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

In the Matter of the Accusation Against: Ashok Lall, M.D. Physician's and Surgeon's Certificate No. A 64108 Respondent.	Case No.: 800-2021-076406

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 24, 2025.

IT IS SO ORDERED: December 26, 2024.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle Anne Bholat, M.D., Chair
Panel A

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **ASHOK LALL, M.D.** **25958 Coleridge Place** **Stevenson Ranch, CA 91381** **Physician's and Surgeon's Certificate No. A 64108,** Respondent.	Case No. 800-2021-076406 OAH No. 2024041004 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Ashok Lall, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, whose address is 355 South Grand Avenue, Suite 1750 Los Angeles, California 90071-5162.

3. On or about December 12, 1997, the Board issued Physician's and Surgeon's Certificate No. A 64108 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-076406, and will expire on July 31, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-076406 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 20, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-076406 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2021-076406. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-076406, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2021-076406, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 64108 to disciplinary action.

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

CONTINGENCY

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

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

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-076406 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.

15. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 64108 issued to Respondent Ashok Lall, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months on the following terms and conditions:

1. EDUCATION COURSE. Within sixty (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 forty (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 sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within sixty (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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within sixty (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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

4. CLINICIAN-PATIENT COMMUNICATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in a clinician-patient communication course 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 clinician-patient communication course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A clinician-patient communication 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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

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

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

this Decision.

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

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

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

If the monitor resigns or is no longer available, Respondent shall, within five (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 fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (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.

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

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

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

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

10. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $40,025.00 (Forty Thousand Twenty-Five Dollars and No Cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 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.

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

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

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (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; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 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.

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

be extended until the matter is final.

17. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his 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.

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

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2021-076406 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, Derek F. O'Reilly-Jones. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10/7/24

ASHOK LALL, M.D.
Respondent

I have read and fully discussed with Respondent Ashok Lall, 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: 10/07/2024

DEREK F. O'REILLY-JONES
Attorney for Respondent

ENDORSEMENT

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

DATED: 10/08/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-076406

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

In the Matter of the Accusation Against: **ASHOK LALL, M.D.** **25958 Coleridge Place** **Stevenson Ranch, CA 91381** **Physician's and Surgeon's Certificate No. A 64108,** Respondent.	Case No. 800-2021-076406 **ACCUSATION**

PARTIES

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

2. On or about December 12, 1997, the Board issued Physician's and Surgeon's Certificate Number A 64108 to Ashok Lall, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2025, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

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

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the

physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

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

6. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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

STATUTORY PROVISIONS

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.

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

8. Section 2242 of the Code states:

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

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

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

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

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

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

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

medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

9. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

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

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

10. 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.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

11. Section 4021 of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

12. Section 4022 of the Code provides:

"Dangerous drug" or "dangerous device" means 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.

COST RECOVERY

13. Section 125.3 of the Code states:

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

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

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

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

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

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

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

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

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

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

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

DRUG DEFINITIONS

14. As used herein, the terms below will have the following meanings:

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety, and muscle spasms, and to prevent seizures. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses, and are used for a limited time period. Benzodiazepines are commonly misused and taken in combination with other drugs of abuse. Commonly prescribed benzodiazepines include alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin), diazepam (Valium), and temazepam (Restoril). Risks associated with use of benzodiazepines include: 1) tolerance and dependence, 2) potential interactions with alcohol and pain medications, and 3) possible impairment of driving. Benzodiazepines can cause dangerous deep unconsciousness. When combined with other CNS depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases. Before initiating a course of treatment, patients should be explicitly advised of the goal and duration of benzodiazepines use. Risks and side effects, including risk of dependence and respiratory depression, should be discussed with patients. Alternative treatment options should be discussed. Treatment providers should coordinate care to avoid multiple prescriptions for this class of drugs. Low doses and short durations should be utilized.

"CURES" means the California Department of Justice, Bureau of Narcotic Enforcement's Controlled Substance Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV and V controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of controlled substances. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Diazepam," also known by the brand name Valium, is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is also a benzodiazepine. It can produce psychological and physical dependence and should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1), and is a dangerous drug as designated in Code section 4022.

"Hydrocodone," also known by the brand names Norco and Vicodin, is a semisynthetic opioid analgesic similar to but more potent than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II

controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"Hydrocodone acetaminophen," also known by the brand name Norco, is an opioid pain reliever. It has a high potential for abuse. In 2013, hydrocodone-acetaminophen was a Schedule III controlled substance. Commencing on October 6, 2014, hydrocodone-acetaminophen became classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"Opioids" are a class of drugs used to reduce pain, including anesthesia, and include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription. Many prescription opioids are used to block pain signals between the brain and the body and are typically prescribed to treat moderate to severe pain. Side effects can include slowed breathing, constipation, nausea, confusion, and drowsiness. Opioids are highly addictive, and opioid abuse has become a national crisis in the United States. Combining opioids with other drugs or alcohol can be fatal, therefore patients should be cautioned about the simultaneous ingestion of alcohol, benzodiazepines, or other CNS depressant drugs during treatment with opioids.

"Phentermine" is a stimulant similar to an amphetamine. It acts as an appetite suppressant by affecting the central nervous system. It is used medically as an appetite suppressant for short term use, as an adjunct to exercise and reducing calorie intake. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(f)(4), and a dangerous drug pursuant to Code section 4022.

"Carisoprodol" is a muscle-relaxant and sedative. It is sold under the brand name "Soma." It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he engaged in gross negligence in the care and treatment of Patients 1 and 2.[1] The circumstances are as follows:

Patient 1:

16. On or about January 21, 2019, Patient 1, a then 71-year-old male, first began treating with Respondent. Patient 1 was noted to have a known history of anxiety, chronic pain syndrome with low back and left shoulder pain, dry mouth, pellet gun injury to the feet, and hypertension. Respondent did not document the probable cause(s) of and the circumstances surrounding the

[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1 and 2.

onset of the patient's chronic pain syndrome. Respondent noted that the patient's blood pressure reading was 144/84.[2] Respondent did not document a physical examination. Respondent noted that Patient 1 was taking Norco every six hours as needed for chronic pain syndrome and diazepam for anxiety. Respondent had the patient sign an Agreement for Long Term Controlled Substance Prescriptions and discussed the need to try to wean the patient off narcotics to see if the patient could be comfortable on a lower dose. Respondent refilled the patient's Norco prescription for his chronic pain syndrome and instructed him to continue the diazepam for anxiety.

17. On or about February 18, 2019, Patient 1 presented to Respondent for a medication review. Respondent noted that Patient 1 was taking Norco for chronic pain to his shoulders and bilateral upper extremities. Respondent also noted that the patient complained of lower back pain. Patient 1's blood pressure was noted to be 138/78. Respondent documented a limited shoulder examination but did not document a back examination. Respondent noted that Patient 1 was unable to wean "off of the pain medications." Respondent noted that Patient 1 was getting cortisone injections to both shoulders by another physician but did not document any other analgesic alternatives. Respondent's assessment was chronic pain syndrome, pain of the left shoulder region and lower back pain. Respondent prescribed 170 tablets of Norco to be taken every 4 to 6 hours as needed for pain. The patient was instructed to follow up in one month.

18. On or about March 18, 2019, Patient 1 returned to Respondent for a medication review. Respondent again noted that the patient was taking Norco for chronic pain to the shoulders and bilateral upper extremities and that the patient continued to complain of lower back pain. At this visit, Patient 1 requested 180 tablets of Norco. The patient also reported that he was taking diazepam "up to 3 times per day" for anxiety and requested a refill. Respondent documented a blood pressure reading of 139/88. Respondent also noted in the Physical Examination section of his note that the patient had full range of motion to all extremities.

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[2] A normal blood pressure reading is less than 120 systolic and less than 80 diastolic. An elevated blood pressure is systolic reading of 120 to 129 ~~systolic~~ and less than 80 ~~diastolic.~~ Stage 1 hypertension is a systolic reading of 130 to 139 or diastolic reading of 80 to 89. Stage 2 hypertension is a systolic reading of at least 140 or diastolic reading of at least 90.

Respondent's assessment was chronic pain, lower back pain, anxiety, and left shoulder pain. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

19. On or about April 15, 2019, Patient 1 presented to Respondent for a medication review. At that time, Respondent documented that the patient should consider left shoulder surgery and that the patient refused. Respondent again advised Patient 1 to "wean (the) Norco as tolerated." Respondent noted a blood pressure of 165/77. No physical examination was documented. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

20. On or about May 13, 2019, Patient 1 presented to Respondent for a medication review. At that time, Respondent noted a blood pressure of 157/75. In the Review of Systems section of the note, Respondent noted that the patient denied depression. In the Physical Examination section of the note, Respondent documented that the patient was depressed. Respondent did not note the circumstances surrounding the depression. Respondent referred Patient 1 to "Psych." Respondent also recommended that the patient use Tylenol as an alternative to Norco. Respondent assessed Patient 1 with chronic pain syndrome, lower back pain and left shoulder pain. There were no physical examination findings to support the assessment and the Review of System section of the note reflected that the patient was without musculoskeletal pain. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

21. On or about June 10, 2019, Patient 1 was seen by Respondent for a medication review. Respondent recommended physical therapy and surgical intervention. Patient 1 declined both recommendations. Respondent advised Patient 1 to use Norco for severe pain only and to use Tylenol otherwise. Patient 1's blood pressure was documented to be 142/68. Respondent's examination of the patient's back was noted to be benign. There was no specific examination of the shoulder documented. There was no follow up regarding the depression documented at the time of the prior visit. In both the review of systems and physical examination section, Respondent noted no depression. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

22. On or about July 8, 2019, Patient 1 was seen by Respondent for a medication review. At that time, Respondent recommended that the patient "wean Norco as tolerated" and to use it

for severe pain only. There was no documentation reflecting that Respondent provided Patient 1 with a structured schedule to wean off Norco. Respondent assessed Patient 1 with chronic pain syndrome, lower back pain and left shoulder pain. There were no physical examination findings to support the assessment[3] and the Review of System section of the note reflected that the patient was without musculoskeletal pain. Respondent documented a blood pressure reading of 134/84 and noted that it was "a little high." Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

23. On or about August 15, 2019, Patient 1 presented to Respondent for a medication review. Respondent's documentation of the visit was similar to prior visits. Respondent noted that Patient 1's blood pressure reading of 154/81 was "high again" and that Patient 1 will "monitor blood pressures at home" and use a "low salt diet." Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

24. On or about August 29, 2019, Patient 1 presented to Respondent for another medication review. On this date, Respondent recorded two different sets of "Assessments/Plan" notes with contradictory documentation. The patient's blood pressure was documented as being "well-controlled" and as being "high today." The documentation under the Review of Systems and Physical Examination sections were similar to the documentation for prior visits. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

25. On or about October 28, 2019, Patient 1 was seen by Respondent for a medication review. Respondent continued the patient's medication management. The patient had a blood pressure reading of 146/71. Respondent noted that the patient had benign essential hypertension. Respondent documented that Patient 1 should be on a low salt diet. He also instructed the patient to monitor his blood pressures at home, keep a record of the readings, and provide Respondent with the readings. With respect to preventative care, Respondent offered an abdominal ultrasound to screen for aneurysm and an arterial Doppler of the lower extremities to screen for blockages given that the patient had a history of hypertension and was 71 years old. Respondent assessed Patient 1 with chronic pain syndrome, lower back pain and left shoulder pain. There

[3] The physical examination section of the note appears to the same as the previous month's note.

were no physical examination findings to support the assessment and the Review of Systems section of the note reflected that the patient was without musculoskeletal pain. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

26. On or about February 18, 2020, Patient 1 saw Respondent for a medication review. Although there ~~is~~ no blood pressure readings documented in Physical Examination section of the note, in his assessment, Respondent noted that the patient's systolic pressure was 150 and that the patient had "benign essential hypertension." Respondent again noted that the patient was instructed to keep a record of his blood pressure readings taken at home and provide a copy of the readings to Respondent. There was no documentation of prior home readings after Respondent previous requested the home readings. Respondent assessed Patient 1 with chronic pain syndrome and lower back pain. There were no physical examination findings to support the assessment and the Review of Systems section of the note reflected that the patient was without musculoskeletal pain. Respondent prescribed 90 tablets of diazepam and 180 tablets of Norco.

27. Patient 1's CURES Report reflects that he filled monthly prescriptions of 90 tablets of diazepam and 180 tablets of Norco prescribed by Respondent between February and July 2020.

28. On or about July 16, 2020, Respondent saw Patient 1 for a medication review. Patient 1 requested that Respondent increase Norco to five times a day. Respondent documented that he again discussed with the patient that his pain medications should be managed by a pain management specialist. Respondent further documented "I FEEL THE PATIENT'S PAIN MEDICATIONS NEED TO BE WEANED. PATIENT ALSO TAKES DIAZEPAM AND HAS BEEN EDUCATED ABOUT THE POSSIBILITY OF RESPIRATORY DEPRESSION FROM THE COMBINATION. PATIENT ALSO ADVISED TO SEE PSYCHIATRY FOR HIS DIAZEPAM."[4] Respondent prescribed 60 tablets of diazepam and 120 tablets of Norco.[5] Although there was no diastolic blood pressure reading documented, Respondent noted that Patient 1's systolic pressure was 150. Respondent again noted that the patient had "benign

[4] Patient 1's CURES report reflects that he had filled Norco by pain management physician, Dr. D.K. on June 5, 2020, and July 2, 2020. This is not noted by Respondent in the patient's chart.

[5] Respondent continued Patient 1 on Norco and diazepam until March 2021 at which time Patient 1's controlled substances were thereafter prescribed by a family practice physician, Dr. A.M.

essential hypertension."

29. On or about August 7, 2020, Patient 1 saw Respondent for a medication review. Respondent documented two different sets of vital signs. Under the Physical Examination section, Respondent noted that the patient's blood pressure reading was 167/78 and his weight was 157 pounds. Under the Assessment section, Respondent noted that the patient's blood pressure was 161/68 and his weight was 258. Respondent documented his recommendation of "low salt diet" and "continue to monitor at home." Respondent assessed Patient 1 with chronic pain syndrome and lower back pain. There were no physical examination findings to support the assessment and the Review of Systems section of the note reflected that the patient was without musculoskeletal pain. Respondent prescribed 60 tablets of diazepam and 120 tablets of Norco.

30. On or about September 4, 2020, Patient 1 was seen by Respondent for a medication review. Respondent documented a blood pressure reading of 151/71. Respondent noted that the patient was on a "low salt diet" and to "[continue] to monitor at home." Respondent assessed Patient 1 with chronic pain syndrome and lower back pain. There were no physical examination findings to support the assessment and the Review of Systems section of the note reflected that the patient was without musculoskeletal pain. Respondent prescribed 60 tablets of diazepam and 120 tablets of Norco.

31. On or about October 5, 2020, Patient 1 was seen by Respondent for a medication review. Respondent documented that a letter was given to Patient 1 "... stating [Patient 1] needs to see psych dr before next visit or meds (diazepam) will not be refilled." There was no blood pressure reading documented. Respondent assessed Patient 1 with chronic pain syndrome and lower back pain. There were no physical examination findings to support the assessment and the Review of Systems section of the note reflected that the patient was without musculoskeletal pain. Respondent prescribed 60 tablets of diazepam and 120 tablets of Norco.

32. On or about November 3, 2020, Patient 1 was seen by Respondent for a medication review. Respondent again documented that the patient needed to be seen by "psych" before the next visit or Respondent would not fill the diazepam prescription, yet, Respondent refilled Patient 1's diazepam that same day. Respondent again assessed Patient 1 with chronic pain syndrome

and lower back pain. There were no physical examination findings to support the assessment and the Review of Systems section of the note reflected that the patient was without musculoskeletal pain. Respondent continued the patient on Norco for the chronic pain syndrome. Also at this visit, Respondent documented that Patient 1 had syncope under the Assessment/Plan section without documentation regarding the circumstances of the syncope or pre-syncope. Respondent noted "sync/collapse discussed with patient in detail, patient is having balancing issues, continue to monitor."

33. Patient 1's subsequent visits with Respondent, from December 20, 2020 through April 1, 2021, were virtual telehealth visits. Respondent's documentation of these visits ~~are~~ handwritten and somewhat illegible. During this timeframe, Respondent continued to prescribe approximately 120 to 180 tablets of Norco and approximately 60 to 90 tablets of diazepam to Patient 1 on a monthly basis.

34. On or about March 17, 2021, Patient 1 had a telehealth visit with Respondent at which time Respondent noted that the patient had questions about Respondent's pain management referral. Respondent noted that Patient 1 had a past medical history of syncope, dizziness and leg pain. With respect to Patient 1's history of present illness, Respondent noted that Patient 1 had no fever, cough, shortness of breath or chest pain. With respect to Patient 1's Review of Systems, Respondent noted that it was negative ~~expect~~ for the history of present illness. In the Physical Exam section of the chart, Respondent noted "chart reviewed." There is no documented blood pressure reading. Respondent's diagnosis was syncope and collapse, pain in leg, and dizziness and giddiness. Respondent's assessment and plan was that the syncope was stable, there were no new issues regarding the pain in the leg, and the patient was "doing ok" with the dizziness stable.[6]

35. On or about March 18, 2021, Patient 1 had a telehealth visit with Respondent to follow up on Patient 1's chronic pain. The patient was noted to be anxious about his upcoming pain management appointment. Respondent's diagnosis was noted to be anxiety, chronic pain

[6] At the time of Respondent's Board interview, he stated that the syncope was more like a vasovagal attack. Respondent did not document this conclusion in Patient 1's medical records nor did he evaluate Patient 1 for vasovagal syncope.

syndrome and lower back pain. There was no reference to the March 17, 2021 syncope episode.

36. On or about March 25, 2021, Patient 1 had a telehealth visit with Respondent to follow up regarding the pain management referral. The note is somewhat illegible. Respondent appears to document that the patient is being weaned off of diazepam and Norco, that the patient needs to follow the recommendation made by the pain management physician and that the patient has hypertension. No blood pressure readings are documented.

37. On or about March 29, 2021, Patient 1 had a telehealth visit with Respondent regarding medication compliance. The note is somewhat illegible. With respect to the Physical Examination section of the note, Respondent documented "chart reviewed." Respondent's assessment was chronic pain syndrome, hypertension, narcotic dependence, left shoulder pain and anxiety. No blood pressure readings are documented.

38. On June 15, 2021, Respondent officially terminated the doctor/patient relationship with Patient 1.

Use of Opiates in Non-Malignant Pain Management.

39. When prescribing opiates in the management of non-malignant pain on an ongoing basis, the standard of care requires that the physician evaluate safe prescribing elements, which includes assessing whether the pain affects the patient's activities and the patient's response of the opiates, as it relates to performance of activities, the level of analgesia response to the opiates, the presence or absence of adverse effects of the opiates, whether there is aberrant behavior, and the patient's affect while on the opiates. While not all elements must be evaluated at every visit or encounter, one or more of these elements should be addressed when there is an ongoing prescribing of opiates.

40. During Respondent's care and treatment of Patient 1, he failed to appropriately document the details of Patient 1's pain and Patient 1's response to treatment. On multiple occasions, Respondent documented that Patient 1's left shoulder pain was "stable," while also documenting that Patient 1 was "still having severe pain" and suffered from chronic pain syndrome. Respondent's documentation of the patient's symptoms was conflicting and contradictory. Respondent noted in his review of Patient 1's systems that the patient was without

musculoskeletal pain on May 13, 2019, July 8, 2019, August 29, 2019, October 28, 2019, February 18, 2020, August 7, 2020, September 4, 2020, October 5, 2020, and November 3, 2020. Respondent's shoulder and back examinations do not justify the continued use of opioids. Respondent failed to describe Patient 1's activities while on and off of opioids. Respondent failed to document specific historical details about the patient's pain to justify the use of opiates. Respondent failed to document specific physical examination details to justify the use of opiates. Respondent's failure to appropriately evaluate for the use of opiates in non-malignant pain management of Patient 1 is an extreme departure from the standard of care.

Evaluation of Syncope

41. A diagnosis and assessment of syncope requires that the physician perform an evaluation and work up of the cause of the syncope, provide treatment to address the syncope, and if necessary, provide the patient with a referral for further care and treatment of the syncope. Syncope among elderly patients with untreated and unmonitored hypertension warrants an expeditious work up and treatment, even during the COVID pandemic. An undiagnosed cause for syncope in an elderly man has substantial clinical implications to the patient if the pathophysiology is cardiac and/or cerebrovascular.

42. Respondent failed to detail the circumstances surrounding Patient 1's syncope reported on March 17, 2021, and failed to follow up regarding the syncope at the patient's subsequent telemedicine visits. Respondent failed to document the need to work up Patient 1's syncope, collapse, dizziness, and giddiness. Respondent failed to document the possible causes of the syncope, collapse, dizziness, and giddiness. Respondent failed to document that he warned Patient 1 not to operate a motorized vehicle while the syncope was being worked up and treatment, if necessary, was to be done. Respondent also failed to refer Patient 1 to the emergency department for further evaluation since his encounter with Patient 1 was a virtual visit. Respondent's failure to properly evaluate Patient 1's syncope episode is an extreme departure from the standard of care.

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Evaluation of Hypertension

43. The standard of care requires that the physician diagnose, manage, and treat a patient with hypertension. There are substantial and irreversible clinical implications if uncontrolled hypertension is not managed with goal-directed therapy. A patient with hypertension should be evaluated for end-organ damage, presence or established cardiovascular or kidney disease, presence or absence of other cardiovascular risk factors, lifestyle factors that could potentially contribute to hypertension, and whether there were potential interfering substances such as chronic use of non-steroidal anti-inflammatory drugs (NSAIDs). It is reasonable to treat hypertension without pharmacologic intervention for approximately three to six months after initial diagnosis to allow for a course of diet, exercise, and self-monitoring. Pharmacologic intervention, along with non-pharmacologic measures, should be considered when the patient has a systolic reading of 130 or greater or a diastolic reading of 80 or greater and one or more of the ~~of the~~ following features: established clinical cardiovascular disease; Type 2 diabetes mellitus; chronic kidney disease; age 65 year or older; or an estimated 10-year risk of atherosclerotic cardiovascular disease of at least ten percent.

44. Respondent failed to properly manage Patient 1's hypertension. Patient 1 had known hypertension and Respondent failed to determine when it had been initially diagnosed. Respondent failed to consistently document Patient 1's blood pressure readings at the time of Patient 1's in-person and telemedicine visits. Respondent failed to address some of the documented high blood pressure readings. Respondent documented on October 28, 2019, and February 18, 2020, that Patient 1 was to "monitor blood pressures at home," yet, he failed to document and assess any of Patient 1's at-home blood pressure readings. Respondent failed to evaluate Patient 1 for end-organ damage, presence or established cardiovascular or kidney disease, presence or absence of other cardiovascular risk factors, lifestyle factors that could potentially contribute to hypertension, and whether there were potential interfering substances such as chronic use of NSAIDs. Respondent failed to document the need for pharmacologic intervention in addition to the "low-salt diet" and "continue to monitor" treatment and management of Patient 1's hypertension. This is an extreme departure from the standard of care.

Patient 2:

45. On or about January 14, 2019, Patient 2, a then 53-year-old female, presented to Respondent with complaints of neck pain as well as ongoing lower and upper back pain. Respondent noted that the patient was being seen for a medication review. Patient 2 was noted to be 51.5 inches tall, weighed 142 pounds, and had a body mass index (BMI) of 37.64.[7] Her blood pressure reading was 130/90. Respondent did not document the details of the patient's complaints of pain. Respondent's documented a benign physical examination. No spinal tenderness was noted. Respondent's assessment was back pain, lumbar spondylosis, improved muscle spasms of the neck and the patient was overweight. Respondent refilled the patient's Norco prescription of 90 tablets. He noted that the patient was to continue using Norco for her back pain but to "wean Norco slowly." Respondent also recommended diet and exercise. Under the patient's medication list, Respondent noted that the patient was taking phentermine for weight management and carisoprodol for her neck pain.

46. Patient 2 was seen by Respondent on or about February 28, 2019 for a medication review. At that time, Patient 2 complained of neck and back pain. Respondent documented that the patient's height was 61 inches (~~10~~ 5 inches taller than her last visit). Her weight had not changed from the prior visit. Patient 2's BMI was noted to be 26.83. Respondent did not document the details of the patient's complaints of pain. Respondent's physical examination was exactly the same as the exam documented at the time of the patient's prior visit. Respondent's assessment was the same as the prior month's assessment: back pain, lumbar spondylosis, improved muscle spasms of the neck, and that the patient was overweight. Respondent refilled the patient's Norco prescription of 90 tablets. He again noted the need to slowly wean the patient's Norco down. Respondent also recommended diet and exercise and prescribed a 30 day supply of phentermine.

47. On or about April 5, 2019, Patient 2 was seen by Respondent for a medication review. Respondent noted that Patient 2 had complaints of neck and back pain and that she had lost about

[7] BMI is a measure of body fat based on height and weight. A BMI less than 18.5 is considered underwent. A BMI of 18.5 to 24.9 is considered normal. A BMI of 25 to 29.9 is considered overweight. A BMI of 30 or greater is considered obese.

6 to 7 pounds. Respondent noted a blood pressure reading of 150/88 and that the patient weighed 137 pounds, and had a BMI of 25.88. Respondent's documented physical examination findings appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck, and that the patient was overweight. Respondent prescribed 90 tablets of Norco, 60 tablets of carisoprodol, and 30 tablets of phentermine. He noted that the patient was "weaning Norco as tolerated."

48. On or about May 13, 2019, Patient 2 returned to see Respondent for a medication review. Respondent noted that Patient 2 had complaints of neck and back pain. Respondent noted a blood pressure reading of 155/78 and that the patient weighed 141 pounds, and had a BMI of 26.64. Respondent's documented physical examination findings appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed. He noted that the patient was "weaning Norco as tolerated."

49. Patient 2's next documented visit with Respondent took place on or about August 1, 2019.[8] Respondent noted that Patient 2 had complaints of neck and back pain with no new complaints. Respondent noted a blood pressure reading of 151/89 and that the patient weighed 144 pounds and had a BMI of 27.21. Respondent's documented physical examination findings appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck that were doing better, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed. Respondent noted that the patient was "weaning Norco as tolerated."

50. Patient 2's next documented visit with Respondent took place on or about October 21, 2019.[9] Respondent noted a blood pressure reading of 146/83 and that the patient weighed 148

[8] Between the May 2019 visit and August 2019 visit, Respondent continued to prescribe 90 tablets of Norco, 60 tablets of carisoprodol, and 30 tablets of phentermine on a monthly basis.

[9] Between the August 2019 visit and October 2019 visit, Respondent continued to prescribe 90

pounds, and had a BMI of 27.96. Respondent's documented physical examination findings appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck that were doing better, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed. Respondent again noted that the patient was "weaning Norco as tolerated."

51. Patient 2's next documented visit with Respondent took place on or about July 2, 2020.[10] Respondent noted a blood pressure reading of 146/85 and that the patient weighed 149.4. Respondent's documented review of systems and physical examination findings appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck that were doing better, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed. Respondent again noted that the patient was "weaning Norco as tolerated" and that he advised the patient to "take about 2 Norco a day.

52. Patient 2 presented to Respondent on or about August 3, 2020, for a medication review. Respondent noted a blood pressure reading of 141/85 and that the patient weighed 150, with a BMI of 28.34. Respondent's physical examination findings again appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck that were doing better, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed. Respondent again noted that the patient was "weaning Norco as tolerated" and that he advised the patient to "take about 2 Norco a day.

53. Patient 2 presented to Respondent on or about September 1, 2020, for a medication review. Respondent noted a blood pressure reading of 150/89 and that the patient weighed 149. Respondent's physical examination findings appear to have been copied from the prior visit.

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tablets of Norco, 60 tablets of carisoprodol, and 30 tablets of phentermine on a monthly basis.

[10] Between the October 2019 visit and July 2020 visit, Respondent continued to prescribe 90 tablets of Norco, 60 tablets of carisoprodol, and 30 tablets of phentermine on a monthly basis.

Respondent's assessment was lumbar spondylosis, muscle spasms of the neck that were doing better, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed.

54. Patient 2 presented to Respondent on or about October 26, 2020, for a medication review. No vital signs were recorded. Respondent's physical examination findings again appear to have been copied from the prior visit. Respondent's assessment was lumbar spondylosis, muscle spasms of the neck that were doing better, and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed. He also noted that he advised the patient to lose weight.

55. On or about June 15, 20201, Patient 2 saw Respondent via a telehealth visit.[11] Respondent noted that no medical physical exam was performed during the telehealth visit and that he had reviewed Patient 2's previous physical examination findings. Respondent's assessment was stable muscle spasm of the back, stable spondylosis and that the patient was overweight. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed.

56. Patient 2's next documented visit with Respondent took place on or about July 12, 2021, via telehealth. Respondent again noted that no medical physical exam was performed during the telehealth call and that he had reviewed Patient 2's previous physical examination findings. Respondent's assessment was stable muscle spasm of the back, menopause, and that the patient was overweight. Respondent noted checking the patient's CURES Report. He also noted that Patient 2's risk complications was high without specifying why the patient was at high risk. Respondent continued the patient on Norco, carisoprodol, and phentermine at the same doses as previously prescribed.

Use of Opiates in Non-Malignant Pain Management.

57. During Respondent's care and treatment of Patient 2, he failed to appropriately document the details of Patient 2's pain. Respondent failed to describe Patient 2's activities while

[11] Between the October 2020 visit and June 2021 visit, Respondent continued to prescribe 90 tablets of Norco, 60 tablets of carisoprodol, and 30 tablets of phentermine on a monthly basis.

on and off of opioids. Respondent continued Patient 2 on the same dose of Norco despite repeatedly documenting that he advised the patient to wean off of Norco. Respondent failed to document specific historical details about the patient's pain to justify the use of opiates. Respondent failed to document specific physical examination details to justify the continued use of Norco. Respondent's failure to appropriately evaluate for the use of opiates in non-malignant pain management of Patient 2 is an extreme departure from the standard of care.

Prescribing of Carisoprodol.

58. Carisoprodol is a centrally-acting skeletal-muscle relaxant to be prescribed for acute musculoskeletal spasm. Carisoprodol's active metabolite, meprobamate, is addictive. The standard of care requires that carisoprodol be prescribed in a safe manner, as needed for acute musculoskeletal spasms. Carisoprodol should not be prescribed on a continuous basis. Other medication alternatives or non-pharmacologic interventions should be considered.

59. Respondent failed to prescribe carisoprodol to Patient 2 in a safe manner. Respondent prescribed carisoprodol to Patient 2 on a regular basis from April 2019 to June 2021, rather than on an "as needed basis" for acute muscle spasms. Respondent continued Patient 2 on the same dose of carisoprodol despite documenting that Patient 2's neck muscle spasms were "improved" and "doing better." Respondent failed to consider other medications or non-pharmacologic interventions in the management of acute muscle spasms. This is an extreme departure from the standard of care.

Evaluation of Hypertension.

60. Despite Patient 2 having high blood pressure readings on every occasion that her blood pressure was taken, Respondent failed to address those abnormal readings. Respondent prescribed phentermine to Patient 2, a medication that increases blood pressure, without addressing the high blood pressure readings. Respondent failed to consider a diagnosis of hypertension. Respondent failed to consider whether the patient's high blood pressure readings were "white coat hypertension" and a result of being recorded in the clinic. Respondent failed to evaluate Patient 2 for end-organ damage, presence or established cardiovascular or kidney disease, presence or absence of other cardiovascular risk factors, lifestyle factors that could

potentially contribute to hypertension, and whether there were potential interfering substances such as chronic use of NSAIDs. Respondent failed to document the need for pharmacologic intervention. Respondent failed to follow up on the abnormal high blood pressure reading on September 2, 2020, even though the patient had an in-person visit the following month on October 26, 2020. Respondent failed to inquire as to the patient's blood pressure readings during her telemedicine visits. This is an extreme departure from the standard of care.

Prescribing of Phentermine.

61. Before prescribing phentermine for weight loss, the standard of care requires an evaluation of the patient's overall risk status, the presence of cardiovascular disease risk factors and other weight related comorbidities. Pharmacological intervention should not be considered for low risk patients. Patients with a BMI of 25 to 29.9, who do not have cardiovascular risk factors or other weight related comorbidities are low risk and should receive counseling on the prevention of weight gain, including advice on dietary habits and physical activity. Moderate risk patients are patients with a BMI of 30 to 34.9 and patients who have a BMI between 25 and 29.9 and with one or more cardiovascular risk factors. Moderate risk patients should be offered or referred to intensive, multicomponent behavioral intervention, including tools and strategies to make dietary changes, increase physical activity, and support and maintain weight loss. Pharmacological intervention may be considered for moderate risk patients.

62. Respondent failed to appropriately assess Patient 2's risk before prescribing phentermine. Given Patient 2's high blood pressure and BMI, she should have been considered at moderate risk. Respondent documented that Patient 2 needed to diet, exercise, continue phentermine, and lose weight. Respondent failed to offer or refer Patient 2 to intensive, multiple component behavioral intervention. Respondent prescribed phentermine continuously at the same dose from February 28, 2019, through June 15, 2021, and failed to assess its necessity or effectiveness. This is an extreme departure from the standard of care.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

63. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated acts of negligence in the care and treatment of Patients 1 and 2. The circumstances are as follows:

64. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

65. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

66. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1 and 2 without an appropriate prior examination and/or medical indication. The circumstances are as follows:

67. The allegations set forth in paragraphs 16 through 40, and 45 through 59, inclusive, are incorporated herein by reference as if fully set forth. During the time Respondent treated Patients 1 and 2, he failed to perform an appropriate corresponding prior examination and determine a medical indication for each dangerous drug that he prescribed to each patient.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

68. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patients 1 and 2. The circumstances are as follows:

69. The allegations set forth in paragraphs 16 through 40, and 45 through 59, inclusive, are incorporated herein by reference as if fully set forth. During the time Respondent treated Patients 1 and 2, he excessively prescribed dangerous drugs to each patient.

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FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

70. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records. The circumstances are as follows:

71. The allegations in the First Cause for Discipline, above, are incorporated herein by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 64108, issued to Respondent Ashok Lall, M.D.;

2. Revoking, suspending or denying approval of Respondent Ashok Lall, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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

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

DATED: MAR 20 2024

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

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