from Michael Muldoon, M.D.) 30 pills of APAP/Hydrocodone Bitartrate 325/10 mg.
- April 3, 2012 (from unknown) 21 pills of Suboxone.
- April 10, 2012 45 pills of Diazepam, 30 pills of Temazepam, and (from unknown) 30 pills of Suboxone.
- April 16, 2012 (from NP Everhart) 90 pills of Diazepam.
- April 18, 2012 15 pills of Suboxone.
- April 25, 2012 (from unknown) 90 pills of Suboxone.
- April 28, 2012 (from NP Everhart) 60 pills of Temazepam.
- May 7, 2012 (from NP Everhart) 90 pills of Diazepam.
- June 23, 2012 (from NP Everhart) 90 pills of Diazepam.
- June 28, 2012 90 pills of Suboxone.

- July 1, 2012 (from NP Everhart) 90 pills of Soma and 60 pills of Temazepam.
- July 23, 2012 (From PA Kureshi) 270 pills of Oxycodone Hydrochloride, 90 pills of MS Contin,
- July 30, 2012 (from NP Everhart) 90 pills of Soma
- August 2, 2012 (from NP Everhart) 60 pills of Temazepam, 90 pills of Suboxone (from respondent).
- August 6, 2012 (from PA Kureshi) 180 pills of MS Contin, 60 pills "CER" of MS Contin 50 mg, 60 pills of Ascomp w Codeine
- August 25, 2012 (from NP Everhart) 90 pills of Soma
- September 4, 2012 180 pills of Norco 325/10 mg, 60 pills of Aspirin/Butalbital/Codeine.
- September 6, 2012 (from NP Everhart) 60 pills of Temazepam.
- September 7, 2012 60 pills of MS Contin
- September 21, 2012 (from NP Everhart) 90 pills of Soma
- September 28, 2012 60 pills of Aspirin/Butalbital/Codeine
- October 2, 2012 (from PA Kureshi) 180 pills of MS Contin and 60 pills of Kadian and from NP Everhart 60 pills of Temazepam.

According to E's notes during this time her pain pattern remained the same, as described, moderate to severe.

At E's January 27, 2012, visit with respondent E reported she continued to have moderate to severe pain in her joints with frequent migraines. She was taking the Kadian more than prescribed because she did not realize the prescription was different than the MS Contin she was prescribed. She continued to have breakthrough pain that was not managed well with the Norco. Respondent documented that there was no change in her pain pattern. Respondent continued E on her current medication regimen but the Norco was discontinued and she was placed back on Percocet for a short time. She was advised to return in two weeks for follow-up and medication refill.

At E's February 7, 2012, visit, E reported she was having moderate RA symptoms and migraine pain with her pain meds. She said the pain was manageable with the pain meds. She was able to function independently with the pain meds and her pain was rated as 5/10 with meds. Her medication regimen remained the same and she was told to return in four weeks for follow-up and medication refill.

However, as documented in CURES, on February 27, 2012, respondent issued a prescription for 30 pills of Norco 325/10 mg. There was no accompanying note, or prescription, for this prescription.

For a reason not documented, E's March 2, 2012 visit was cancelled. At her March 6, 2012 visit, E reported the same moderate pain pattern and she was reported to be functioning at baseline. Her medication regimen was continued and she was advised to return in one month for follow-up and mediation refill.

At her March 27, 2012, visit she stated that she was able to babysit her grandson and able to do chores at home. For another reason not documented respondent prescribed 30 pills of Dilaudid 4 mg but otherwise continued E on the

same medication regimen, but he did not issue prescriptions that date. She was to return in one week for follow-up and medication refill.

At this visit, respondent had E submit to a UDS. According to the lab report, the results were consistent with the medications E was prescribed. Respondent documented he reviewed the results on April 11, 2012.

At her April 3, 2012, visit she reported she threw out her pain meds because she was having some withdrawal symptoms. E described her moderate to severe pain as "all over" but went off her meds for three days. She told respondent she threw away her medications because she was having some withdrawal symptoms and wanted to go on Suboxone and was having a lot of headaches. But, she was reported as functioning at baseline and without the meds the pain was severe. Respondent discontinued all of E's opiates meds and prescribed Suboxone to her. He wanted her to return in one week.

At her April 10, 2012, visit E reported that the Suboxone dose was too low and she was not able to take the Xanax because it made her "loopy." E reported no change in her pain pattern. She was described as functioning well and the pain with meds was severe. Respondent increased the Suboxone and continued her on Valium until she saw a psychiatrist.

E's next visit with respondent was on April 24, 2015. She reported she was still looking for a psychiatrist. She said she was going to be leaving to go to Minnesota. Her pain was reported as moderate with meds. Respondent continued E on her current medication regimen. He scheduled her for a follow up appointment upon her return from Minnesota in two to three months. Respondent documented that he wanted her to submit to a UDS at her next visit.

At E's April 24, 2012 visit, there was no change in E's pain pattern. Respondent refilled E's Suboxone prescription and prescribed 90 pills of Valium and Restoril. E stated that she was leaving to go to Minnesota. However, according to CURES E continued to fill prescriptions for medications at San Diego area pharmacies during the time she was allegedly in Minnesota. Thus, it was questionable whether E was in Minnesota after her April 24, 2012 visit.

Records after April 24, 2012, were in EMR format. E's next appointment was documented as July 23, 2012. However, before this visit, on June 28, 2012, respondent prescribed 90 pills of Suboxone to E. There was no accompanying note for this prescription.

At any rate, at E's July 23, 2012 visit with respondent, E told respondent she continued to have pain due to rheumatoid arthritis with occasional severe migraine headaches. She said she was okay as she was traveling in Minnesota for two months but she was now hurting everywhere. She was reported to be functioning at baseline. Respondent decided to discontinue Suboxone and have E go back on Kadian, one pill every 12 hours and Oxycodone, one to two pills every four hours. She was instructed to return in two weeks for follow-up.

At her next appointment on August 6, 2012, E reported that she was doing only a little better than she was when she was on Suboxone. She further said the change from Suboxone to Kadian did not appear to help and there was no change in her pain pattern. Respondent discontinued Oxycodone and issued a prescription for MS IR for breakthrough pain. Prescriptions for 60 pills of Kadian and 180 pills of MS IR were

issued. She was advised to return in one month for follow-up. She was also given Fiorinal with codeine for her migraine headaches.[34]

E's next visit was on September 4, 2012. She reported no change in her pain pattern. Respondent continued the Kadian but discontinued the MS IR due to the side effects. The note did not document the side effects E reported. In place of MS IR respondent wrote a prescription for 160 pills of Norco 10/325 mg. He advised E to return in one month. There was no mention in this note that E's Suboxone was discontinued

E next saw respondent on October 2, 2012. At this visit E reported she was having moderate to severe chronic pain and she was "not doing well now." She said she was under a lot of stress at home. She reported the change to Norco did not help her. She added she was having swelling everywhere. Respondent reported that she was functioning at baselines. Respondent increased the Kadian from 50 mg to 60 mg and restarted the MS IR and stopped the Norco. He advised E to return in one month. There was also no mention in this note that E's Suboxone was discontinued

21. As noted above, E died on October 5, 2012, purportedly of "Acute Morphine Codeine, Diazepam, Doxepin, and Hydroxyzine Intoxication," according to a summary of the Medical Examiner's report in a memorandum complainant prepared. This memo was admitted as background information for the investigation that resulted in the filing of the accusation against respondent. The Medical Examiner's report was not submitted as evidence. Thus, it cannot be found that the cause of death was as characterized by complainant in the memorandum.

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[34] Fiorinal with codeine is the brand name for Butalbital and codeine.

Testimony of Complainant's Expert, Dr. Helm

22. Complainant called Sanford Helm, M.D., as an expert. Dr. Helm is a well-respected expert in the field of pain management and has authored numerous peer reviewed articles and studies in the field. Dr. Helm obtained his Medical Degree from Tufts University in 1977 and completed an internship in Internal Medicine at Boston City Hospital in 1978 and a residency at UCLA in 1980. He is a Diplomate of the American Board of Anesthesiology with a subspecialty certification in pain medicine. Dr. Helm is also a Diplomate of the American Board of Pain Medicine and a Diplomate of the American Board of Pain Physicians with competency and certification in regenerative medicine in interventional pain. He has been a member of numerous societies in the field of pain medicine and has held leadership positions in them. Dr. Helm is on the editorial board of numerous publications in the field of pain management and medicine. Dr. Helm is the Medical Director of The Helm Center for Pain Management in Laguna Woods where he practices medicine and has a clinical practice treating patients. He is licensed to practice medicine in California.

23. Dr. Helm reviewed the medical records and other materials submitted as evidence in this matter relating to respondent's care of each of the five patients at issue in this matter and wrote reports detailing his findings and conclusions regarding departures by respondent from the applicable standards of care. In his testimony he articulated the applicable standards of care, the factual bases for his opinions, and the level of departures from the standards of care. In identifying the standards of care, Dr. Helm referenced the Board's 2007 and 2014 *Guidelines for Prescribing Controlled Substances for Pain* ("Guidelines," 2007 and 2014).

His testimony was, for the most part, consistent with the reports he wrote.

Dr. Helm's opinions are summarized as follows:

24. Patient A. Regarding Patient A, Dr. Helm identified the following issues: Failure to adequately monitor opioid use, failure to recognize addictive behavior (incompetence but factual basis not alleged), inappropriate prescribing, inadequate record keeping, and failure to obtain a consultation with an addictionologist.

With respect to the first issue he identified, failure to adequately monitor A's opioid use, Dr. Helm identified the standard of care as follows;

> The care was provided up until May 2015, so that the MBC guidelines adopted in November 2014, entitled Guidelines For Prescribing Controlled Substances For Pain, apply. These guidelines differ from the previous guidelines in that they mandate a higher level of risk stratification and monitoring. Understand that while the guidelines do not comprise the standard of care, they do approximate what a reasonably trained physician in the community would do in similar circumstances, so that the guidelines can be used as a structure within which to compare and understand standard of care.

Dr. Helm exhaustively reviewed in his testimony A's records and identified specific instances where A displayed aberrant behavior that a reasonably prudent doctor should have recognized. Notably, A's son repeatedly communicated with respondent that he was concerned his mother was abusing drugs he was prescribing her and A had three inconsistent urine screens. A also admitted she obtained meds from a friend, was missing a fentanyl patch, and admitted that a med she took made

her "loopy." Respondent did not critically assess whether this information meant that A was misusing her meds and, instead, superficially complied with the current guidelines.

Dr. Helm was particularly critical of respondent's failure to reach out to A's son. As he put it there was no reason why he could not have listened to A's son without compromising A's rights under HIPAA. He commented that patients often dismiss concerns raised by family members regarding their drug use. Based on A's son's efforts to communicate to respondent that A was abusing her meds, respondent had reason to know she was abusing the meds he was prescribing. It is common, he added, for concerned family members to reach out to a pain management doctor with concerns about their loved one's use of prescription drugs. Dr. Helm did not believe that respondent's communication with the Medical Board absolved him of his duty to critically assess the son's concerns. It must be noted, per A herself in her letter to respondent dated June 30, 2015, that she abused meds respondent was prescribing her and respondent missed the signs of A's abuse.

Dr. Helm believed, accordingly, that respondent departed from the standard of care he identified and that this departure was extreme.

With respect to the second issue Dr. Helm identified in his report, inappropriate prescribing,[35] Dr. Helm articulated the standard of care as follows:

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[35] The first amended accusation alleges that respondent repeatedly and excessively prescribed, furnished, dispensed and/or administered high dose opioids to Patient A. But, Dr. Helm did not identify this as an issue in his report or testimony and, consistent with complainant's burden of proof in this matter, no conclusion can be drawn regarding this allegation.

> The impetus behind the revision of the MBC guidelines in November 2014 was the realization that the use of controlled substances for the treatment of pain had created a public health crisis. Chief amongst the various reassessments that came with that realization was the understanding that the doses and combinations of medications used mattered. Specifically, data showed that, on a population basis, MEDs somewhere between 50 and 120 mg led to higher death rates and other complications. While the guidelines only state that at an MED of 80, one should consider referral to a pain management specialist, which Dr. Qian is, and there is no upper limit presented, it is important for the pain management physician to be able to justify why the higher doses are needed.
>
> The risks from the concurrent use of sedating drugs is also noted in the guidelines. They recommend that the benzodiazepines should be tapered. If that cannot be done, opioids should be titrated more slowly and at lower doses.

Dr. Helms stated that respondent provided A with an MED of 300, though he recognized there was no upper limit in the amount of opioids respondent prescribed A. But, even without an upper limit, respondent also prescribed Soma 350 mg four times a day. Soma in this dose is equivalent to taking meprobamate, a drug with known sedative and abuse potential. Further, A was taking Alprazolam and Temazepam. As Dr. Helm put it, the combination of opioids, benzodiazepines and

Soma is a well-known favorite triad of drug abusers. This combination puts the user at risk of overdose and creates, by the doctor's actions, a public health hazard.

Respondent's notes, however, according to Dr. Helm, did not reference the concomitant use of Alprazolam and Temazepam, which A's primary doctor provided, although CURES made that information available to respondent in the CURES report he obtained on November 18, 2014. Dr. Helm commented that as a pain management physician, respondent ought, as a matter of standard of care, use the CURES report, meaning respondent should have considered the information in it when assessing the opiates he was prescribing A.

Dr. Helm concluded that respondent departed from this standard of care and the failure to recognize the patient risk associated with the simultaneous use of high dose opioids, benzodiazepines and Soma was an extreme departure from the standard of care.

In addition to these departures, Dr. Helm found the following two simple departures from standards of care. The standard of care required respondent to identify opiates he was prescribing and explain in A's notes why he was prescribing them.

In one instance, on August 25, 2011,[36] A received a prescription for 30 pills of Dilaudid from respondent and respondent failed to identify that he prescribed this med to A and why.

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[36] The prescription is from August 29, 2011. (Exhibit 9, AGO 0224.) Dr. Helm incorrectly identified the prescription as being from August 25, 2011 in his report.

Dr. Helm also concluded that respondent committed a simple departure from the standard of care when he failed, on September 4, 2013, to refer respondent to an addictionologist. In his note from this date, Dr. Qian believed a referral was appropriate, but he did not take the next step to actually make the referral, notwithstanding the difficulty obtaining a referral to an addictionologist, which he acknowledged. As he put it in his report, according to the American Society of Addiction Medicine, addiction is "characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response." By this definition, A was an addict and the consultation should have been made for her.

In addition to these opinions regarding the standards of care, Dr. Helm found that respondent's failure to recognize A's aberrant behavior represented a lack of knowledge. However, complainant in the first amended accusation did not specifically allege this as a basis for discipline against A and, thus, it was not considered as a possible basis for discipline against respondent.

25. Patient B. Regarding Patient B, Dr. Helm identified the following issues: Failure to recognize signs of probable substance abuse, inappropriate prescribing, and failure to adequately document the reasons for changing B's opioid medications. Dr. Helm identified these issues in a report he prepared, which was materially consistent with his testimony.

In evaluating respondent's treatment of B, Dr. Helm exhaustively reviewed in the course of his testimony B's records and he applied the standards of care he identified with respect to his review of respondent's treatment of Patient B.

With respect to the first issue, failure to recognize signs of probable substance abuse, Dr. Helm noted that B consistently displayed aberrant behavior, repeatedly obtained early refills on her pain meds, had inconsistent UDS, which respondent failed to address, B "stockpiled" her pain meds, and she was overconsuming her pain meds. Dr. Helms stated that a pain management doctor should be able to identify these as signs of possible substance abuse. He added it is incumbent on the pain management specialist to cast a critical eye on a patient for possible signs of aberrant behavior as a matter of the standard of care. Respondent failed to do so with respect to Patient B and as a result he departed from the standard of care. Dr. Helm found the departure extreme.

With respect to the second issue he identified, inappropriate prescribing, in his testimony he connected this issue to respondent's failure to recognize in B's records the risks of concurrently prescribing benzodiazepines, Soma and opiates. Dr. Helm acknowledged that there is no upper limit in the amount of opiates a pain management specialist may prescribe but this specialist must as a matter of the standard of care document why the benefits of the meds he or she prescribes outweigh the risks. Dr. Helm emphasized that the concurrent use of Soma, benzodiazepines, opiates is "a very dangerous combo."

Dr. Helm opined that respondent departed from the standard of care as identified in his analysis of respondent's concurrent prescribing of Soma, benzodiazepines and opiates to Patient A. He concluded that respondent's "prescribing pattern" for Patient B represented an extreme departure.

With respect to the next issue he identified regarding respondent's care of B, respondent's failure to adequately document the reasons for changing B's opioid meds as a matter of adequate record keeping, Dr. Helm stated that pain management

doctors are required to appropriately maintain records of treatment under the guidelines before and after 2014. A doctor, he said, must explain why he is taking a certain course of treatment. Dr. Helm found that respondent departed from the applicable standard of care when he failed to record his reasons for changing B's opioid meds. He found the departure to be extreme.

26. Patient C. Regarding respondent's treatment of Patient C, Dr. Helm exhaustively reviewed in his testimony C's records and respondent's prescription of opiates with sedating meds to C. He noted that respondent prescribed opiates in the MED range between 480 and 650.

Dr. Helm identified the following issues: inappropriate prescribing, failure to recognize the risk to Patient C associated with the concurrent use of high dose opioids, benzodiazepines, and inadequate record keeping regarding respondent's failure to document his prescription of Klonopin to Patient C on January 12, 2011.[37]

With respect to the inappropriate prescribing issue, Dr. Helm emphasized that the board's November 2014 Guidelines codified an "awareness," as he put it in his report, of the risk inherent in prescribing higher doses of opioids with other sedating medications such as Soma and Valium. He noted that prescribing a combination of these meds requires a higher level of vigilance.

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[37] Klonopin is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Klonopin is an anti-anxiety medication in the benzodiazepine family.

As he found with regard to respondent's care and treatment of Patients A and B, Dr. Helm felt that respondent did not appear to be aware of the inherent risk of prescribing high doses of opioids to C with Soma and the benzodiazepine Valium and, as a result, inappropriately prescribed this combination of meds to C. Dr. Helm emphasized in his testimony regarding respondent's treatment of Patient C that Soma, in particular, is not indicated for long term use as respondent prescribed it to Patient C and, if a doctor does prescribe Soma in combination with benzodiazepines and opiates the doctor must document that the benefits of this combination of meds is worth the risk, which respondent failed to do. Dr. Helm noted that respondent failed, further, to document his rationale for prescribing the combination of high dose opiates with Valium, Soma, and also Ambien. Dr. Helm found the departure to be extreme.

Regarding the inadequate record keeping issue, he again noted that both the 2007 and 2014 Guidelines require record keeping that adequately explains the patient's treatment and response to treatment.

Here, Dr. Helm found that respondent issued a prescription to C on January 12, 2011, without an accompanying note to describe the reason he was prescribing this med. He concluded that this was a simple departure from the standard of care.

27. Patient D. Regarding Patient D, Dr. Helm reviewed D's medical records and other information and went over in detail in his testimony what these records showed regarding respondent's treatment of D. Based on his review of these records, Dr. Helm identified the following issues: failure to adequately monitor opioid use, failure to appropriately perform ongoing patient assessments of Patient D including failure to note abscesses on his arms, failure to identify his renal failure through use of a comprehensive metabolic panel, failure to address lack of improvement through use of a comprehensive metabolic panel, and failure to recognize the risk to D associated

with concurrent use of high dose opioids, benzodiazepines, and Soma. Respondent also failed to get a completed Opioid Risk Tool from Patient D, after 2011 he failed to get USDs from Patient D, and between 2013 and 2015 and he failed to appropriately document his rationale for the changes in opioids that he prescribed to Patient D. Dr. Helm identified these issues in his report dated November 27, 2017.

Dr. Helm, in his analysis of the inappropriate prescribing issue relating to respondent's care of D, wrote the following:

> The impetus behind the revision of the MBC guidelines in November 2014 was the realization that the use of controlled substances for the treatment of pain had created a public health crisis. Chief amongst the various reassessments that came with that realization was the understanding that the doses and combinations of medications used mattered. Specifically, data showed that, on a population basis, MEDs somewhere between 50 and 120 mg led to higher death rates and other complications. While the guidelines only state that at an MED of 80, one should consider referral to a pain management specialist, which Dr. Qian is, and there is no upper limit presented, it is important for the pain management physician to be able to justify why the higher doses are needed.
>
> The risks from the concurrent use of sedating drugs is also noted in the guidelines. They recommend that the benzodiazepines should be tapered. If that cannot be done, opioids should be titrated more slowly and at lower doses.

As part of his analysis of this issue, Dr. Helm first noted that respondent provided D with a MED of 300 and this by itself was not a departure from the standard of care. But, respondent also prescribed to D Soma and Xanax, and Dr. Helm emphasized in his report and in his testimony that the combination of Soma, benzodiazepines and opioids were a well-known triad of meds for drug abusers and the combination of these meds puts the user at increased risk of overdose. Dr. Helm concluded that, in terms of inappropriate prescribing this combination of meds to D, respondent failed to recognize the risks to Patient D associated with the concurrent use of these meds. Dr. Helm expounded as to what he meant here in his testimony. He explained that respondent's failure to document the risks of prescribing this triad of meds to D showed that respondent did not appreciate these risks. As he put it in his testimony, there was no acknowledgement in respondent's notes of the risks prescribing this combination of meds to D. He commented that if the issue was D's anxiety or sleep problems for D to need to take Soma and/or Xanax, drugs like Trazadone were safer alternative meds to prescribe than these meds. Dr. Helm added further that respondent's advisement to D not to take Soma with Xanax in August 2015 highlighted the problem of respondent prescribing these meds to D because the Xanax or Soma could still have been in D's system when he later took Xanax or Soma with the possibility of an overdose. He found the departure to be extreme.

In his testimony, Dr. Helm stated, in answer to the question whether respondent excessively and repeatedly prescribed high risk opioids to D, that respondent did and, as part of his answer, he noted that respondent failed to explain the risks of opioids and why the risks outweighed the benefits of prescribing these meds.

As further part of his evaluation of respondent's treatment of D, Dr. Helm identified the following specific applicable categories he found in the guidelines:

Patient Evaluation and Risk Stratification, Consultation, Compliance Monitoring, and Ongoing Patient Assessment.

Under the Ongoing Patient Assessment category, Dr. Helm found that respondent did not perform appropriate ongoing patient assessments of D, and committed an extreme departure from the standard of care, in the following ways: Respondent failed to note abscesses on D's arms, failed to identify D's renal failure by use of a comprehensive metabolic panel, failed to document D's aberrant behavior when his mother threw away his medications and D asked for early refills, and respondent also failed to note D showed no improvement in pain ratings despite high doses of opioids.

Concerning respondent's failure to note the abscesses on D's arms, Dr. Helm reached this conclusion for these reasons: He stated that, because D was suffering from end stage renal disease, and given his abnormal creatinine and BUN levels upon his April 16, 2014, hospitalization, D would not have appeared healthy when D saw respondent two weeks before his hospitalization on March 24, 2014. As a general matter, considering the number of years he had been treating him and prescribing opioids with acetaminophen, Dr. Helm noted that respondent should have obtained a metabolic panel for D. He added that respondent could have obtained this panel from D's primary doctor.

Regarding whether respondent should have noticed the abscesses on D's extremities as part of his assessment of D, Dr. Helm believed that it would have been hard for respondent to miss the abscesses on D's arms and legs had he examined D on March 24, 2014, particularly because D reported he examined D's left ankle and found it "tender and swelling." He testified that, within a reasonable degree of medical probability, D had necrotizing cellulitis when D saw respondent on March 24, 2014. At

this March 24, 2014, visit, it was noted, D also complained of shoulder pain, and had respondent examined his arm that might have allowed him to see abscesses on his arm. But, respondent testified he did not exam D's shoulder because D's orthopedic doctor was responsible for his shoulder and for legal reasons respondent was not able to examine the shoulder. Here, it is noted further that D complained that he was experiencing swelling in his right leg, had "trouble" walking, and walked with a cane, which seemed to have been reasons for respondent to examine D's right leg, not just his left ankle.

In his opinion Dr. Helm stated these abscesses would not have healed between the eight days Patient D left the hospital and when D saw respondent on April 30, 2014. Dr. Helm noted he stated that respondent said in his interview with an HQIU investigator on August 17, 2017, that D typically wore a T-shirt at this visit.[38] He found the departure here to be extreme.

Under this same category, Dr. Helm found that respondent departed from the standard of care when he did not document his rationale for changes in opioids prescribed. He found the departure here to be simple.

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[38] Respondent pointed out that had D been wearing a T shirt, the condition of D's arms would have been hard to ignore. But, respondent could only state that D "typically" wore a T shirt. Considering D refused to have his blood pressure taken in January 2014, most likely because he would have had to show his arms and been unable to hide his drug abuse, it was plausible that D was not wearing a T shirt when he saw respondent on March 24, 2014.

Under the Complainant Monitoring category, Dr. Helm stated that respondent departed from the standard of care when he failed, after 2011, to obtain a UDS for D. He found the departure to be simple.

Similarly, under this same category, Dr. Helm found that respondent failed to obtain a "completely filed out" ORT and this departure was also a simple departure from the standard of care. He did not, however, define what he meant when he stated that the ORT form was not "completely filled out" because D completed the form, albeit his answer concerning his history of substance abuse was not accurate.

28. Patient E. Regarding Patient E, Dr. Helm identified the following issues relevant to the allegations in the first amended accusation: Periodic review and failure to maintain adequate records.

With respect to the Periodic Review issue he identified, Dr. Helm articulated and applied the applicable standard of care:

> This evaluation is therefore made with reference to those guidelines. They state, under Periodic Review, that "Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities."

Based on his review of E's records, Dr. Helm found that respondent departed from the standard of care because, despite being on MEDs between 29 and 219, in

addition to Valium, Fiorinal with codeine and Soma and hydroxyzine, E did not report improvement and failed to respond to opioid therapy. Despite this lack of improvement, respondent did not reassess the effectiveness of the opioid therapy. In Dr. Helm's opinion, respondent's failure to assess in periodic review the effectiveness of opioid therapy, with or without other controlled substances, was an extreme departure from the standard of care.

With respect to the second issue he identified, inadequate record keeping, Dr. Helm repeated the standard of care he articulated above. He found, even after his review of additional records respondent provided, that respondent failed to maintain adequate records of his treatment of E. In his testimony he highlighted several instances where respondent's notes were inadequate. In E's March 6, 2012, visit notes, respondent first mentioned he was prescribing Fiorinal with codeine to E, but did not document why he was prescribing her this med although he noted she had chronic migraines. She was advised to return in one month. However, three weeks later, on March 27, 2012, E returned and for a reason respondent did not document he wrote a script for 30 pills of Dilaudid 4 mg. It is notable that E reported at this March 27, 2012, that her "pain pattern" remained "unchanged," respondent found her to be functioning at baseline, and she reported she was able to care for her grandson.

Dr. Helm noted that per CURES E filled a prescription for Suboxone on June 28, 2012, but there was no script in E's records and no accompanying chart note.

In E's July 23, 2012 note, respondent did not document his rationale for switching E back to opioids from Suboxone. Similarly, in E's September 4, and October 2, 2012 notes respondent also did not document his rationale for continuing to prescribe opioids and discontinuing Suboxone. In light of the records respondent

provided before the hearing, Dr. Helm concluded that respondent committed a simple departure from the standard of care.

Respondent's Testimony

29. Respondent has been working in the field of pain management and rehabilitation medicine since 2002 and, according to his curriculum vitae, he is Board Certified in Physical Medicine and Rehabilitation and a Diplomate of the American Board of Pain Medicine. After receiving his medical training in China, respondent completed a residency in Physical Medicine and Rehabilitation at Loma Linda University and an internship at the Department of Anesthesiology at the University of Arkansas for Medical Sciences. From 2009 to 2011, he was Medical Director of Scripps Chronic Pain Rehabilitation Program.

The focus of respondent's practice is the treatment of chronic pain management patients and he considers himself a comprehensive pain management doctor. He has an active practice where he treats 30 to 40 patients a day. All of his patients are referred to him by other doctors.

30. As revealed at the hearing, respondent is not board certified in the field of pain medicine, but at one point was a Diplomate of the American Board of Pain Medicine. His certification lapsed. On his website for his practice he incorrectly represented he remained board certified in pain medicine. He testified that this was an error on his part based on his understanding that he was eligible to recertify. Immediately after the mistake was discovered, respondent corrected his website and presented evidence that he made this correction at the hearing.

31. Respondent testified regarding his treatment of each of the five patients at issue in this matter. His testimony regarding the treatment of these patients is summarized as follows:

32. Patient A. In the context of discussing his treatment of Patient A, respondent noted that the pain management doctor's duty is to optimize the doses of opioid pain medications a patient receives and once optimized not to change the doses much as long as possible, considering the patient's tolerance, and while monitoring the patient's functionality. The key, as he put it, is to manage the "tolerance." The more you use the longer you lose "efficacy". In response to a question on cross examination, respondent acknowledged that a long-term opioid pain management patient can experience opioid induced hyperalgesia, a condition where a patient develops a tolerance to opiates and becomes more sensitive to pain. He emphasized that CDC guidelines did not allow a reduction in pain meds as long as the patient receives a benefit from their use.

He stated further, in discussing his record keeping, that a patient's functioning is more important than pain scales. Functionality is the most important feature he would want to see in an established patient such as Patient A.

With respect to Patient A specifically, respondent believes that the amount of pain medications he prescribed her was appropriate and not excessive considering her condition and that she was functioning well on the meds he prescribed. He stated that he was monitoring her based on her baseline he identified in 2009 when she started treatment with him and periodically he reviewed A for purposes of continuing her on opioid therapy and he documented these reviews in A's records. Respondent acknowledged that he did not revise A's baseline. He noted that he saw A on a

monthly basis, tried alternative non-opioid therapies for A, had her sign several pain management agreements, had her submit to UDS, and ran CURES.

Respondent addressed A's son's concerns about her use and possible misuse of meds. In an effort to know how to respond to her son in light of A's insistence that he not contact him, respondent stated he contacted the Board. He did not want to be accused of abandoning A. The Board suggested he obtain a letter from A, which he did. In this letter she emphasized that she did not want her son's involvement in her care. Respondent further stated, as he documented in A's records, that he had a lengthy discussion with A about her son's emails to him and asked her if she was taking her meds as prescribed. He commented that he is not a "detective" and cannot tell who is right or wrong. For this he said A might have needed to see an addictionologist, which he recommended she see.

Concerning his recommendation to her that she see an addictionologist, respondent stated that it is difficult to find an addictionologist in San Diego and insurance does not cover them. As a result, although he recommended to A that she see an addictionologist, he did not make an effort to find an addictionologist for A to refer her to one.

Respondent, further, saw no problem with A's friend helping her manage her pain meds, and he had trust in A's friend to help A in this regard. He said that he obtained a copy of her friend's identification, but a copy of this card was not in A's records. Similarly, respondent was not concerned that A had obtained a Duragesic patch from a friend. He stated that he did not consider it to be aberrant behavior if she got the medication from a friend as long as the medication was for a medical purpose.

In answer to a question on cross concerning his documentation of A's treatment, specifically his prescription of Dilaudid to her on August 29, 2011, without a chart note, respondent said it would have been a "perfect" charting for him to have documented the Dilaudid prescription.

33. Patient B. Respondent testified that B was one of the most complex orthopedic pain management patients he had seen, and he struggled hard to manage her pain.

With respect to his care of Patient B he said he believes he did not excessively prescribe medications to her. He explained, as he did regarding his discussion of his treatment of Patient A, that he tried to optimize B's dosages of the meds and after she reached this therapeutic range, as a matter of his practice, he did not change her meds much. In general, he believes the core medication regimen should not be changed. B was having relief from her pain and had improved function. In fact, given her condition, he could see that he could be criticized for not prescribing B enough pain meds.

In setting this therapeutic range, respondent added that "trust is the key," and he respects the patient's input. In this context he noted that B's husband was a retired executive of a major public utility, accompanied B to her appointments and respondent trusted him to help B manage her pain medications. With respect to B specifically he did not want to increase the therapeutic range and he discussed with her lowering the medications. Respondent acknowledged that by September 14, 2012, she was receiving 900 MEDs, three times the 300 MEDs she had been receiving, because she was not doing well. Oddly, he documented at this visit that B was "functioning fine at baseline."

Respondent does not believe he failed to recognize signs of possible substance abuse by B, he noted he discussed with her appropriate pain management at her October 26, 2012, visit, and he increased B's Dilaudid due to B's breakthrough pain. Respondent stated he tried to wean B down from the medications she was taking on February 1, 2013, and he constantly tried to use non-opioid therapies on her.

With respect to B's report that she was out of Percocet on April 25, 2014, he agreed this was significant, though he did not seem to agree that it was an indication of aberrant behavior. It is, thus, unclear why he considered this significant.

Respondent stressed that B self-reported she was out of meds. He did not believe that she was diverting the medication because she did not have a financial need to sell the meds. He stated that she was taking more meds because of the injuries she incurred to her left knee specifically. As he put it, B was in essentially emergency situations and given B's long term relationship with respondent, that B's husband was supporting her, and the trust respondent had in B, respondent was not concerned that she was engaging in substance abuse.

With this noted, after B reported she used up her Percocet on April 25, 2014, respondent changed B's plan somewhat; he prescribed her Oxycodone to use for the next week, but he kept her core regimen unchanged.

Regarding his overall management of B, respondent noted he had B complete an ORT on July 15, 2015, which showed she was a moderate risk of opioid medication abuse, he had her submit to UDS screens, and ran two CURES reports on her. He discussed having a pain pump, administered LESIs to her, and referred her to a neurosurgeon. In discussing this management of B, and to explain the amount of pills he was prescribing her, respondent stressed at least a couple of times in his testimony

that he was working closely with B's orthopedic surgeon. B's records do not document this, however.

Respondent also addressed his prescription to B of the "triad" of Soma, benzodiazepines, and opiates. He disagrees that this "triad" of these meds represented a risk to B. He noted that B signed a pain management agreement. He did not, however, explain the connection between the risk of concurrent use of these medications with B's pain management agreement.

Later in his testimony, respondent tried to clarify his testimony regarding the concurrent use of Soma, benzos and opiates. He stated that now he rarely prescribes Soma and rarely prescribes Soma with opiates. Respondent described the prescription of these meds as a "sensitive topic." He did not elaborate what he meant by this.

In answer to a series of questions on cross examination, respondent acknowledged that he should have documented a discussion he had regarding two prescriptions she obtained from Dr. Killeen at her August 12, 2015, visit, as documented in the CURES report he obtained in July 2015. At the same time, he said he believes he was not required to use CURES in monitoring patients in 2015. His testimony in this regard is at odds with Dr. Helm's testimony.

He also agreed that he should have documented his rationale why he dismissed the result of the December 2, 2011, UDS screen that was negative for Oxycodone. Elsewhere, in his testimony, it is noted, respondent stated he gave little, if any, weight to a lab's conclusion that a result was "inconsistent" because he believes that this was the job of the doctor to make this conclusion, not the lab. Yet, respondent did not document his conclusions concerning inconsistent or consistent lab results in any of the patients notes at issue in this matter.

34. Patient C. With respect to Patient C, respondent stated he was both C's secondary treating doctor under C's workers' compensation claim and his primary treating doctor for pain management. He prepared reports thus for workers' compensation to document and substantiate the nature and extent of C's pain condition in addition to the progress notes he typically kept. He prescribed C between 500 and 640 MEDs during the period at issue in this matter.

In the context of his care of C, respondent testified he addressed C's concerning expressions that he was depressed and, as indications of the extent of his depression, C stated he "couldn't take it anymore" and the pain was "eating away at his brain." Respondent recognized at the time that C was suicidal and this caused respondent to go on "alert," as he put it. If C was not under the care of a behavioral health specialist, which he documented, he would have referred him to a psychiatrist or psychologist. At the same time, respondent did in fact refer C to a Dr. Shanowitz for a consultation on August 3, 2013.

In this context, respondent stated it would not have been appropriate to lower C's pain meds because more than subtle changes in his pains would have pushed C to suicide. He noted that C was not asking for more pain meds. At this point in his testimony, respondent emphasized the "pain crisis" and that, in the future, it will be recognized that loss of pain meds has caused an increase in suicides among this patient population.

In discussing his treatment of C's pain, respondent noted he encouraged C to try alternative therapies, respondent utilized Toradol and LESI injections to treat him, and he sought to gradually reduce the amount of pain meds he was taking. In 2012 and 2013, and considering that C was functioning at the same level without negative side effects, the standard of care respondent believes applied did not require him to

lower C's pain meds; he does not believe he was giving C excessive dosages of the pain meds. The meds were helping him function. Without them, at the levels he was prescribing, he would not have been able to walk or function.

Respondent stressed that C was a compliant pain management patient. C never asked for early refills, he timely made his appointments with him, which he said was an important factor in his assessment of any patient's compliance, his hygiene appeared good, and he appropriately interacted with respondent.

35. Patient D. Concerning Patient D, respondent prescribed between 480 and 640 MEDs. He said that D was not engaging in aberrant behavior and specifically he did not consider D's mother's throwing out his meds as an indication of possible aberrant behavior because he believed D's explanation. He also stated that CURES showed that D was compliant with his pain medication regimen. Respondent noted otherwise that D was managing his medications "fine," but he was having good and bad days. Respondent found it "significant" that D was working full time. He stressed this point in his testimony. As he stated, the reason D was functioning well was D was able to work full time. To respondent, that D was working full time meant that he followed the standard of care. However, as discussed earlier in this decision, the record shows that D was not unemployed and respondent's understanding that he was working was wrong. In D's record, D is documented to have lost his job and hospital records in April and November 2014 recorded that he was "unemployed." Further, and notably, D applied for Social Security disability due to end stage renal disease, depression, and other conditions. The agency responsible for processing D's claim advised respondent of his disability claim.

Respondent acknowledged in his testimony that D obtained opioids in greater than 30-day supplies because D was scheduled for visits, on occasion, in less than one-

month increments. He agreed that D's opioid pain meds should have lasted 30 days. Respondent explained that D obtained pills in greater than 30-day supplies for "insurance reasons." At the same time, he acknowledged that "respiratory depression" from taking too many opioids is a risk to a pain management patient, but he said he addressed whether D was engaging in drug abuse at every visit.

With respect to D's condition when he saw him on March 24, 2014, before his April 2014 hospitalization, respondent said that he did not notice abscesses on D's arms, he examined D's knee but not his shoulder out of concern he might get sued if he examined his shoulder because an orthopedic doctor was taking care of D's shoulder. He testified he was unaware of D's hospitalization. He acknowledged that D at a prior visit declined to have his blood pressure taken which would have required D to expose his arm. Respondent said that neither his PA nor his assistant reported this to him though the note was in bold and in caps. Respondent added that he did not find D's complaint of right leg "swelling" significant enough to document in his exam of the knee. He otherwise stated, on cross exam, that the "swelling" in D's leg was different than the leg "edema," or swelling, that was assessed at the hospital. He said it was different because the swelling reported at the hospital was due to renal failure.[39] Respondent added that the nurse's assessment of swelling in D's leg was not accurate, and he repeated this assertion, noting that the emergency room "mislabels" a lot of

[39] Respondent did not explain how he could conclude that the swelling reported at the April 2014 hospital visit was due to renal failure when the swelling D reported at his March 24, 2014, visit was not. His testimony seems to be an effort on his part to distance himself from the possibility that D's health was deteriorating at his March 24, 2014, visit.

patients. Respondent, further, disagreed with the emergency room doctor's April 16, 2014, assessment of D where the doctor noted scars on all four of D's extremities. Respondent stated that the hospital did not do a very good job with respect to D, though it is unclear if he was referring to its treatment of D or documentation of his condition. He did not explain why the nurse's report and the doctor's assessment were not accurate.

Respondent stated that at his March 24, 2014, visit D appeared healthy and he did not observe lesions, abscesses, or track marks on D's extremities. Respondent also stated that his assistant did not report to him that D had any such conditions. He said that D's skin condition likely healed before D's visit with him on April 30, 2014, though he could not say the skin condition "completely" healed before this visit. Respondent noted that D received a blood transfusion and his creatinine and BUN levels were normal such that he would have appeared healthy.

Concerning how D was able to fill a prescription for opioids from respondent while he was hospitalized in April, respondent speculated that a family member may have called. However, as noted, there was no documentation to accompany the prescription.

In response to questions on cross-examination, respondent said that a referral for D for a metabolic panel since D was on high dose opioids for many years would have been a good idea. D also acknowledged that having D submit to a UDS would also have been a good idea. He had D submit to only one UDS in 2009. In the context of answering these questions, respondent repeated that D appeared to be functioning because he was working full time. In fact, as noted, according to hospital records and D's application for Social Security disability, D was unemployed and not functioning

well. He was suffering from end stage renal disease, depression, in addition to the orthopedic conditions that required pain management.

36. In his testimony, respondent felt it important to challenge the Medical Examiner's conclusions that D died from toxic levels of morphine, oxycodone and alprazolam, and therapeutic levels of hydrocodone and carisoprodol (Soma). Respondent offered his opinion that the Medical Examiner's opinion was wrong and D, in fact, died from "pulmonary edema." He did not articulate how he reached this conclusion or, for that matter, why he felt it important to assert this as part of his response to the allegations against him.[40] His opinion is given no weight.

37. Respondent commented that in general he felt he closely followed D and would not change what he did. He stated he referred D to a psychiatrist or psychologist, but this referral was not noted in D's records.

38. Patient E. Respondent detailed his treatment of E as recorded in E's notes. He stated he did not fail to assess the effectiveness of the opioids he prescribed her and he documented how E responded to the medications both in terms of pain and functioning levels and, thus, was assessing the effectiveness of the meds.

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[40] The cause of D's death is considered only as evidence of the inherent risk of prescribing high dose opioids to D as a matter of the applicable standards of care, a risk that respondent appeared to acknowledge in his testimony. It is not necessary to conclude that respondent's conduct, as found in this decision, caused D's death and the fact of D's death is not determinative regarding assessing whether or not respondent departed from applicable standards of care, the degree of any found departures, or the level of discipline to impose.

Respondent discussed with E properly taking her pain meds and she was taking them as prescribed. He said he found nothing aberrant in her behavior.

Respondent did not agree with Dr. Helm that he should have lowered the dose of the pain meds. He said he was concerned that E might have a rheumatoid arthritis (RA) flare-up. E had RA for 25 years and had few pain management options, aside from increasing prednisone, respondent noted.

On cross-examination, respondent acknowledged that E's records contained the following deficiencies, even after he found additional records not long before the hearing:

- On Feb 27, 2012 per CURES, APAP Hydrocodone Bitartrate was prescribed to E, but the chart note and written prescription for that prescription were missing from E's records;
- There was an April 3, 2012 chart note, but the prescription for Suboxone was missing, although the prescription was recorded in CURES;
- There was no April 18, 2012, chart note or prescription for Suboxone, although the prescription was filled on April 18, 2012 according to CURES;
- There was an April 24, 2012, chart note, but the prescription for Suboxone was missing;
- There was no June 28, 2012, chart note or script for Suboxone, although the prescription was filled on June 28, 2012, according to CURES.

- There was no chart note for August 2, 2012, although a prescription for Suboxone was filled on August 2, 2012, according to CURES.

Respondent discussed E's decision to discontinue the opiate meds he was prescribing her. He stated that E was dependent, as opposed to addicted, to opioids and the best way to address this was to put her on Suboxone, which he did.

On cross examination respondent was asked about E's notes which consistently described her as experiencing moderate to severe pain levels while she was functioning at baseline making it seem that her baseline state was to be in a constant state of moderate to severe pain. In light of this, respondent was asked to explain how he could have assessed the opioids he was prescribing her were working. Respondent did not give a clear or articulate response to this set of questions.

39. Respondent testified that he has made changes to his practice which he documented in an outline he prepared dated October 12, 2019. (Exhibit WW.) He identified the following areas where he has improved his practice and implemented procedures to comply with the Board's 2014 Guidelines:

- Treating chronic pain patients using a conservative comprehensive pain management approach
- Chronic Opioid Therapy
- Suboxone
- Record keeping
- Public education about risk of opioids

In each of these areas, respondent detailed procedures and practices he has implemented and now follows. As highlights of the changes he has made, he uses UDTs, CURES, and ORT when he screens new patients. He also prescribes Naloxone and Narcan spray to all of his opioid pain management patients. Respondent further has created a patient coordinator position whose job is to coordinate with all of the doctors of a patient. Respondent also has improved his record keeping system.

40. Respondent submitted certificates to show that he has completed education courses in the pain management field. These documents show that in April 2013 Respondent completed a medical record keeping course through the University of California, San Diego, Physician Assessment and Clinical Education Program (PACE) and a Physician Prescribing Course in January 2018, also through PACE. Respondent also submitted proof that he has taken courses in various medical practice topics in pain management, including a course in "Renal Failure" in 2010.

Testimony of Joseph Shurman, M.D.

41. Respondent called Joseph Shurman, M.D., to testify as an expert on his behalf. Dr. Shurman is a licensed physician who specializes in the management of chronic pain. He was board certified in Anesthesia and Pain Management, but his certifications have lapsed because, as he stated, his focus is now on research and "dealing with the pain management or opioid crisis." Dr. Shurman received his medical degree from Temple University in 1967. He served his internship at Chestnut Hill Hospital and completed his residency specializing in anesthesia at Massachusetts General Hospital.

42. Dr. Shurman prepared a report in which he summarized respondent's treatment of the patients in this matter. His testimony followed what he wrote in his

report in many respects, but in it he stated he reviewed the patient records at issue in this matter and other information. (Exhibit G.) However, during his testimony, Dr. Shurman said he could recall whether he actually reviewed the patient records or whether he relied on respondent's representations concerning what the records said. Dr. Shurman's testimony regarding his review of the records is discussed later in this decision in assessing the weight to be given to his opinions.

43. During his hearing testimony, Dr. Shurman reviewed sections of patient records projected on a wall and answered questions regarding these records relating to respondent's care and treatment of the five patients. His testimony is summarized as follows:

44. Patient A. Dr. Shurman stated that respondent adequately recorded A's baseline when he first met her, which supported her need for opioid therapy. He had A sign a pain agreement, which was not a requirement at the time, and thus respondent exceeded the standard of care by doing this.

Dr. Shurman did not agree with Dr. Helm that respondent failed to document his discussions with A regarding his monitoring of A's opioid use. He cited as an example of adequate documentation a note dated September 6, 2011, in which respondent justified a prescription for Dilaudid due to a "flare-up" for pain in her foot. He cited, further, that respondent recorded in a note dated October 30, 2012, that A was taking her meds as prescribed, she was not taking all her pills at once and, on September 4, 2013, respondent documented that A assured him that she was taking her meds as prescribed.

Dr. Shurman addressed the UDS screens administered to A as a matter of respondent's monitoring of her. He stated that it was not the standard of care to

administer UDS at the time. For the five UDS tests performed between 2009 and 2014, Dr. Shurman said he saw no tests indicating aberrant behavior. Dr. Shurman, however, adopted a restrictive definition of what constitutes "aberrant behavior" as he stated later in his testimony. In this testimony, Dr. Shurman said that true aberrant behaviors are limited to addicts, and not patients who misuse their meds. At the same time, paradoxically, in his report Dr. Shurman wrote that "up to 50% of these patients [patients on high dose opioids] have aberrant behavior." (Exhibit G, AGO F-017.) It is, thus, not clear what Dr. Shurman meant when he referred to aberrant behavior in his testimony with regards to Patient A, or any of the other patients in this matter.

Dr. Shurman did not find any reason to fault respondent for not contacting A's son. He stressed it was understandable that A would have been upset that her son expressed concerns about A's possible misuse of pain meds. He noted that respondent had invited A's son to see him, but there was no evidence of this.

Dr. Shurman disagreed that respondent should have tried to refer A to an addictionologist. He said that it was A's responsibility to see an addictionologist once respondent recommend to her that she see one.

Dr. Shurman concluded that respondent did not commit any departures from applicable standards of care with respect to his care and treatment of Patient A.

45. Patient B. With respect to Patient B, Dr. Shurman first stated, as part of the reason respondent needed to prescribe the levels of pain meds he did to B that B had failed shoulder surgery. But, as discussed earlier, B's records did not indicate she in fact had failed shoulder surgery. B's records indicate only that it seemed to respondent B had failed shoulder surgery. It was not documented that B's orthopedic

doctor concluded she had failed shoulder surgery, and respondent did not document he discussed B's condition with this doctor.

Concerning whether respondent failed to recognize signs of B's probable substance abuse, Dr. Shurman stated that respondent was aware that B may have a substance abuse issue, as recorded in his plan for B in her October 26, 2012 note. In this note, respondent recorded that he discussed with B "pain management." From his plan it was not possible to infer, however, that respondent was aware that B may have had a substance abuse issue. He did not mention that she may have a substance abuse issue though he had B submit to a point of care screen which tested positive for opiates. Dr. Shurman found it significant for some reason that respondent advised B she needed to be on time.

Later in his testimony, Dr. Shurman sought to clarify what he meant when he stated that respondent recognized that B may be engaging in substance abuse. He cited language in B's November 18, 2013, note in which respondent noted that B was a "high risk patient due to high dosage of pain medications and multiple on-going pain disorders and medical issues. It is difficult to reduce her pain meds due to these issues." Dr. Shurman emphasized that respondent's use of the phrase "high risk patient" incorporated the concept, as he put it, of probable substance abuse.

In this regard he cited other references in B's March 6, 2014, and May 2, 2014, notes in which respondent characterized B as a "high risk patient due to high dosages of pain medications . . ." to support his interpretation that respondent recognized B as possibly engaging in substance abuse.

Otherwise, Dr. Shurman found support for his view that respondent understood B may have had a substance abuse problem in B's March 22, 2013, note in which

respondent stated that B "has been on high dose [*sic*] of pain medications" and "[n]eeds more monitoring." He further found support for his reading of respondent's understanding regarding possible substance abuse in a May 10, 2013, note in which respondent noted for follow up: "Management of opioid pain medications and other potential habit forming medications."

With respect to the allegations whether respondent excessively prescribed medications to B, Dr. Shurman found that the dosages were not excessive and were appropriate.

Dr. Shurman also disagreed that respondent committed any departure from the standard of care regarding the allegation that respondent failed to recognize the risk of concurrent use of Soma, benzodiazepines and opioids. Dr. Shurman addressed this issue in his report. (Exhibit G, AGO F-019). He arrived at the conclusion that there was no departure based on discussions he had with a Dr. Pesce, who told him it was "common to see this mixture," and another doctor, Dr. Aronoff. Dr. Shurman also found support for his opinion from pharmacists he may or may not have consulted. He stated that "when one consults pharmacist in this area and asks about that time [when respondent prescribed these meds to B] it was common during that period for these mixtures to be concurrently prescribed." (*Ibid.*) Dr. Shurman did not elaborate in his testimony why it is significant that pharmacists said it was common to prescribe this combination of meds.

46. Patient C. Concerning respondent's care and treatment of Patient C and whether he excessively prescribed meds to him, Dr. Shurman concluded that respondent appropriately prescribed meds to C and the dosages were appropriate. In reviewing his records during the hearing, Dr. Shurman cited records that showed C had significant issues with pain and functionality, was noted to have difficulty doing home

routines, and without the pain meds C's pain was worse and he could not function at all.

He disagreed with Dr. Helm that the dosages should have been lowered or titrated given C's "suicidal" state. He noted that the pain meds were the only thing that were keeping C going, as he put it, and given his "emotional status" it was not appropriate to decrease his meds. Dr. Shurman noted further that C wanted to see a psychiatrist, and respondent was trying to obtain one for him. Here, Dr. Shurman commented that there have been lawsuits against doctors who did not prescribe enough pain meds.

In his treatment of C, Dr. Shurman pointed out that respondent did not just prescribe meds to him. He utilized non-opioid therapies on B which included LESI and Toradol injections and a stimulator. As he put it, respondent was trying as much as he could to treat C.

Dr. Shurman also addressed the allegation that respondent failed to recognize the risk of concurrently prescribing to C Soma, benzodiazepines and opioids. He said there was nothing in the record to indicate that respondent failed to recognize the risks of the concurrent use of these meds.

47. Patient D. Dr. Shurman in his analysis of respondent's treatment of Patient D stressed, as respondent also stressed, that D was working full time. Dr. Shurman emphasized the importance that D was working as part of respondent's management of D's pain because it showed he was functioning with the meds. He said, in terms of measuring D's functioning with the pain regimen he was following, it was "very significant" that D was working full time and he cited respondent's documentation to support that he was working full time. As noted earlier, D's records

indicate in fact he was unemployed and had applied for Social Security disability benefits and he was not functioning well. With this noted, Dr. Shurman stated that respondent was prescribing D moderate amounts of opioids, about 480 MEDs, which he found was an appropriate level considering D's pain condition. Dr. Shurman commented that he found that respondent gave D "model care."

Dr. Shurman did not believe that the record showed that D was engaging in aberrant behavior. Specifically, he found that D's mother throwing out his pain meds did not constitute an indication of possible aberrant behavior. Here, Dr. Shurman said that respondent was right to believe D's explanation given his relationship to D. Concerning his monitoring of D for possible aberrant behavior, Dr. Shurman gave respondent an "A+" for obtaining CURES in August 2015 to rule out aberrant behavior. He also cited the ORT that he had D complete in July 2015 as an example of his effective monitoring of D.

But, Dr. Shurman conceded on cross examination that he did not know that D refused to have his blood pressure taken on January 27, 2014. This is a notable oversight for several reasons. First, it contradicts his testimony that respondent effectively monitored D and D was not engaging in possible aberrant behavior. Dr. Shurman, moreover, recognized the significance of D's refusal to have his blood pressure taken. He testified his refusal to allow this was a "significant data point" that required respondent to ask D why he refused to have his blood pressure checked. Indeed, as a significant data point, respondent missed it, and it likely reflected D's illegal drug use that, at least in part, led to his April 16, 2014, hospitalization. As a second reason his failure to note D's refusal to have his blood pressure taken is important is that it reflects that Dr. Shurman did not adequately review D's records.

The third reason Dr. Shurman's lack of knowledge about D's refusal to have his blood pressure taken relates to Dr. Shurman's testimony concerning the abscesses on D's arms, as revealed in his April 2014 hospitalization. Dr. Shurman was adamant in his testimony that these abscesses would not have been evident at D's March 24, 2014, or April 30, 2014, visits with respondent.[41] He did not base his opinion on his assessment of D's skin condition. He based his conclusion on discussions he had with an unnamed internist/critical care ER doctor, according to the report he prepared. (Exhibit G, AGO F-024-025.)[42]

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[41] Dr. Shurman also testified that there was nothing to indicate that D was suffering from renal failure and, in any event, it was not a pain management doctor's job to identify or treat renal issues. He further said that D would have appeared healthy upon his discharge from the hospital on April 22, 2014, due to the blood transfusions and other treatment he received.

[42] Dr. Shurman testified that he brought D's medical records to this doctor to obtain his opinion regarding whether the abscesses could have developed within 24 to 48 hours. (Exhibit G, AGO F-025.) He did not state in his report that he brought these records to this doctor or whether the records he brought were a complete set of D's records. No information in his report identified this doctor by name or qualifications and this doctor's opinion was quoted in general terms. Because he adopted this doctor's opinion as his opinion, this doctor's qualifications or the information he reviewed cannot be assessed, and given that this doctor opined only that the abscesses "could" develop within 24 to 48 hours, Dr. Shurman's opinion is given no weight in evaluating whether D had these abscesses on March 24, 2014.

Yet, it is reasonable to infer that the reason D did not want his blood pressure taken was that he did not want respondent to see his arms because his arms revealed evidence of his illicit drug use. It is noted that respondent's medical assistant felt D's refusal was significant enough that this assistant documented his refusal in bold capitalized letters for respondent to see. As depicted in photos taken on April 16, 2014, the extent and nature of the abscesses, necrotizing skin, scars and injection sites on his extremities suggest that the condition of his arms as pictured would have been notable to respondent had he examined D's arms on March 24, 2014. Dr. Helm testified credibly in this regard, and D's refusal to show his arms for his blood pressure to be taken supports his testimony.

48. In the context of his discussion of respondent's treatment of D, Dr. Shurman felt it important to express his disagreement with a recommendation in the 2014 Guidelines regarding discontinuing opioid therapy. (Exhibit 4, page 18.) He stated he strongly disagrees with the Guidelines recommendation that tapering of the opioid medications may be warranted if not completely stopped when a patient is not compliant or engaging in aberrant behavior. Dr. Shurman cited the risk to opioid pain management patients if opioids are stopped or tapered too drastically and cited for support of his view a recent advisement from the California Department of Public Health dated August 27, 2019, which advised providers against abruptly discontinuing opioids in any patient who is physically dependent on opioids, or implementing rapid tapers in patients with long-term dependence.

As he documented in his report, Dr. Shurman found that respondent did not depart from any standards of care in his treatment of D.

49. Patient E. With respect to respondent's care and treatment of Patient E, Dr. Shurman stated in his testimony that in his opinion E showed improvement due to

the pain meds she was taking. Her pain level went from a "severe" level to a moderate level, as recorded in E's April 24, 2012, note. He stated her baseline was at a 10/10 pain level and with pain meds, and according to another record dated October 28, 2011, E's pain level was 7/10 with meds.

Respondent, also, assessed, in Dr. Shurman's opinion, the effectiveness of the opioid therapy and documented this assessment in a document dated November 14, 2011. According to this note, respondent reported E's "Interim History," wrote that "Norco not enough for pain," E tried a Duragesic patch, she was still in a lot of pain, she was not functioning well, and with Norco, E identified her pain level as 5/10. Dr. Shurman cited another note, dated February 7, 2012, which recorded E's pain scale as 5/10 with pain meds and noted that she was functioning at home independently with pain meds as further evidence of his assessment of the effectiveness of the opioid therapy.

As a general matter, Dr. Shurman commented some pain patients do not improve; they just maintain as E appeared to have been doing with moderate to severe pain levels.

Dr. Shurman concluded in his report that respondent did not depart from any standards of care in his treatment of Patient E.

50. As revealed in a series of questions posed to Dr. Shurman, and by communications he had with third persons in the course of investigating and preparing his report, Dr. Shurman saw his role more as an advocate for respondent than as a dispassionate expert. This does mean that his testimony is instantly discounted, particularly where his opinion may be supported by the evidence of record. Also, although he was acting as respondent's advocate, Dr. Shurman was an

articulate character witness for respondent and his testimony is considered in this respect.

A number of documents evidence Dr. Shurman's role as an advocate for respondent. One notable such document is an email Dr. Shurman sent on September 17, 2018, to Amadeo Pesce, Ph.D., whom he was consulting on respondent's matter. It reads:

> . . . Qian is a good doc with a massive practice. I hope that we can save him from the penalties for "extreme departure of the standard of care". . .

Towards this goal of helping respondent with a favorable assessment of his treatment of the five patients, Dr. Shurman had contacted Dr. Pesce, who formerly was director of Millennium Lab, to assess respondent's treatment of the five patients and, more specifically, to assess the lab reports from UDS tests and the medications respondent prescribed. In an email he sent to Dr. Pesce on September 16, 2018, he instructed Dr. Pesce "to write a note on the following brackets" and then identified the following four areas he wanted him to address: [regarding Patient A] "not uncommon to use this combination of drugs during the years 2009-2013...," "the urine screens...re duration of hydrocodone in urine and why the hydrocodone could be negative and no confirmatory tests...patient [B]," "urine screen presence of Xanax....????" being prescribed by another doctor, "[Patient C] not uncommon to see high dose opioids and benzos in the years 2008-2014 in a subsect of certain patients with intractable pain..." [Ellipses in original.]

In addition, again, to fashion his opinions as favorably to respondent as possible, Dr. Shurman relied on respondent's understanding of information in the

medical records as he represented this information to Dr. Shurman. This was revealed in an answer to the question on cross-examination whether he "actually reviewed the records and didn't just rely on Dr. Qian's representation here," with reference to Patient D's records. Dr. Shurman testified he was not able to recall whether he reviewed these records, which given his role as an expert was a remarkable statement. He then stated that he was "surprised" that Patient D declined to have his blood pressure taken, which suggested he did not review D's records, or he did not adequately review D's records.

That he was relying, at least in part, on respondent's representations of the information in the medical records is also evident from Dr. Shurman's draft report. (Exhibit 67.) In it, Dr. Shurman wrote a note for himself, or another reviewer, that "[respondent] sent me a note stating that he did not see this patient and this time and had no notes, no visits and no prescriptions." He then added, "Again, the implication was that it was his nurse practitioner [who saw the patient-not respondent] and he states that it was not his nurse practitioner [*sic*] and does not know who the nurse practitioner worked for."

In this same draft version of his report, there is also what appears to be respondent's handwritten comments to Dr. Shurman's characterization of the information in D's records regarding the times respondent checked his blood pressure and took vital signs. Here, in his comments on Dr. Shurman's report, respondent did not state that D declined to have his blood pressure checked at his January 2014 visit, and Dr. Shurman did not identify this information in his report. As noted, Dr. Shurman said he was "surprised" at the hearing that D declined to have his blood pressure taken and was not aware of this information.

Further, in text messages complainant obtained between Dr. Shurman and respondent's attorneys, Dr. Shurman sought substantive input from respondent's attorneys regarding the final version of his report. In one text message, respondent's lawyer wrote: "We are almost done with your expert report it is a work of art we will send it to you soon for signature." In another text message, Dr. Shurman asked respondent's lawyer to provide "fillers" to the draft report he sent to respondent's attorneys. In an email dated April 11, 2019, respondent's lawyers sent Dr. Shurman the final report for his approval and signature.

With this noted, Dr. Shurman did not try to hide his bias on respondent's behalf. He testified he found common cause with respondent because respondent is "on the wrong side of a political era of opioids." Dr. Shurman explained what he meant by this statement in his report. In his report he offered his view that regulators such as the Board have unfairly "targeted over-prescription by physicians" at the expense of patients suffering from chronic pain. (Exhibit G, F-012.)

51. Dr. Shurman's bias on respondent's behalf was further evidenced by his characterization of the standard of care regarding the year when pain management doctors should have been utilizing UDS screens. He testified that this standard of care did not apply before the 2014 Guidelines and he repeated this when asked questions relating to UDS screens obtained for the patients in this matter. But, Dr. Shurman expressed a completely different view in an expert report he wrote dated January 19, 2011, which he prepared for a disciplinary matter (Exhibit 70) involving another doctor. Dr. Shurman wrote in this report:

> We know clinically from various studies that even the best doctors cannot judge their patients, and urine screens have

become the standard of care in the pain specialty world, not quite yet in Family Practice.

52. Dr. Shurman sought to clarify his earlier opinion on this matter. He said that new information he learned since he wrote his earlier expert report changed his opinion. On this point, complainant showed Dr. Shurman an article Dr. Pesce, who Dr. Shurman cited as an expert in this matter as noted earlier, wrote in *The Journal of Pain Medicine* in 2012 (Exhibit 71). In this article Dr. Pesce affirmed Dr. Shurman's understanding of the standard of care in 2011 and, in fact, cited Dr. Helm's study on this issue to support this understanding. Dr. Pesce wrote the following:

> Published guidelines indicate that, prior to initiating opioids or other controlled substances, patients should be tested at baseline and then random testing should be conducted between two and four times per year unless an abnormal screen is observed or patient exhibits unusual behaviors.

Evaluation of Expert Testimony and Evidence

53. In resolving the conflicts in the expert testimony in this matter, Dr. Helm's opinions are weighed more heavily against Dr. Shurman's opinions. In making this assessment, consideration has been given to the qualifications and credibility of both experts, including any biases they have that could color their opinions and their review of the evidence, the reasons for their opinions, and the factual bases of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

54. As a general matter, Dr. Helm's opinion is deemed more credible than Dr. Shurman's opinion because Dr. Shurman had a clear bias in respondent's favor that colored his testimony in all respects, while Dr. Helm testified as a dispassionate expert. Dr. Helm testified in a clear and thoughtful manner and answered questions posed to him, including questions that challenged his opinions, patiently and without evasion.

Dr. Helm's testimony was, further, well-based in the evidence of record and Dr. Helm answered questions in a clear and unequivocal manner. Additionally, Dr. Shurman did not appear to have full understanding of the medical records of the patients in this proceeding and relied on information he obtained from third persons for his opinions. Thus, Dr. Helm's testimony is found more persuasive than Dr. Shurman's and Dr. Helm's opinions are accepted in most respects.

55. In conducting this evaluation, it is noted that only evidence within the seven-year statute of limitations has been considered. Dates that are referenced outside the seven-year statute are considered only as background.

FIRST AND SECOND CAUSES FOR DISCIPLINE REGARDING PATIENT A

56. The first amended accusation identifies conduct where respondent is alleged to have committed gross and simple negligence in his care and treatment of Patients A, B, C, D and E.

With respect to Patient A, the first amended accusation alleges that respondent failed to adequately monitor Patient A's opioid use, repeatedly and excessively prescribed, furnished, dispensed, and/or administered high dose opioids to Patient A, and respondent failed to recognize the risk to Patient A associated with the concurrent use of high dose opioids, benzodiazepines, and Soma. Regarding the excessive

prescribing issue, Dr. Helm did not identify this as an issue in the report in this matter and it is not considered accordingly.[43]

The first amended accusation also alleges that respondent committed simple departures when he failed to document that he prescribed Dilaudid to Patient A and failed to refer A to an addictionologist.

Taking each of the allegations in turn, Dr. Helm first concluded that respondent departed from the applicable standard of care he identified when respondent failed to adequately monitor A's opioid use and that this departure was extreme. His opinion is well-based on the record and is found persuasive. Dr. Helm reached his conclusion for several reasons: first, respondent took no steps to communicate with A's son who repeatedly expressed his concern that his mother was abusing drugs respondent prescribed her. His concern, it must be stressed, was accurate. As Dr. Helm pointed out in his testimony in response to respondent's explanation why he did not communicate with her son, respondent could have listened to A's son, which did not require him to disclose A's information to her son. Further, as a matter of his inadequate monitoring of A, respondent ignored A's three inconsistent urine screens, and he seemed to ignore aberrant behavior where A reported she obtained meds from a friend, was

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[43] In his analysis, Dr. Helm did not testify that respondent excessively prescribed opioids to Patients A, B, and C, as alleged in the first amended accusation, if only the amount of MEDs is considered. Dr. Helms stated that that there was no upper limit of opioids during the time respondent prescribed opioids to Patients A, B and C, as measured in MEDs. At the same time, he stated that while there is no upper limit, it is important for the pain management physician to be able to justify why the higher doses are needed.

missing a fentanyl patch, and admitted that a med she took made her "loopy." As Dr. Helm found, respondent did not critically assess and process this information as a pain management specialist should have.

With respect to the second issue he identified, failure to recognize the risk to Patient A of concurrent use of opiates, benzos and Soma, Dr. Helms found that respondent departed from the standard of care he identified and his failure to recognize the patient risk associated with the simultaneous use of high dose opioids, benzodiazepines and Soma was an extreme departure from the standard of care. As noted immediately above, Dr. Helm in his testimony and report appeared to combine this issue in his report and in his testimony with the excessive prescribing issue. No conclusion can be made, thus, regarding whether respondent excessively prescribed meds to A and this allegation is not sustained.

With this noted, Dr. Helm, in finding that respondent departed from the standard of care as alleged under subparagraph (c) of Paragraph 12, emphasized that the combination of opioids, benzodiazepines and Soma is a well-known favorite combination of drug abusers and this combination of drugs places the user at risk of overdose and creates, by a doctor's own actions, a public health hazard. Dr. Helm's opinion that respondent failed to recognize the risk to Patient A associated with the concurrent use of high dose opioids, benzodiazepines, and Soma and that this failure constituted an extreme departure is found to be persuasive.

Moreover, Dr. Helm correctly found that A's notes did not reference A's accompanying use of Alprazolam and Temazepam, which A's primary doctor provided, although respondent knew that A's primary doctor was prescribing these meds from the CURES report he obtained on November 18, 2014. Dr. Helm stressed here that respondent, as a pain management specialist, as a matter of standard of care, should

have used the CURES report and the information in it in assessing the opiates he prescribed A. A's notes do not support an interpretation, as respondent asserted, that he both advised A of the risk of using this triad combination of meds and was aware of this risk. His notes contain general, even vague language, regarding his discussions with A concerning her pain management.

In addition to these departures, Dr. Helm found the following two simple departures from the applicable standards of care: On August 25, 2011, A received a prescription for 30 pills of Dilaudid from respondent, but respondent failed to identify that he prescribed this med to her and why he prescribed it. Respondent did not dispute this allegation and Dr. Helm's opinion here is accepted.

Dr. Helm further concluded that respondent committed a simple departure from the standard of care when he failed, on September 4, 2013, to refer respondent to an addictionologist. While respondent believed a referral was appropriate, he did not take the next step according to Dr. Helm to make the referral. Dr. Helm believed that A was an addict by the accepted definition of this term, and the consultation should have been made for her.

Dr. Helm's testimony that respondent committed a simple departure when he failed to refer A to an addictionologist is found persuasive and is accepted. With this stated, respondent's failure to make this referral is mitigated by the difficulty he would have had obtaining an addictionologist, a difficulty Dr. Helm recognized.

First and Second Causes of Discipline Regarding Patient B

57. The first amended accusation alleges that respondent committed gross negligence and repeated negligence acts with respect to his care of Patient B as follows: Respondent failed to recognize signs of probable substance abuse,

respondent repeatedly and excessively prescribed, furnished, and/or administered high dose opioids to Patient B, respondent failed to recognize the risk to Patient B associated with concurrent use of high dose opioids, benzodiazepines, and Soma, respondent failed to adequately document reasons for changing Patient B's opioid medications.

Dr. Helm persuasively found that respondent failed to recognize signs of B's probable substance abuse. In support of this conclusion Dr. Helm cited respondent's early refills on her pain meds, inconsistent UDS, and her "stockpiling" and overconsuming of her pain meds. Dr. Helm stressed that respondent as a pain management specialist should have cast a critical eye at B's behavior for signs of possible substance abuse and should have been able to identify signs of B's possible substance abuse. In Dr. Helm's opinion, respondent failed to make this critical assessment and as a result he departed from the standard of care. Dr. Helm found the departure extreme. His conclusions here are well supported in the record and found persuasive.

Dr. Helm also found, as he did in his conclusions regarding Patient A, that respondent failed to recognize, as documented in B's records, the risks of concurrently prescribing benzodiazepines, Soma and opiates. Dr. Helm conflated, in his testimony, the issue whether respondent repeatedly and clearly excessively prescribed opioids with the issue of respondent's failure to recognize in B's records the risks of prescribing concurrently benzodiazepines, Soma and opiates. He did not, however, clearly connect respondent's failure to recognize the risks of taking the triad of meds with excessively prescribing opioids. Thus, the allegations at subparagraph (b) and (c) under Paragraph 14 of the first amended accusation are read as a single charge concerning respondent's concurrent prescription of benzodiazepines, Soma and

opiates. No conclusion, therefore, can be reached concerning the allegation whether respondent excessively prescribed opiates to B and this charge is not sustained.

With this noted, Dr. Helm opined that respondent's "prescribing pattern," as he put it, of the "dangerous" combination of benzodiazepines, Soma and opiates constituted a departure from the standard of care. He found this departure was extreme. His testimony that respondent did not document that he recognized the risks of concurrently prescribing this combination of meds is well supported in the record and is found to be persuasive. His conclusion that the departure was extreme is also found persuasive.

Dr. Helm further concluded that respondent failed to adequately document reasons he changed Patient B's opioid medications and explain why he took the certain course of treatment he took with respect to Patient B. Dr. Helm's opinion that respondent departed from the standard of care he identified is found persuasive and well-supported in the record based on a review of B's records. A review of these records supports Dr. Helm's opinion in this regard. Respondent's reasoning for prescribing the medications he prescribed B is hard to follow and decipher. Dr. Helm found the departure to be extreme and his conclusion here is also found persuasive.

FIRST AND SECOND CAUSES FOR DISCIPLINE REGARDING PATIENT C

58. Concerning Patient C, the first amended accusation alleges that respondent repeatedly and clearly excessively prescribed, furnished, dispensed and/or administered high dose opioids to Patient C and he failed to recognize the risk to Patient C associated with concurrent use of high dose opioids, benzodiazepines, and Soma. The first amended accusation also alleges that respondent committed a simple

departure from the standard of care when he failed to document the prescription for Klonopin to C on January 12, 2011.

Concerning the excessive prescription of high dose opioids, Dr. Helm, with respect to the inappropriate prescribing issue, again discussed this issue in the context of respondent's failure to recognize risk inherent in prescribing higher doses of opioids with other sedating medications such as Soma and Valium. As a result, the allegation as set forth in the first amended accusation at subparagraph (a) of Paragraph 16 is not sustained.

In addressing the importance of recognizing the inherent risk of prescribing the triad of meds, as he put it, Dr. Helm emphasized that prescribing this combination of these meds required a higher level of vigilance on respondent's part. His opinion that respondent departed from the standard of care and that the departure was extreme was well supported in the record and Dr. Helm's reasoning was clear and articulate. As he stated with regards to Patients A and B, Dr. Helm felt that respondent did not appear to be aware of the inherent risk of prescribing high doses of opioids to C with Soma and the benzodiazepine Valium. He testified that that Soma, specifically, as prescribed to Patient C, was not indicated for long term use and if respondent was prescribing this med to C for long term use he should have documented that the benefits of medication in combination with the opioids and benzos he was prescribing was worth the risk, which respondent did not do.

Regarding the inadequate record keeping issue, Dr. Helm found respondent's failure to document his reasons for issuing C a prescription for Klonopin, a benzodiazepine, on January 12, 2012, to be a simple departure consistent with the 2007 and 2014 guidelines. Respondent did not dispute Dr. Helm's testimony here. His testimony was persuasive and is accepted.

FIRST AND SECOND CAUSES FOR DISCIPLINE WITH RESPECT TO PATIENT D

59. The first amended accusation alleges that respondent committed gross negligence when he failed to appropriately monitor Patient D's opioid use, failed to appropriately address Patient D's aberrant drug behavior, including his early refills and his statement that his mother threw away his controlled pain medications, failed to appropriately perform ongoing patient assessments of Patient D, including failure to note abscesses in his arms, failure to identify renal failure through use of a comprehensive metabolic panel, and failure to address lack of improvement in his report pain scores, and he failed to recognize the risk to Patient D associated with concurrent use of high dose opioids, benzos, and Soma. The first amended accusation also alleges that respondent committed repeated negligent acts when he failed to have D submit to a UDS.

In his analysis of respondent's treatment of D, Dr. Helm identified specific categories he found in the Guidelines and applied these categories to his overall assessment of respondent's treatment of D: Patient Evaluation and Risk Stratification, Consultation, Compliance Monitoring, and Ongoing Patient Assessment.

Under the Ongoing Patient Assessment category, Dr. Helm found that respondent did not appropriately assess D, and he committed extreme departures from the applicable standards of care as follows: he failed to note abscesses on D's arms, he failed to identify D's renal failure by use of a comprehensive metabolic panel, he did not document that he considered D was engaging in aberrant behavior when his mother threw away his medications and D asked for early refills, and respondent failed to record D showed no improvement in pain ratings despite high doses of opioids, did not document his rationale for changes in opioids prescribed, and failed to obtain a completely filled out ORT.

First, concerning whether respondent should have noticed the abscesses on D's arms as part of his monitoring of D, Dr. Helm reached the conclusion that abscesses on his arms should have been apparent to respondent had he appropriately assessed D at his March 24, 2014, visit with him for these reasons: In his opinion Dr. Helm believed that because D was suffering from end stage renal disease, had very abnormal creatinine and BUN levels upon his April 16, 2014, hospitalization two weeks after his visit on March 24, 2014, with these levels D would not have appeared healthy when D saw him and examined him, and the abscesses would have been apparent to respondent had he examined his arms. As he put it, it would have been hard for respondent to miss the abscesses on D's arms and legs had he examined D on March 24, 2014.

Dr. Helm's testimony is found credible and well-supported based on D's reported condition on March 24, 2014, information in D's hospital records, and other information in the record. Based on the information in these records, it is reasonable to conclude that had respondent conducted even a superficial exam of D's arms this exam would have shown he had abscesses and evidence of his drug use. According to D's March 24, 2014, visit record with respondent, D was not doing well. He reported he had left shoulder pain, he had trouble walking, he walked with a cane for support, and he said he had "a lot of swelling" in his right leg. Respondent wrote in his report that he examined D's left ankle and found it tender and swollen, but the nature and extent of his exam of D's other extremities including his arms are not clear and not well-documented. Respondent explained in his testimony that he could not examine D's shoulder for legal reasons because another doctor was responsible for D's right shoulder. In the light of information in D's records and his hospitalization, respondent's testimony here is particularly not credible and appears to be a self-

serving effort to try to excuse his failure to conduct even a superficial physical exam of D's arm.

Two weeks after D's visit with respondent D was admitted with severe infections in all four extremities due to intravenous drug use. As recorded by nurses and the emergency room doctor, upon his April 16, 2014, hospital admission, D had "***chronic*** infections in all 4 extremities that he reports have been healing." (Exhibit 35, AGO 5204, emphasis added.)[44] The emergency room doctor observed that D had in "[b]oth upper extremities" "open wound [*sic*]" and "multiple healed scars from drug abuse." (Exhibit 3, AGO 5230.) A photo of D's right forearm shows (Exhibit 35, AGO 5343) he had black flaking and dying skin with a sizeable red open wound. A photo of his left forearm also shows black flaking and dying skin with a sizeable red open wound. (Exhibit 35, AGO 5346.) A photo of his right leg shows multiple scars from injection sites. (Exhibit 35, AGO 5345.) Hospital records additionally documented that D had "massive right lower edema." Notably, the condition of D's right leg at the hospital correlates with the condition of D's right leg as D reported it at his March 24, 2014, visit with respondent where D complained of a lot of swelling in his right leg. In his testimony, respondent tried to distinguish the swelling in D's right leg as observed at D's hospital admission from the swelling reported at his March 24, 2014 visit. His testimony here is also found to be particularly not credible and appears to be an effort on respondent's part to try to excuse his failure to examine D's right leg.

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[44] "Chronic" is defined, according to Merriam-Webster, as "persisting for a long time or constantly recurring" and "long-lasting and difficult to eradicate." The use of this word by clinical staff suggests that D had the infections on his arms for some time.

Aside from these records, other information in D's records supports the conclusion that D's arms would have shown evidence he was abusing drugs had respondent examined D's arms and legs on March 24, 2014. At D's January 24, 2014, visit with respondent D inexplicably refused to have his blood pressure taken and in D's record D's refusal was highlighted by respondent's assistant for respondent to note. To have his blood pressure taken, D would have been required to show his arms to the assistant. As discussed earlier, it is reasonable to conclude that D refused to have his blood pressure taken in January 2014 because if D had shown his arms to have his blood pressure taken his arms would likely have shown he was abusing drugs. Dr. Shurman in his testimony acknowledged this as a possibility when he referred to D's refusal to have his blood pressure taken as a "significant data point."

Dr. Helm noted other deficiencies in respondent's monitoring of D that constituted extreme departures from the standard of care: Respondent failed to identify D's renal failure by use of a comprehensive metabolic panel, failed to document D's aberrant behavior when his mother threw away his medications and D asked for early refills, and respondent also failed to note D showed no improvement in pain ratings despite high doses of opioids. Dr. Helm's testimony is found credible with respect to these deficiencies and well-supported in the record. Concerning his failure to obtain a comprehensive metabolic panel for D, a number of factors should have made obtaining a metabolic panel necessary: the swelling in D's right leg as reported on March 24, 2014, the letter in July 2015 to respondent from the state agency processing his Social Security disability claim indicating that D was reported to have End Stage Renal Disease, D's physical appearance on April 30, 2014, and respondent's long term use of acetaminophen. In addition, respondent's failure to consider that D was engaging in aberrant behavior based on his mother throwing away his medication

and his obtaining early refills of high dose opioids from respondent further reflected respondent did not adequately monitor D.

In addition, as a matter of his ineffective monitoring of D, D showed no improvement in his functioning. In fact, by March 2014, D's condition worsened and he was not functioning well. Yet, respondent incorrectly thought that D was functioning well because he was working full time. In fact, D was unemployed and had applied for Social Security disability benefits due, in part, to End Stage Renal Disease.

Dr. Helm also concluded that, as he found with respect to respondent's care and treatment of the other patients, respondent failed to recognize the risks to Patient D associated with the concurrent use of Soma, benzos and opioid meds and found the departure from the standard of care here to be extreme. His testimony is found to be credible and supported in the record. In reaching his conclusion, Dr. Helm testified that respondent did not document in D's notes the risks of prescribing this triad of meds to D and this failure to document this risk showed he did not appreciate these risks. As he stated, D's notes do not contain any acknowledgement of the risks in prescribing this combination of meds to D. Dr. Helm added that respondent's advisement to D not to take Soma with Xanax in August 2015 highlighted the problem of respondent prescribing this combination of meds to D because the Xanax or Soma could still have been in D's system when he later took either of these meds with the possibility of an overdose. Dr. Helm added further that if respondent was prescribing Soma or Xanax to D for sleep or anxiety there were safer medication alternatives.

Aside from the extreme departures from standards of care he found, Dr. Helm in addition found that respondent committed simple departures from the standard of care when he did not document his rationale for changes in opioids prescribed, and when he failed to obtain, after 2011, a UDS for D. His testimony here is found credible.

It is difficult to find, based on a review of D's records, respondent's rationale for changing opioids respondent prescribed D.

Dr. Helm additionally found that respondent failed to obtain a "completely filed out" ORT and this departure was also a simple departure from the standard of care. As discussed earlier, Dr. Helm did not define what he meant when he stated that the ORT form was not "completely filled out" because D completed the form, although D's answer concerning his history of substance abuse was not accurate. Dr. Helm's testimony here is thus not found credible and the allegation is not sustained.

FIRST AND SECOND CAUSES FOR DISCIPLINE REGARDING PATIENT E

60. The first amended accusation alleges that respondent committed gross negligence when he failed to assess the continued opioid drug therapy for Patient E in light of her reporting no improvement in pain over ten months. The accusation also alleges that respondent committed a simple departure from the standard of care for failing to maintain adequate records.

Dr. Helm testified that respondent committed an extreme departure from the standard of care for failing to assess in periodic review the effectiveness of opioid therapy, with or without other controlled substances. Dr. Helm's testimony is supported by the evidence of record and is found persuasive. As documented in E's records, during the time respondent treated E, E showed no improvement in her moderate to severe pain condition. Despite this lack of improvement, respondent did not document he assessed the effectiveness of the opioids he was prescribing her for purposes of continuing her on opioid therapy.

Dr. Helm also found that respondent failed to maintain adequate records of his treatment of E and that this failure represented a simple departure from the standard

of care. His testimony is found persuasive and is accepted. Dr. Helm highlighted in his testimony the following instances where respondent's notes were inadequate. In E's March 6, 2012, visit note, respondent first mentioned he was prescribing Fiorinal with codeine to E, but did not document why he prescribed this med to her, although he noted she had chronic migraines. After this visit, respondent advised her to return in a month, but she returned three weeks later on March 27, 2012. For a reason respondent did not document, at this visit, he wrote a script for 30 pills of Dilaudid 4 mg.

Dr. Helm further noted that per CURES E filled a prescription for Suboxone on June 28, 2012, but no script is found in E's records for this prescription and no accompanying chart note.

In E's July 23, 2012, note, respondent did not document his rationale for switching E back to opioids from Suboxone. Similarly, in E's September 4, and October 2, 2012, notes he also did not document his rationale for continuing to prescribe opioids and discontinuing Suboxone.

THIRD CAUSE FOR DISCIPLINE

61. The first amended accusation alleges that respondent demonstrated incompetence in his treatment of Patients A, B and C. However, Dr. Helm did not testify that respondent demonstrated incompetence in his care and treatment of Patients A and C and no conclusion according regarding this allegation can be made based on this record.

FOURTH CAUSE FOR DISCIPLINE

62. The first amended accusation alleges that respondent committed repeated acts of clearly excessive prescribing drugs or treatment to Patients A, B, C,

and D. As discussed in the analysis of Dr. Helm's conclusions regarding respondent's departures from standards of care, Dr. Helm did not conclude that respondent excessively prescribed opioids to Patients A, B, C and D, although he criticized respondent for concurrently prescribing Soma, benzodiazepiness and opioids to these patients, failing to document the risks of taking this combination of meds, and his lack of rationale for prescribing opioids. In fact, the record does not support the allegation that respondent excessively prescribed meds to these patients. For the most part, respondent did not vary the dosages of opioids to these patients very much, with some exceptions. As a matter of his practice, respondent credibly testified that he did not change the dosages of opioids he was prescribing once he reached a certain level based on the patient's ability to function. With the exception of his prescription of opioids to Patient B, whose MEDs increased from 300 to 900, respondent followed this practice. Dr. Helm, further, acknowledged that there was no upper limit in terms of MEDs for a pain management specialist to prescribe.

FIFTH CAUSE FOR DISCIPLINE

63. The fifth cause for discipline alleges that respondent failed to maintain adequate and accurate records in connections with the five patients at issue in this matter.

A review of the records of each of these patients reveals that respondent's record keeping for all five patients often did not include his rationale to justify prescribing the levels of opioids he prescribed and the reasons he prescribed certain other medications, including benzodiazepines, to these patients. As discussed above, Dr. Helm articulated his concerns about respondent's record keeping both in terms of his failure to justify his rationale for prescribing the levels of opioids he prescribed

and, also, with respect to respondent concurrently prescribing the "triad" of meds, Soma, benzos and opioids, to Patients A, B, C and D.

In questions posed to Dr. Helm on cross-examination, Dr. Helms acknowledged instances where respondent adequately charted the patient records. But, even with these instances of adequate charting considered, between 2011 and 2015, respondent failed to maintain adequate and accurate records for all five patients in the following instances: With respect to Patient A, he failed to document the prescription he wrote for Dilaudid for A on August 25, 2011. With respect to Patient B, Dr. Helm failed to record his reasons for changing B's opioid meds. With respect to Patient C, he failed to document the prescription he wrote for Klonopin for C on January 12, 2011. With respect to Patient D, between 2013 and 2015, respondent failed to appropriately document his rationale for the changes in opioids that he prescribed to Patient D. With respect to Patient E, respondent in E's March 6, 2012, visit note, did not adequately document why he was prescribing Fiorinal with codeine to E, and why three weeks later, on March 27, 2012, he wrote a script for E for 30 pills of Dilaudid 4 mg. Additionally, respondent did not document his rationale for writing E a prescription for Suboxone about June 28, 2012. Respondent, moreover, did not document in E's July 23, 2012 note, his rationale for restarting E back on opioids after prescribing her Suboxone. Respondent, similarly, in E's September 4, and October 2, 2012 notes, did not document his rationale for continuing to prescribe opioids and discontinuing Suboxone.

Character Evidence

64. A number of individuals testified on respondent's behalf as character witnesses and submitted letters on his behalf.

Amy Magnusson, M.D., has been a licensed doctor in California since 2001 and is board certified in Physical Medicine and Rehabilitation with a subspecialty certification in brain injury and spinal cord medicine. Dr. Magnusson testified on respondent's behalf.

Dr. Magnusson began working with respondent in the area of rehabilitation and pain management in 2003 and worked closely with him until he started his own practice. Over the years she has shared patient referrals with him. She had the chance to observe respondent's interactions with patients and review his care and treatment of chronic pain patients, his medical reports and recommendations. During her interactions with respondent she stated that respondent provided the highest quality of care to his patients and she believes he is one of the few pain management doctors she would ask to care for her patients due to his dedication and professionalism. She has always known him to practice within the standard of care and has no reservations in sending complicated patients to him for treatment. Dr. Magnusson is familiar with the allegations in the first amended accusation.

Autumn Phillips, Psy.D., is a licensed clinical psychologist specializing in the treatment of chronic pain. Dr. Phillips also testified in this matter.

Dr. Phillips has worked closely with respondent for nearly 10 years. Initially, she worked with respondent at a Functional Restoration program for patients with chronic pain. Respondent worked closely with Dr. Phillips as part of this program which utilized multimodal care such as psychology, physical therapy, nutrition and exercise. Based on her work with respondent Dr. Phillips believes that respondent is a dedicated and caring physician who is mindful of medical and psychosocial considerations. She has referred close friends and family to respondent for care. Dr. Phillips is aware of the charges against respondent as detailed in the first amended accusation.

Jerome Stenehjem, M.D., is a board certified doctor in the field of Physical Medicine and Rehabilitation and the current medical director of the Sharp Allison deRose Rehabilitation Center at Sharp Memorial Hospital. Dr. Stenehjem in his practice treats between 40 to 60 patients per week. Dr. Stenehjem testified on respondent's behalf.

Dr. Stenehjem has known respondent for many years and worked closely with him. He regards respondent as a compassionate, experienced, dedicated and valued member of the medical community. Over the years he has referred numerous patients to respondent and respondent, in turn, has referred patients to him. Based on his working relationship with him Dr. Stenehjem has confidence in his abilities and desire to provide the best care possible to patients. He hopes respondent will be able to continue to care for the many patients who depend on him and the valuable service he provides them and the community. Dr. Stenehjem is familiar with the allegations contained the first amended accusation against respondent.

In addition to these three doctors, Patient C testified on respondent's behalf. Patient C believed that respondent's care and treatment allowed him to function and he remains respondent's patient. He values the care and treatment respondent has provided him.

65. In addition to the testimony of these persons, respondent submitted declarations from the following persons: Renjit Sundharadas, M.D., who has known respondent for 10 years and practices in the field of physical medicine and pain medicine, Walter Strauser, M.D., who has known and worked with respondent for about 20 years in the pain management field, Robert Scott, M.D., who has known respondent for 15 years and worked with him in the pain management and rehabilitation medicine field, and Michael Moon, M.D., who has known respondent

during respondent's medical residency, and also practices in the field of pain management and rehabilitation medicine.

These doctors described respondent as a competent, compassionate, skilled, and dedicated doctor who has practiced medicine, to their knowledge, within the standard of care. The declarations of these doctors were admitted as administrative hearsay pursuant to Government Code section 11513, subdivision (d), and they supplement and explain the testimony of the character witnesses that respondent is a compassionate and dedicated doctor.

Parties Arguments

66. In closing arguments complainant asserted that respondent as a pain management doctor had a duty to take a thorough approach documenting his drug treatment rationale because he was prescribing powerful drugs to a vulnerable subset of patients seeking relief from pain. Most notably, respondent did not document he recognized the risk of concurrently prescribing Soma, benzodiazepines and opioids. Respondent fell far short of his duty as a pain management specialist and two of his patients died from drugs he prescribed them. Complainant argued that Dr. Helm's testimony should be accepted because he was an unbiased objective expert with significant experience in the field of pain management. In contrast, Dr. Shurman, in multiple ways, displayed himself as an expert with an interest in the outcome of respondent's matter and his opinions should not be accepted.

In terms of the degree of discipline to impose, complainant asks for the following terms and conditions for discipline: Seven years' probation, a 60-day suspension, surrender of DEA permit, prohibition on prescribing Schedule II and III controlled substances, requirements that respondent maintain records and provide

access to records and inventory, take education, prescribing practices and medical record keeping courses, take and successfully complete a clinical competency program, be supervised by a practice monitor, and other terms and conditions.

Respondent, in closing, made a detailed refutation of the evidence presented against him, as documented in a multi-page outline. (Exhibit BBB.) The outline contains selective citations to portions of the extensive record in this matter. Respondent asks, at most, for any violations found, that respondent be reprimanded.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the first amended accusation are true.

The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Statutes Regarding Causes to Impose Discipline

3. Section[45] 2227, subdivision (a), states:

> 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.

[45] References are to the Business and Professions Code unless otherwise stated.

(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 the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Section 2234 provides in part:

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

[¶] . . . [¶]

(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.

(d) Incompetence. . . .

5. Section 2266 provides:

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.

6. Section 4022 defines a dangerous drug as:

> . . . any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
>
> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

7. Section 725, subdivision (a), provides, in part, "Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

8. Section 2266 provides that 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. Section 651 provides, in part:

> (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.
>
> (b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:
>
> (1) Contains a misrepresentation of fact.
>
> (2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

[¶] . . . [¶]

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

[¶] . . . [¶]

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

[¶] . . . [¶]

(h) Advertising by any person so licensed may include the following:

[¶] . . . [¶]

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician's and surgeon's licensing board prior to January 1, 2019, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of

California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience. A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2019, shall retain that approval.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician's and surgeon's licensing board prior to January 1, 2019, or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

Decisional Authority Regarding Standard of Care

10. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. Incompetence has been defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Id.* at 1054).

Decisional Authority Regarding Incompetency

11. Incompetence has been defined as a "general lack of present ability to perform a given duty." (See, *Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 837-838, where the court distinguished negligence from incompetence when it stated, "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty.") In *James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109, the court held: "Incompetence generally is defined as a lack of knowledge or ability in the discharge of professional obligations."

Case Law Regarding Unprofessional Conduct

12. In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575, the appellate court noted that "unprofessional conduct" as that term was used in Business and Professions Code section 2361 (now section 2234), included certain enumerated conduct. (*Id.* at p. 575.) The court further stated (*Ibid.*):

> This does not mean, however, that an overly broad connotation is to be given the term "unprofessional conduct;" it must relate to conduct which indicates an unfitness to practice medicine. [Citations.] Unprofessional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. [Citation.]

Public Letter of Reprimand

13. Section 2233 provides as follows:

> The board may, by stipulation or settlement with the affected physician and surgeon, issue a public letter of reprimand after it has conducted an investigation or inspection as provided in this article, rather than filing or prosecuting a formal accusation. The public letter of reprimand may, at the discretion of the board, include a requirement for specified training or education. The affected physician and surgeon shall indicate agreement or nonagreement in writing within 30 days of formal notification by the board of its intention to issue the letter.

The board, at its option, may extend the response time. Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board.

Disposition Regarding Causes for Discipline

CAUSE EXISTS UNDER THE FIRST CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR CONDUCT CONSTITUTING GROSS NEGLIGENCE

14. Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient A based on the findings in this decision. Respondent failed to adequately monitor Patient A's opioid use and failed to recognize the risk to Patient A associated with concurrent use of high dose opioids, benzodiazepines, and Soma. Complainant did not prove by clear and convincing evidence that respondent repeatedly and excessively prescribed, furnished, or dispensed high dose opioids to Patient A.

Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient B based on the findings in this decision. Respondent failed to recognize signs of probable substance abuse, failed to recognize the risk to Patient B associated with concurrent use of high dose opioids, benzodiazepines, and Soma, and failed to adequately document reasons for changing Patient B's opioid medications. Complainant did not prove by clear and convincing

evidence that respondent repeatedly and excessively prescribed, furnished, or dispensed high dose opioids to Patient B.

Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient C based on the findings in this decision. Respondent failed to recognize the risk to Patient A associated with concurrent use of high dose opioids, benzodiazepines, and Soma. Complainant did not prove by clear and convincing evidence that respondent repeatedly and excessively prescribed, furnished, or dispensed high dose opioids to Patient C.

Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient D based on the findings in this decision. Respondent failed to appropriately monitor Patient D's opioid use, address his aberrant drug behavior including his early refills and his statement that his mother threw away his controlled pain medications, respondent failed to appropriately perform ongoing patient assessments of Patient D, including failure to note abscesses on his arms, failure to identify his renal failure through use of a comprehensive metabolic panel, and failure to address lack of improvement in his reported pain scores. Respondent also failed to recognize the risk to Patient D associated with concurrent use of high dose opioids, benzodiazepines, and Soma.

Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient E based on the findings reached in this decision. Respondent failed to assess the effectiveness of continued opioid drug therapy for Patient E in light of her reporting no improvement in pain over ten months.

CAUSE EXISTS UNDER THE SECOND CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR REPEATED NEGLIGENT ACTS

15. Complainant proved by clear and convincing evidence that respondent committed repeated negligent acts in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of Patient A based on the findings in this decision. Respondent failed to document the prescription for Dilaudid issued to Patient A on August 29, 2011, and respondent to get a consultation with an addictionologist for Patient A.

Complainant proved by clear and convincing evidence that respondent committed a negligent act in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of Patient B to the extent gross negligence was found as detailed immediately above.

Complainant proved by clear and convincing evidence that respondent committed a negligent act in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of Patient C based on the findings in this decision. Respondent failed to document the prescription for Klonopin issued to Patient C on January 12, 2011.

Complainant proved by clear and convincing evidence that respondent committed repeated negligent acts in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of Patient D based on the findings in this decision. Respondent failed to get a UDS from Patient D after 2011 and between 2013 and 2015, and he failed to appropriately document his rationale for the changes in opioids that he prescribed to Patient D.

Complainant proved by clear and convincing evidence that respondent committed a negligent act in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of Patient E based on the findings in this decision. Respondent failed to maintain adequate records documenting his treatment of Patient E and the prescription of medications to her. Complainant did not prove by clear and convincing evidence that respondent committed a negligent act when he failed to obtain a completed ORT from Patient E based on the findings in this decision.

CAUSE DOES NOT EXIST UNDER THE THIRD CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR INCOMPETENCE

16. Complainant did not prove by clear and convincing evidence that respondent demonstrated incompetence in his care and treatment of Patients A, B, C, in violation of Section 2234, subdivision (d), based on the findings reached in this decision.

CAUSE DOES NOT EXIST UNDER THE FOURTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR REPEATED ACTS OF CLEARLY EXCESSIVE PRESCRIBING

17. Complainant did not prove by clear and convincing evidence that respondent demonstrated incompetence in his care and treatment of Patients A, B, C, and D in violation of Sections 725 and 2234 based on the findings reached in this decision.

CAUSE EXISTS UNDER THE FIFTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS

18. Complainant proved by clear and convincing evidence that respondent failed to maintain adequate and accurate records in his care and treatment of Patients A, B, C, D and E, in violation of Sections 2234 and 2266 based on the findings reached in this decision.

Respondent failed to maintain adequate and accurate records for all five patients in the following instances: With respect to Patient A, he failed to document the prescription he wrote for Dilaudid for A on August 25, 2011. With respect to Patient B, Dr. Helm failed to record his reasons for changing B's opioid meds. With respect to Patient C, he failed to document the prescription he wrote for Klonopin for C on January 12, 2011. With respect to Patient D, between 2013 and 2015, respondent failed to appropriately document his rationale for the changes in opioids that he prescribed to Patient D. With respect to Patient E, respondent in E's March 6, 2012, visit note did not adequately document why he was prescribing Fiorinal with codeine to E, and why three weeks later, on March 27, 2012, he wrote a script for E for 30 pills of Dilaudid 4 mg. Additionally, respondent did not document his rationale for writing E a prescription for Suboxone about June 28, 2012. Respondent, moreover, did not document in E's July 23, 2012 note, his rationale for restarting E back on opioids after prescribing her Suboxone. Similarly, respondent, in E's September 4, and October 2, 2012 notes, did not document his rationale for continuing to prescribe opioids and discontinuing Suboxone.

CAUSE EXISTS UNDER THE SIXTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR UNPROFESSIONAL CONDUCT

19. Complainant proved by clear and convincing evidence that respondent engaged in unprofessional conduct in his care and treatment of Patients A, B, C, D and E, in violation of Sections 2234 based on the findings reached in this decision. As found, respondent's conduct breached the rules or ethical code applicable to a physician in good standing.

CAUSE EXISTS UNDER THE SEVENTH CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR A PUBLIC COMMUNICATION CONTAINING FALSE, FRAUDULENT, MISLEADING, OR DECEPTIVE STATEMENT, CLAIM OR IMAGE

20. Complainant proved by clear and convincing evidence that on October 10, 2019, respondent represented on his internet website advertising his medical practice that he was board certified in pain medicine when he had not been board-certified in pain medicine since 2014 and his board certification had lapsed. Respondent removed the representation of his board certification from his website the day he was asked about it at this hearing.

The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

21. With causes for discipline having been found, the determination now must be made regarding the degree of discipline and the terms and conditions to

impose. In this regard, the board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) states:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

22. For each of the violations established relating to respondent's care and treatment of Patients A, B, C, D and E, the board's disciplinary guidelines provide that revocation is the maximum discipline and provided the following minimum recommended terms and conditions:

- For gross negligence and repeated negligent acts under Business and Professions Code section 2234, subdivisions (b) and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices.

- For excessive prescribing under Business and Professions Code section 725, revocation, stayed, and five years' probation, with conditions including a 60-day suspension, a Drug Enforcement Administration (DEA) controlled substances restriction, maintenance of controlled substance records, education course, prescribing practices course, medical record keeping course, professionalism course, clinical competence course, and monitoring.

- For a violation of Business and Professions Code section 651, one-year probation with conditions including an education course, professionalism program, practice monitoring and prohibited practice.

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

23. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy, supra*, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

The determination whether respondent's license should be revoked or suspended includes an evaluation of the nature and severity of the conduct and rehabilitation and mitigation factors as set forth under California Code of Regulations, title 16, section 1360.1, which provides as follows:

When considering the suspension or revocation of a license, certificate or permit on the ground that a person holding a license, certificate or permit under the Medical Practice Act has been convicted of a crime, the division, in evaluating the rehabilitation of such person and his or her eligibility for a license, certificate or permit shall consider the following criteria:

(a) The nature and severity of the act(s) or offense(s).

(b) The total criminal record.

(c) The time that has elapsed since commission of the act(s) or offense(s).

(d) Whether the licensee, certificate or permit holder has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person.

(e) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(f) Evidence, if any, of rehabilitation submitted by the licensee, certificate or permit holder.

24. After considering the board's guidelines, and the factors under California Code of Regulations, title 16, section 1360.1, the evidence of rehabilitation, and mitigation, and the evidence of record as a whole, it is determined that a five-year period of probation with specific terms and conditions will ensure public protection. With these terms and conditions, it is not necessary that respondent's license be

revoked, suspended, or that he be barred from prescribing controlled substances as complainant recommends. These terms and conditions will require that a practice monitor supervise respondent's practice, respondent successfully take and complete a clinical competency program, record keeping, prescribing practice and additional educational courses. This determination is made considering that respondent has made efforts to correct his prescribing and record keeping practices and he has no disciplinary history. A departure from the Board's Disciplinary Guidelines is warranted in light of these considerations in this respect: Respondent is not barred from the solo practice of medicine and no such order is imposed.

The determination regarding the level of discipline is made for these reasons: The nature and extent of respondent's conduct was serious and exposed his patients to harm. This is most clear with respect to respondent's prescribing of the dangerous "triad" combination of medications, Soma, benzodiazepines, and opioids, to four of the five patients unaware of the risk this combination of medications posed to each of them, a risk Dr. Helm pointedly and credibly discussed. Tragically, as amble proof of this risk, Patient D died from "toxic levels of morphine, oxycodone and alprazolam, therapeutic levels of hydrocodone and carisoprodol (Soma)," according to the San Diego County Medical Examiner. In his hearing testimony, respondent vigorously, and not convincingly, disputed the Medical Examiner's conclusions and, in so doing it is reasonable to infer, seemed to not accept that this triad of meds posed any risk. This highlights both the serious implication of the Medical Examiner's conclusion in terms of what it says about respondent's practice of prescribing the triad of meds he prescribed D without giving due consideration to the risks involved when prescribing this combination of meds. It also reflects, as a matter of considering the sufficiency of respondent's rehabilitation, that respondent does not take full responsibility for his failure to recognize the particular risk of prescribing this triad of meds. His refusal to

accept responsibility for exposing D to this risk is an aggravating factor in favor of serious discipline even in light of respondent's testimony, late in his testimony, that he now rarely prescribes Soma.

Respondent's failure to appropriately assess patients A, B, D and E for ongoing opioid therapy also represented serious misconduct over an extended time. In this regard, respondent ignored indications of possible substance abuse, including inconsistent UDS, and aberrant behaviors, regarding Patients A, B, and D. He dismissed concerns raised by A's son that A was misusing the meds he prescribed her, concerns which were accurate. He ignored B's stockpiling of pain meds and her early refills. Respondent also uncritically accepted D's explanation why his mother threw away his meds in November 2013. He failed to notice D's deteriorating physical condition with skin infections on his arms and legs, due to drug abuse, between April 2014 and August 2015, during which time D was twice hospitalized and he applied for Social Security disability based in part on End Stage Renal Disease. In late July 2015, respondent was advised D had applied for Social Security Disability on this basis, yet he continued to prescribe high dose opioids, Xanax and Soma to him in August and September 2015, shortly before he died. Respondent did not obtain a UDS from D after 2011.

With respect to Patient E, respondent continued to prescribe opioids to her without indications she was, in fact, benefiting from opioid therapy.

In addition, respondent's inadequate and inaccurate record keeping represented serious deficiencies in his practice of pain management medicine. His record keeping for all five patients was superficial, at best, even after he completed a medical record keeping course in 2013. Respondent did not document his rationale for prescribing Soma both in combination with benzodiazepines and opioids and as a

separate medication. He also, notably, did not record his rationale for prescribing benzodiazepines. In general, his patient assessments, both in terms of the nature and extent of the physical exams he recorded, their "baseline" states he noted, the reasons he prescribed the meds he prescribed and his rationale for changing meds he was prescribing, and the dosages he was prescribing, were hard to follow and/or discern. A number of times respondent prescribed controlled substances to patients without accompanying notes. As such, he shall be ordered to retake a record-keeping course.

With this stated, a number of factors have been considered in respondent's favor: respondent presented evidence from several well-respected physicians in the field of pain management and rehabilitation medicine, including Dr. Shurman, that he is a conscientious, caring, respected and dedicated member of the community. Patient C spoke of him as a caring doctor who helped him with his intractable pain. Irrespective of the deficiencies found in this decision, respondent closely followed each of the patients in this matter in an effort to treat their pain conditions and was very responsive to each of them. Also, as noted earlier, respondent has made substantive changes to his practice, which reflects his effort to correct the conduct at issue and rehabilitate himself, including how he prescribes Soma.

Concerning respondent's request that his license be subject to a public reprimand for any found violations, respondent's request is denied. Considering the nature of the respondent's violations of the Medical Practice Act, even for just those violations respondent did not appear to dispute, a reprimand is not appropriate. Respondent's conduct did not constitute minor violations of the Medical Practice Act

With respect to respondent's misrepresentation that he was board certified in pain medicine on his website, this was a good faith error on respondent's part which,

once brought to his attention, he immediately corrected. It is not a factor in favor of serious discipline.

ORDER

Certificate No. A72430 issued to respondent, John Xiao-Jing Qian, M.D., is revoked. However, the revocation is stayed, and respondent is placed on probation for five years upon 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.

4. 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 for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education 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 did 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 first amended accusation and/or a petition to

revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(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. Notification

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

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

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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 Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

13. 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. Upon successful completion of probation, respondent's certificate shall be fully restored.

14. 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.

15. License Surrender

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

and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. 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.

DATE: November 20, 2019

DocuSigned by:
Abraham Levy
C84184237D2243C...
ABRAHAM M. LEVY
Administrative Law Judge
Office of Administrative Hearings

EXHIBIT "B"
ACCUSATION AND
PETITION TO REVOKE PROBATION
MEDICAL BOARD CASE NUMBER 800-2021-081788

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **JOHN XIAO-JIANG QIAN, M.D.** **P.O. Box 675594** **Rancho Santa Fe, California 92067** **Physician's and Surgeon's Certificate No. A 72430,** Respondent.	Case No. 800-2021-081788 **ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

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

2. On or about July 1, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A 72430 to John Xiao-Jiang Qian, 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 June 30, 2024, unless renewed.

DISCIPLINARY HISTORY

3. In a disciplinary action entitled *In the Matter of the First Amended Accusation Against John Xiao-Jiang Qian, M.D.*, Case No. 800-2014-009588, the Board issued a Decision and Order, effective February 10, 2020, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of 5 years subject to various terms and conditions. A true and correct copy of the Board's Decision and Order in Case No. 800-2014-009588 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

JURISDICTION

4. This Accusation and Petition to Revoke Probation is brought before the Board under the Board's Decision and Order in the case entitled *In the Matter of the First Amended Accusation Against John Xiao-Jiang Qian, M.D.*, Case No. 800-2014-009588 and the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2220 of the Code states, in relevant part:

> 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 ...

STATUTORY PROVISIONS

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 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.

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.

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.

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FACTUAL ALLEGATIONS

10. Patient A[1]

(a) On or about April 1, 2020, Respondent saw Patient A for an initial pain management evaluation. Patient A suffered from chronic low back pain that was managed with medication and intermittent interventional pain procedures to include epidural injections. Before seeing Respondent, Patient A received from another medical provider three (3) injections at the sciatic nerve, but she only experienced limited relief from her pain. Respondent's treatment plan was to administer a series of three (3) epidural injections to Patient A.

(b) On or about May 21, 2020, Respondent administered an epidural injection (lumbar transforaminal) to Patient A. During a follow-up appointment, Patient A reported "0% improvement" and that her pain was "worse after the injection."

(c) On or about June 24, 2020, Respondent administered a second epidural injection (lumbar transforaminal) to Patient A.

(d) On or about August 31, 2020, during a follow-up appointment, Patient A reported that the June 24 injection provided her "70% pain relief" but that the relief only lasted for two (2) weeks. Patient A also reported having continued sciatic pain and with "constant sharp to burning pain" that radiates in her leg. She also reported feeling "numbness and tingling" following the June 24 injection.

(e) On or about September 16, 2020, Respondent administered a third epidural injection (lumbar interlaminar) to Patient A. During a follow-up appointment two (2) weeks later, Patient A reported "0% improvement" and that the injection only made the pain worse and that she had to go to the Emergency Department "due to severe pain." Patient A also reported having numbness "all over her left lower extremity, weakness, burning and cold sensation."

[1] For patient privacy purposes, Patient A's true name has not been used in the instant Accusation and Petition to Revoke Probation to maintain patient confidentiality. The patient's identity is known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery in accordance with Government Code section 11507.6.

(f) Chart documentation completed by Respondent involving the three (3) epidural injections he gave to Patient A were incorrect, inaccurate and/or incomplete including, but not limited to, consent forms incorrectly identifying the procedure, inaccurately recording information, and missing dates recorded by the physician performing the procedure (i.e., Respondent).

11. Patient B[2]

(a) Between in or around September of 2020 and in or around January 2022, Respondent treated Patient B for pain management and related medical issues.

(b) During this timeframe, Respondent performed multiple surgical procedures to address Patient B's pain including cervical lumbar radiofrequency ablations.

(c) During this same timeframe, chart documentation completed by Respondent involving the care and treatment he gave to Patient B were incorrect, inaccurate and/or incomplete including, but not limited to, repeated discrepancies between the consent form and operative notes as to what type of procedure was performed and/or which side it was performed on; forms do not clearly describe the name of the procedure that was to be performed; and forms do not clearly include the name of the physician performing the procedure (i.e., Respondent).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent has subjected his Physician's and Surgeon's Certificate No. A 72430 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient A, as more particularly alleged hereinafter:

13. Paragraph 10, subparagraphs (a) – (e), above, are hereby incorporated by reference and realleged as if fully set forth herein.

[2] For patient privacy purposes, Patient B's true name has not been used in the instant Accusation and Petition to Revoke Probation to maintain patient confidentiality. The patient's identity is known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery in accordance with Government Code section 11507.6.

14. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to, the following:

(a) Respondent failed to utilize interventional pain procedures that did not present an unnecessary danger to Patient A, in light of the insignificant degree of pain relief and the limited duration of pain relief reported by Patient A, in response to the initial rounds of epidural injections.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 72430 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A and B, as more particularly alleged hereinafter:

16. Paragraphs 10 and 11, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

17. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 72430 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A and B, as more particularly alleged in paragraphs 10 and 11, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

CAUSE TO REVOKE PROBATION

(Failure to "Obey All Laws")

18. At all times after the effective date of the Board's Decision and Order in Case No. 800-2014-009588, Probation Condition No. 8 provided:

> 8. 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.

19. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 8, referenced above, in that Respondent violated sections 2227, 2234 and 2266, of the Code, as more particularly alleged in paragraphs 10 through 17, 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 72430, issued to Respondent John Xiao-Jiang Qian, M.D.;

2. Revoking, suspending or denying approval of Respondent John Xiao-Jiang Qian, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent John Xiao-Jiang Qian, M.D., to pay the Board the costs of the investigation and enforcement of this case;

4. Ordering Respondent John Xiao-Jiang Qian, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: 2/16/2024

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

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