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

In the Matter of the First Amended Accusation Against: Michele Allegra Gomez, M.D. Physician's and Surgeon's Certificate No. A 77883 Respondent.	Case No.: 800-2019-054399

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 October 2, 2025.

IT IS SO ORDERED: September 2, 2025.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Vice Chair
Panel A

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

In the Matter of the First Amended Accusation Against:

MICHELE ALLEGRA GOMEZ, M.D.,

Physician's and Surgeon's Certificate No. A 77883

Respondent.

Agency Case No. 800-2019-054399

OAH No. 2024030563

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on May 19 through 22 and 28 and on July 9, 2025, by videoconference.

Deputy Attorney General Caitlin Ross represented complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorney Virgil F. Pryor represented respondent Michele Allegra Gomez, M.D.

The matter was submitted for decision on July 9, 2025.

FACTUAL FINDINGS

1. Respondent Michele Allegra Gomez, M.D., has held Physician's and Surgeon's Certificate Number A 77883 since February 6, 2002. At the time of the hearing, this certificate was active and was scheduled to expire on February 28, 2026. The Medical Board of California has never taken any disciplinary action against respondent.

2. Acting in his official capacity as the former Executive Director of the Board, William Prasifka filed an accusation against respondent in April 2022. Respondent returned a timely notice of defense. Complainant Reji Varghese later replaced Prasifka as the Board's Executive Director and filed a first amended accusation in April 2025.

3. Complainant seeks disciplinary action against respondent because of respondent's allegedly negligent prescribing of controlled substances to four patients between 2015 and 2019. Respondent denies having departed from the standard of care in any respect regarding these four patients.

Professional Experience

4. Respondent graduated from medical school in 2000. In 2003, she completed a residency in family medicine.

5. Respondent is licensed to practice medicine only in California. She became board-certified as a family physician in 2003, but recently has allowed this certification to lapse.

6. Between mid-2003 and mid-2022, respondent was a family physician in a small private practice in Burlingame. She retired from this practice in mid-2022 and does not intend to return to primary care medicine. Respondent testified specifically that she will never again prescribe opioid medications for outpatient use.

7. In addition to her primary care practice, and during approximately the same period, respondent provided reproductive health care at a dedicated reproductive health clinic. She participated in a program to train family medicine residents to provide early-pregnancy surgical abortions, and later in programs to provide and to train other providers in medication abortions. Respondent continued these activities until late 2024.

8. Three physicians who have known respondent since medical school (Melissa Nothnagle, M.D.; Jack Resneck, M.D.; and Megan Schwarzman, M.D.) testified and provided letters stating their high opinions of respondent's professionalism, competence, and empathy. They emphasized, from their own personal knowledge, the challenges that primary care physicians face in treating patients with complex medical needs that include chronic pain. Each of these physicians urges the Board not to discipline respondent.

9. Respondent's former colleague and supervisor, Aaron Roland, M.D., also testified in her support. Dr. Roland has known respondent for about 30 years, having met her during her family medicine residency. While they worked together, he considered respondent very careful and thorough, and believed that she delivered high-quality care. Although Dr. Roland also treated some of the patients whose care is at issue in this matter, he did not testify specifically about any of their care.

Patient A

10. Patient A had received primary medical care through respondent's medical practice for several years, beginning in 2008, before respondent herself began treating Patient A. The medical records in evidence do not show precisely when Patient A began using opioid medications for chronic pain, but do show that Patient A's opioid use began in or before 2009. Patient A had retired for disability in or before 2008, and had started using a wheelchair at about the same time. During the time period at issue in this matter (2015 to 2019), Patient A was in her middle 60s, with a long list of medical problems including severe osteoarthritis,[1] morbid obesity, and chronic obstructive pulmonary disease.

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[1] Respondent's medical records note repeatedly that although Patient A believed herself to have rheumatoid arthritis, no such diagnosis had occurred. In March 2019, Patient A saw a rheumatologist who diagnosed "inflammatory arthritis" and prescribed an immune-modifying drug (hydroxychloroquine, or Plaquenil).

COURSE OF TREATMENT

11. In 2009, Patient A used extended-release oxycodone (OxyContin),[2] as well as short-acting acetaminophen with hydrocodone (Norco).[3] She consulted a physical medicine and rehabilitation specialist, an orthopedic surgeon, and a pain management specialist in 2009, all of whom considered her opioid use reasonable under her then-current circumstances.

12. From time to time beginning in or before 2012, Patient A experienced financial challenges filling her OxyContin prescriptions. To cover these gaps in OxyContin availability, Patient A received prescriptions for methadone,[4] which was available to her at much lower cost but which she considered less effective for her than extended-release oxycodone.

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[2] Oxycodone is an opioid drug used for pain control. Oxycodone is a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(M)) and a dangerous drug (Bus. & Prof. Code, § 4022).

[3] Hydrocodone is an opioid drug used for pain control. It is commonly sold in a formulation that combines hydrocodone and acetaminophen, under the brand name Norco. Hydrocodone is a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(I)) and a dangerous drug (Bus. & Prof. Code, § 4022).

[4] Methadone is an opioid drug used for pain control and to prevent opioid withdrawal. Methadone is a controlled substance (Health & Saf. Code, § 11055, subd. (c)(14)) and a dangerous drug (Bus. & Prof. Code, § 4022).

13. Respondent re-referred Patient A to the pain management specialist in 2013. Patient A saw this provider in June 2013, and he again deemed Patient A's opioid use reasonable under her then-current circumstances. At this time, Patient A was using 240 milligrams of OxyContin and up to 60 milligrams of hydrocodone (in Norco) per day; she also was taking an anti-inflammatory medication (meloxicam). The pain management specialist counseled Patient A regarding switching safely between methadone and OxyContin when OxyContin was not available.

14. During the entire period at issue (June 2015 through August 2019), respondent prescribed the same amount of OxyContin (240 milligrams per day) and Norco (up to 60 milligrams of hydrocodone per day) each month to Patient A, except that she skipped prescribing OxyContin in some months because Patient A would not have been able to fill the prescription. Respondent or a colleague also prescribed varying amounts of methadone for Patient A, calculated to fill gaps in Patient A's OxyContin access. Finally, beginning in approximately 2017, respondent prescribed an opioid overdose reversal agent (naloxone, or Narcan) to Patient A, who kept it on hand but never used it.

15. Respondent and her colleagues also counseled Patient A repeatedly after mid-2013 to use methadone only as a substitute for OxyContin, but not to take these medications at the same time. Complainant contends that the evidence shows that Patient A did not follow this instruction, and that respondent should have known that Patient A did not follow this instruction, primarily because Patient A often filled prescriptions for OxyContin and for methadone on the same day or very close in time.

16. Patient A usually used a mail-order pharmacy for OxyContin, however, meaning that she did not receive the medication until several days after the pharmacy recorded having filled each prescription. Moreover, the amounts of medication

dispensed each year, overall, are more consistent with respondent's instructions to Patient A than with the possibility that Patient A violated these instructions by taking these medications simultaneously. Respondent and her colleagues believed that Patient A followed their instructions regarding not mixing OxyContin with methadone, and in light of all evidence this belief was reasonable.

17. Several times during Patient A's medical relationship with respondent and respondent's colleagues, Patient A consulted specialists regarding whether she would be a good candidate for surgical hip replacement. Because of her size, she was not. Patient A also explored the possibility of bariatric surgery, but specialists recommended against such surgery for her as well because of pulmonary issues.[5]

18. While receiving her primary medical care from respondent, Patient A also was in regular care with specialists including a pulmonologist, a cardiologist, and an otolaryngologist. Overall, Patient A was an active participant in her own care, making and keeping most medical appointments as her providers recommended and communicating with them frequently by telephone and email.

19. Patient A had episodic in-home physical therapy, and reported to respondent that she followed her home exercise program intermittently. Respondent encouraged Patient A on multiple occasions to try aquatic exercise, and made referrals for it, but Patient A did not go until late 2018. Once Patient A started aquatic exercise, she discovered that she enjoyed it and that it helped her lose weight and improve her comfortable mobility.

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[5] Patient A began using injectable weight-loss medication in late 2019, with success. Such medication was not available to her before 2019, however.

20. Beginning in 2017, respondent's notes from each appointment with Patient A state that respondent had reviewed a report about Patient A from the Controlled Substance Utilization Review and Evaluation System (CURES) before the appointment. Respondent identified no controlled substance prescriptions that were inconsistent with the prescriptions Patient A obtained from respondent's practice. Respondent also conducted urine drug screens approximately annually in and after 2017, with no unexpected results. Respondent's medical records show that respondent recognized Patient A's physical dependence on opioid drugs, and hoped eventually to help Patient A reduce her drug use without experiencing more pain, but identified no signs of drug misuse or diversion.

21. At an appointment in October 2017, respondent gave a written "Pain policy" to Patient A. She did not require Patient A to sign a copy of the policy, however.

22. Respondent did not conduct musculoskeletal examinations at every office visit with Patient A, because Patient A's condition was long-standing and stable. Respondent did discuss with Patient A at every or nearly every visit whether her pain management regimen was effective, how well she functioned from day to day, and what else Patient A might do to improve her mental or physical wellness. Patient A reported consistently that although opioid drugs did not eliminate her pain entirely, they reduced it reliably and enabled her to engage in her usual daily activities.

23. In mid-2019, the financial assistance program that Patient A had used to make OxyContin affordable for her ended, and she resumed using methadone. Respondent again referred Patient A to the pain management specialist who had seen her in 2009 and 2013, for guidance regarding alternative medications or pain control strategies. When Patient A saw this specialist in November 2019, she had lost about 30

pounds within the previous year and had been taking hydroxychloroquine to address potential inflammatory arthritis for about eight months. The specialist recommended under these new circumstances that she try reducing her methadone and hydrocodone doses and begin using gabapentin (a non-opioid pain control medication). Patient A continued thereafter to see this specialist for pain management.

EXPERT OPINION REGARDING CARE

24. James J. Huang, M.D., reviewed Patient A's course of treatment and testified for complainant. Dr. Huang is board-certified in internal medicine and practices outpatient primary care medicine at the Loma Linda Veterans Affairs Medical Center. He also is an assistant professor of medicine at Loma Linda School of Medicine. Dr. Huang's experience and training make him familiar with standards of care for providing primary care to complex patients who experience chronic pain.

25. In testimony and in a written report, Dr. Huang described what he considered to be multiple simple departures from the standard of care in respondent's course of treatment and medical records for Patient A. His opinions reflect poor understanding of the relevant circumstances, however. For example, he states definitively that Patient A had rheumatoid arthritis; but before March 2019, no physician had diagnosed Patient A with any form of inflammatory arthritis. He also describes Patient A inaccurately as having a "tobacco addiction"[6] and as a regular

[6] Patient A's medical records state that she smoked about half a pack of cigarettes a day for 10 to 12 years in her youth, and quit smoking in 1979.

alcohol user.[7] Dr. Huang believes that respondent rarely or never discussed Patient A's day-to-day function or pain control with Patient A, but the records show in contrast that they had such conversations at nearly every visit. Dr. Huang characterizes Patient A as having made "incessant attempts for more pain medications" and multiple "early refill requests," neither of which is true. Most importantly, Dr. Huang describes Patient A as procuring opioid drugs often from "other physicians," as if these prescriptions were unknown to respondent; but the evidence shows that between October 2012 and September 2019, Patient A obtained opioid drug prescriptions only from respondent or from other providers in respondent's medical practice.

26. Dr. Huang opines that respondent departed from the standard of care by prescribing OxyContin and methadone "concurrently" to Patient A. Because of the matters stated in Findings 12 through 16 and 25, this opinion is not persuasive.

27. Dr. Huang opines that respondent departed from the standard of care by failing to perform an "objective" assessment of opioid risks to Patient A. Because of the matters stated in Findings 11 through 13, 15, 16, and 20, this opinion is not persuasive.

28. Dr. Huang also opines that respondent departed from the standard of care by having failed to recognize Patient A's "opioid use disorder." Although Patient A was undoubtedly physically dependent on opioid drugs, given her long-term use, the matters stated in Findings 10 through 23 do not show her to have had an "opioid use disorder." Moreover, the matters stated in Findings 13, 15, 20, 21, and 23 also show

[7] Patient A reported drinking alcohol very rarely, and no evidence contradicted this report.

respondent to have recognized the risks to Patient A from her ongoing opioid regimen, and to have acted to mitigate them. Dr. Huang's opinion on this topic also is not persuasive.

29. Dr. Huang opines that respondent departed from the standard of care by failing to use urine drug screens or CURES reviews frequently enough to monitor Patient A's opioid use. In light of all matters summarized in Findings 14, 18, 20, and 25, this opinion is not persuasive.

30. Dr. Huang opines that respondent conducted and documented inadequate physical examinations of Patient A, and inadequate assessments of her day-to-day function and pain control. In light of the matters stated in Findings 10, 22, and 25, this opinion is not persuasive.

31. Dr. Huang opines that respondent departed from the standard of care by failing to have Patient A sign a pain management agreement, and by failing to ensure that Patient A had given informed consent to opioid drug use. His opinion that the standard of care between 2015 and 2019 required patient signatures on pain management agreements, even for patients who had been using stable opioid doses for many years, is not persuasive. Moreover, in light of all matters stated in Findings 10 through 23, his opinion that respondent's records do not reflect Patient A's informed consent to opioid drug treatment also is not persuasive.

Patient B

32. Patient B was born in 1987. Her mother was a patient in respondent's medical practice, and Patient B first began receiving primary care there in or before 2011. She had received drug therapy for regular migraines as well as treatment for various acute complaints.

COURSE OF TREATMENT

33. According to respondent's practice's medical records, Patient B sought care on several occasions between 2012 and 2015 for pain (in her neck, her abdomen, and her back). She ignored or rejected recommendations that she try non-drug interventions or non-addictive medications, however, or that she seek diagnostic care from a specialist.

34. Patient B saw respondent for abdominal pain in April 2013, for example. Respondent's notes from that visit note specifically that Patient B had a history of "polysubstance abuse."

Oxycodone Prescribing

35. Dr. Roland saw Patient B in April 2015, when Patient B complained of low back pain. Patient B listed several medications she claimed to have tried and asked him whether he had "something else" to prescribe. Dr. Roland recommended physical therapy, but Patient B stated that she worked for a chiropractor and would obtain similar treatment from her employer.

36. Dr. Roland prescribed oxycodone with acetaminophen (Percocet) to Patient B in May 2015. At a follow-up visit in June 2015, however, he counseled Patient B that pain medications were a "band-aid," and noted that Patient B's persistent pain complaints suggested that these medications did not seem to be helping Patient B in any event. He recommended that Patient B consult a spine specialist, but she did not.

37. Instead, in February 2016, Patient B telephoned the practice again for an appointment, stating specifically that she wished to see respondent rather than any

other practitioner. At this appointment, on February 8, 2016, Patient B complained of low back pain. She told respondent that the Percocet Dr. Roland had prescribed in 2015 was not effective, and that she had tried some of her aunt's methadone also without effect. Patient B told respondent that she wanted oxycodone alone, because the "blue ones" worked best for her.

38. Respondent's notes say that she examined Patient B and observed nothing unusual about Patient B's spine or gait. Respondent and Patient B had a "long discussion" about Patient B's options, and Patient B declined referrals to a physical therapist or a pain specialist. Respondent prescribed nabumetone, an anti-inflammatory drug. In addition, after what respondent describes as "[e]ducation" regarding "risk of addiction, development of tolerance, etc." respondent noted that she and Patient B had established a "[v]erbal pain contract . . . (no sharing, selling, using other than prescribed, or getting narcotics from any other provider, must be seen in office [every three months])." Respondent prescribed 30 5-milligram oxycodone tablets for Patient B, to be taken one per evening as needed for pain.

39. Two days later, Patient B contacted respondent by email to say that the "back medication has not helped." Respondent told Patient B that she could try taking two oxycodone tablets (10 milligrams in total) at bedtime. On February 22, 2016, two weeks after receiving the oxycodone prescription, Patient B again contacted respondent by email to say that her back pain was still severe, but that four oxycodone tablets at once (20 milligrams) "finally felt a little better." Because Patient B said she

had used all or nearly all the oxycodone respondent had prescribed on February 8, respondent prescribed more oxycodone, this time as 30 20-milligram tablets.[8]

40. Patient B filled this prescription on February 29, 2016. On March 15, 2016 (16 days later), she emailed respondent to say that she had only four tablets left and needed an early refill. Although Patient B had failed since February 8 to use oxycodone as respondent had prescribed (and although she had stated in email to respondent on March 10 that she was not taking nabumetone at all), respondent prescribed more oxycodone; this time, she prescribed 60 20-milligram tablets and advised Patient B to "keep it at no more than 2 per day."

41. Patient B did not restrict herself to two 20-milligram oxycodone tablets per day. Rather, she stated in a telephone call to respondent's office on March 24, 2016, that she sometimes took three in a day; and she stated in an email on March 29 that sometimes she took four. On March 31 (two weeks after Patient B had filled the previous prescription), respondent again prescribed 60 20-milligram oxycodone tablets to Patient B.

42. Eight days later (on April 7, 2016), Patient B telephoned respondent's practice, asking to speak with any provider except for Dr. Roland. She told nurse practitioner Lillian Nelson that she already had used about 30 of the 60 20-milligram tablets she had received on March 31, because she was taking four to five tablets (80 to 100 milligrams of oxycodone) every day. She asked for "a higher dose," and noted that she would be married over the coming weekend (April 9 and 10, 2016).

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[8] Complainant alleges that respondent prescribed four 20-milligram tablets per day (120 tablets) on this date, but the evidence does not support this allegation.

43. Respondent prescribed 14 40-milligram OxyContin tablets to Patient B, telling Patient B that she should take one tablet each morning and evening and that she also could take half of a 20-milligram oxycodone tablet "every 4-6 hours if you need it for extra pain control." Respondent warned Patient B "YOU MUST NOT DRINK ANY ALCOHOL OR USE ANY OTHER DRUGS" while taking these opioid medications, and asked Patient B to make an appointment "ASAP after your wedding."

44. Patient B emailed respondent on April 12, 2016. She stated that she had called the office to make an appointment but was refused because she owed money to the practice. In the meantime, she asked respondent to refill her oxycodone prescription, because "I think someone took them from my hotel room during my wedding."

45. Because respondent was not available on April 12, 2016, Dr. Roland answered Patient B's email. He declined on April 13 to refill her oxycodone prescription, stating "I do not feel comfortable refilling this controlled substance, certainly [not] without a face to face consultation." He also forwarded Patient B's message and his reply to respondent, with an additional note: "I would be very cautious in refilling any meds for her. So far no objective source of pain. Several concerning med seeking episodes. Admitted recreational drug use in the past. At least require unannounced drug screen at future visits."

46. Patient B came to see Nelson on April 14, 2016. Before the visit, Nelson obtained a CURES report regarding Patient B's controlled substance prescriptions over the previous year and identified only prescriptions from respondent's practice. Patient B told Nelson, however, that after losing her own medications on April 9 she had taken some "blue" pills her aunt supplied, both that evening and the next day. Nelson surprised Patient B by requesting a urine sample for drug screening. She also

scheduled Patient B for a follow-up appointment with respondent, and prescribed 30 20-milligram oxycodone tablets for Patient B's use, three per day, in the meantime.

47. Patient B's urine sample showed that she recently had used cocaine, as well as an opioid drug. Respondent, Nelson, and Dr. Roland discussed this result, and respondent noted on April 18, 2016, that she did "not feel comfortable continuing to prescribe [Patient B] pain medications as she has lied to me and to" Nelson. On April 20, 2016, however, after reviewing Patient B's recent medical history in preparation for their appointment on April 21, respondent noted that she would continue prescribing to Patient B (to address what respondent believed was "real pain"), but only after discussing "rules" with her.

48. Respondent saw Patient B on April 21, 2016, and recorded that Patient B had agreed expressly to several rules that would govern respondent's prescribing going forward:

> MUST NOT use any recreational drugs. We may check urine drug screens at random office visits.
>
> MUST see pain specialist to discuss options for pain control, regardless of co-pay.
>
> MUST call us if you feel your pain control is not adequate and that you might need to increase your dose. If you do not call first and then run out of medication early, medications might not be refilled early and you may experience withdrawal symptoms.

> MUST [follow up] in OFFICE every month until we get you on a stable regimen, then every 3 months when dose is stable.

Respondent prescribed 120 20-milligram oxycodone tablets to Patient B (no more than four, or 80 milligrams, per day), ordered magnetic resonance imaging, and referred Patient B to an interventional pain management specialist.

49. Neither respondent nor Patient B followed respondent's rules. On May 4, 2016, about three weeks later, Patient B emailed respondent to say that she had been taking "up to 7 throughout the day and don't feel any relief at all" and that she needed an early medication refill. Respondent obliged by prescribing 60 30-milligram oxycodone tablets and directing Patient B to take no more than five (150 milligrams in total) per day. Patient B then returned to see respondent on May 19, 2016, where she received a further prescription for 150 30-milligram oxycodone tablets and instructions to return not in one month but in three. Patient B also gave another urine sample that day for drug screening, which did not show any unexpected result.

50. Respondent's prescribing relationship with Patient B continued in much the same manner for the next two years. Patient B saw respondent in person on July 28, 2016, and then not again until November 3, 2016. Respondent did not obtain urine samples on either date. In the interim, Patient B escalated her oxycodone use and requested early medication refills; respondent agreed. By November 3, Patient B was receiving monthly prescriptions from respondent for 240 30-milligram oxycodone tablets (240 milligrams per day). She still had not gone to the pain management specialist, and said she could not go for financial reasons. In December 2016, based on some laboratory test results suggesting a possible explanation for Patient B's low back pain, respondent referred Patient B to a rheumatologist, who Patient B also did not

see. Respondent increased Patient B's monthly oxycodone prescription to 270 30-milligram tablets in June 2017, at their first face-to-face appointment since November 2016, but again did not obtain urine drug screening.

51. Patient B came to respondent's office on July 16, 2018, and gave a urine sample for drug screening (her first screening since May 2016). It was positive for cocaine. Dr. Roland recommended that respondent "refer [Patient B] for drug detox and discontinue prescribing opiates."

52. Respondent sent email to Patient B on July 19, 2018, telling Patient B that respondent intended to refill Patient B's "pain meds" for the next 30 days, but to refer Patient B thereafter to a pain management specialist. Her email did not include any recommendation that Patient B consider treatment for a substance use disorder.

53. Patient B replied by asking respondent to help Patient B wean herself from opioid drugs. Respondent then gave Patient B two options: (1) go to a pain management specialist, or (2) follow a 19-week taper plan that respondent would prescribe and monitor. Patient B chose the second option. For this reason, respondent continued prescribing oxycodone to Patient B, initially in amounts matching the taper plan respondent had proposed.

54. Respondent decreased Patient B's prescription from 270 to 210 milligrams of oxycodone per day over two weeks, but then tapered it more slowly than she originally had planned because Patient B complained of significant withdrawal symptoms. By mid-October 2018, respondent had reduced Patient B's prescription to 120 milligrams of oxycodone per day. Patient B did not fill any oxycodone prescriptions from respondent after October 15, 2018.

55. On December 6, 2018, Patient B's mother telephoned respondent. According to respondent's note regarding this conversation, Patient B's mother told respondent that Patient B had entered a Kaiser Permanente substance use disorder treatment program and had begun using Suboxone (buprenorphine with naloxone) for medication-assisted treatment of her opioid use disorder.

56. Respondent's notes regarding Patient B attribute Patient B's reluctance to follow respondent's recommendations for diagnostic specialty care, and respondent's reluctance to insist on regular urine drug screens, to Patient B's financial challenges. During the period between February 2016 and October 2018 when respondent prescribed opioid medications to Patient B, however, respondent's records mention that Patient B took several international trips. Patient B also told respondent on at least one occasion that paying out-of-pocket for opioid medications cost Patient B more than $300 per month. Finally, in January 2018 Patient B told respondent that she believed she might have health coverage at Kaiser Permanente through her husband, but professed not to have time to confirm this coverage or to establish care there.

Zolpidem Prescribing

57. At her appointment on February 8, 2016, Patient B also complained of insomnia, which she attributed to "chronic back pain and stress." She asked respondent to prescribe zolpidem (Ambien)[9] to her, because she had used it before successfully. Respondent did so, prescribing 30 5-milligram zolpidem tablets and

[9] Ambien is a brand name for zolpidem, a hypnotic drug used as a sleep aid. It is a controlled substance (Health & Saf. Code, § 11057, subd. (d)(32)) and a dangerous drug (Bus. & Prof. Code, § 4022).

instructing Patient B not to take them on the same evenings that Patient B took oxycodone.

58. Despite Patient B's rapidly escalating oxycodone prescriptions (as described above in Findings 39 through 43 and 48 through 50), respondent or her colleagues prescribed zolpidem to Patient B again in June 2016, August 2016, October 2016, and December 2016 (all 30 5-milligram tablets). Patient B filled another zolpidem prescription from respondent in December 2017, and more zolpidem prescriptions from respondent's colleagues (although not from respondent herself) in 2018.

EXPERT OPINIONS REGARDING CARE

59. Dr. Huang's opinions regarding respondent's care for Patient B reflect a reasonably accurate understanding of Patient B's treatment history.

60. Respondent presented competing expert testimony from Gregory R. Polston, M.D. Dr. Polston is a pain management specialist, not a primary care provider. Nevertheless, because of his training and experience, which includes receiving referrals from primary care providers and collaborating with them on patient care, Dr. Polston is familiar with standards of care for providing primary care to complex patients who experience chronic pain.

61. Dr. Polston's opinions regarding respondent's care for Patient B do not reflect careful attention to Patient B's treatment history. His failure to analyze the most significant facts about Patient B (as summarized below in Findings 70 and 71) undermines the persuasiveness of all his opinions regarding respondent's care for her.

62. Dr. Huang opines that respondent did not perform a thorough or adequate physical examination of Patient B on February 8, 2016. The factual basis for

this opinion is unclear, because Dr. Huang also states that respondent took a "thorough history" of Patient B's back pain and because respondent's notes state specifically that respondent did examine Patient B's spine. This opinion is not persuasive.

63. Dr. Huang opines as well that respondent committed a simple departure from the standard of care by failing to refer Patient B to an orthopedic specialist. Dr. Roland already had recommended a spinal specialist to Patient B, however (as noted in Finding 36), and Patient B declined respondent's offer to refer Patient B to a pain management specialist. In light of these facts, this opinion also is not persuasive.

64. Dr. Huang opines that respondent committed a simple departure from the standard of care by prescribing oxycodone to Patient B before having her try non-opioid medications. Dr. Polston disagrees, pointing out that Patient B's records showed her already to have tried numerous non-opioid medications.

65. On this issue, Dr. Huang's opinion is more persuasive than Dr. Polston's. Dr. Polston points to the 2014 Medical Board of California "Guidelines for Prescribing Controlled Substances for Pain," which in his view "suggest[]" but "do not require" that a primary care provider turn to non-opioid medications before prescribing opioids. This characterization misreads these Guidelines; overall, the Guidelines in no way countenance immediate opioid prescribing to patients who (like Patient B) have previous substance use disorder histories and who (like Patient B) complain about pain that lacks any known cause. Dr. Huang's opinion that the standard of care in 2016 called for respondent to explore all potential non-opioid options for Patient B's back pain complaints is more persuasive than Dr. Polston's opinion that opioid prescribing to Patient B on February 8, 2016, was within the standard of care.

66. Moreover, respondent in fact did prescribe a non-opioid medication to Patient B on February 8 (nabumetone), but did not wait to see whether it helped Patient B before also prescribing oxycodone. In addition, and as described in Finding 40, when Patient B revealed that she had not even used the nabumetone respondent prescribed, respondent simply prescribed more oxycodone. Respondent committed a simple departure from the standard of care by prescribing oxycodone to Patient B without having exhausted non-opioid medication options.

67. Dr. Huang opines that respondent departed from the standard of care by filing to perform a "proper opioid risk stratification." The basis for this opinion also is unclear, because respondent's records (as summarized in Findings 34 and 38) show that respondent recognized Patient B's substance abuse risk when respondent began prescribing oxycodone to Patient B. Dr. Polston's opinion that respondent acted within the standard of care by recognizing and documenting Patient B's risks is more persuasive.

68. Dr. Huang opines that respondent departed from the standard of care by choosing oxycodone for Patient B rather than "hydrocodone or tramadol," which he characterizes as medications with lower "potency." Although his criticism of respondent's choice to prescribe opioid medication at all is persuasive (as summarized in Findings 64 through 66), his criticism of the particular drug respondent chose is unsupported and unpersuasive.

69. Dr. Huang opines that respondent committed simple departures from the standard of care by increasing Patient B's daily oxycodone prescriptions (from 5 milligrams per day to 80 milligrams per day in the first two months and to 240 milligrams per day in the first year), and by failing to recognize and act on clear signs that Patient B was abusing her oxycodone. He points to Patient B's "frequent

early refill requests and refusal to comply with recommended consultations together with the frequent excuses of traveling out of town and lost/stolen medications" (all summarized in Findings 39 through 50) as signs that would have led a reasonable provider acting within the standard of care to suspect addiction or diversion; he notes further that both Dr. Roland and nurse practitioner Nelson raised exactly this concern to respondent (as summarized in Findings 45 and 47). Dr. Huang's opinions on this issue are both reasonable and persuasive.

70. In contradiction, Dr. Polston opines that respondent committed no departures from the standard of care in escalating Patient B's daily oxycodone prescriptions or by failing to recognize Patient B's opioid abuse and intervene to address it. He bases this opinion on his understanding that respondent "clearly documents aberrant behaviors and tells [Patient B to] stop illicit use and outlines unacceptable behavior," and questions whether Dr. Huang "reviewed the chart at all."

71. Patient B's chart shows clearly that her oxycodone dose escalated rapidly (as summarized in Finding 69), not gradually. It shows as well that despite documenting "aberrant behaviors," respondent continued prescribing more and more oxycodone to Patient B (as summarized in Findings 46 and 47); that despite outlining "unacceptable behavior," respondent accepted such behavior (as summarized in Findings 48 through 50 and 56); and that despite referring Patient B to diagnostic specialty providers and telling Patient B that she would not continue prescribing oxycodone to Patient B unless Patient B pursued these referrals (as described in Findings 48 and 50), respondent continued prescribing oxycodone to Patient B even though Patient B took no steps at all to seek diagnosis of or treatment for any problem that might actually have been causing her pain. Moreover, respondent prescribed to Patient B not over a few weeks or months but over more than two years,

and continued despite several clear opportunities for respondent to interrupt the prescribing relationship and guide Patient B toward substance use disorder treatment. Even when Patient B asked respondent for help tapering her oxycodone use, but then asked to slow the taper because it was too difficult (as summarized in Findings 53 and 54), respondent did not refer Patient B either to a pain management specialist or to a substance use disorder treatment provider. Rather, and as summarized in Findings 54 and 55, respondent stopped prescribing oxycodone to Patient B only because Patient B stopped requesting it; and Patient B stopped requesting it only because she had sought substance use disorder treatment elsewhere. Dr. Polston's opinion addresses none of these facts, and is not at all persuasive.

72. Dr. Huang opines that respondent departed from the standard of care by prescribing zolpidem to Patient B for insomnia, particularly in combination with oxycodone. Dr. Polston disagrees, simply denying that prescribing zolpidem under Patient B's circumstances in and after February 2016 departed from the standard of care. In light of Patient B's rapidly escalating oxycodone use, and her clear disregard of respondent's instruction not to use both oxycodone and zolpidem at the same time, Dr. Huang's opinion is persuasive and Dr. Polston's is not.

73. Finally, Dr. Huang opines that respondent departed from the standard of care by failing to have Patient B sign a pain management agreement. On this issue, Dr. Polston's opinion that this failure did not depart from the standard of care is more persuasive. Overall, respondent's records show that respondent counseled Patient B, and communicated in writing with Patient B regarding the terms on which respondent would prescribe oxycodone to Patient B; neither these records nor any authorities cited by either Dr. Huang or Dr. Polston show that Patient B's signature was specifically necessary to meet the standard of care. Respondent's own failure to adhere to the

prescribing conditions she set for Patient B, not her failure to secure Patient B's signature, was respondent's chief departure from the standard of care.

Patient C

74. Patient C is a woman who was in her early 50s between 2015 and 2018. The evidence does not show when she began receiving primary care from respondent. Patient C had undergone bilateral total knee replacement surgeries and two surgeries on her right wrist, and had chronic obstructive pulmonary disease. Patient C also had a history of methamphetamine abuse, but professed (until early 2018) to have been abstinent since 2001.

75. Patient C reported significant life stressors to respondent throughout their relationship. She described financial hardship, and had a falling-out with her siblings when her brother decided to sell their family home. Patient C also had, according to respondent's records, several family members who had substance use disorders, either active or in remission.

COURSE OF TREATMENT

76. Medical records in evidence show that Patient C had received regular prescriptions of opioid and benzodiazepine medications since 2011 or earlier. She visited an emergency room because of altered consciousness in July 2011, which treating providers determined to have resulted from combining carisoprodol,[10]

[10] Carisoprodol, sold under the brand name Soma, is a muscle-relaxing drug. Carisoprodol is a dangerous drug. (Bus. & Prof. Code, § 4022.)

morphine,[11] and alcohol. She also visited an emergency room twice in early September 2011 because of falls; on the second visit, the treating physician noted significant "opiate intoxication on arrival."

Opioid Prescribing

77. Patient C had bilateral knee replacement surgeries in early 2012, but did not decrease her morphine use thereafter. In October 2012 and for about a year thereafter, respondent prescribed 500 milligrams of extended-release morphine (MS Contin) per day as well as up to 150 milligrams of fast-acting morphine per day for "breakthrough" pain.

78. A visit note from July 2013 includes a specific "Chronic Pain Interval Assessment," addressing "Analgesia," "Activities/Function," "Adverse Events," "Aberrant Behavior," "Assessment," and "Action Plan." No visits after this date include this checklist. Respondent's ongoing problem list for Patient C in and after 2013 does include physical dependence on opioid drugs.

79. In October 2013, respondent prescribed 600 milligrams of MS Contin per day as well as up to 45 milligrams of oxycodone (in Percocet) to Patient C, because Patient C was experiencing increasing pain in her right shoulder. Respondent's notes from this visit state that her "plan" is for Patient C to "be back to her usual regimen" the next month, but Patient C did not reduce her opioid consumption.

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[11] Morphine is an opioid drug used for pain control. Morphine is a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(L)) and a dangerous drug (Bus. & Prof. Code, § 4022).

80. At an office visit on January 30, 2014, respondent and Patient C discussed both Patient C's persistent musculoskeletal pain and her low mood. Respondent noted that despite 600 milligrams of morphine and 45 milligrams of oxycodone per day, Patient C still complained of "10/10" pain. She also noted having told Patient C that Patient C's persistently low mood could result both from pain and from "NARCOTIC USE." Respondent did not refer Patient C either to a pain management specialist or to an addiction specialist on this date, however.

81. For some months in 2014, Patient C switched to oxycodone only: 320 milligrams (four 80-milligram tablets) of long-acting OxyContin each day plus up to six 5-milligram short-acting oxycodone tablets. After rotator cuff repair surgery on her right shoulder in June 2014, Patient C did not reduce her oxycodone use.

82. In fall 2014, Patient C suffered an injury to her right foot that resulted ultimately in amputation of parts of two toes. After this injury, she resumed using morphine. Respondent prescribed 600 milligrams of MS Contin and up to 180 milligrams of short-acting morphine per day. She continued to prescribe these amounts for the next several years, occasionally with early refills.

83. In January 2015, Patient C received a prescription from respondent for a cough suppressant syrup containing codeine.[12] Respondent refilled this prescription several times, but by August 2015 began to believe that Patient C was misusing this medication. Respondent's notes from a visit on that date state that "several

[12] Codeine is an opioid drug used for pain control and cough suppression. Codeine is a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(g)) and a dangerous drug (Bus. & Prof. Code, § 4022).

pharmacies called our office to confirm [prescriptions for codeine cough syrup] supposedly called in by our office, using our doctors' names and info, for [patients] that were not ours."

84. Respondent later learned that despite complaining of a persistent cough, Patient C had been filling only prescriptions for codeine cough syrup and not prescriptions for the inhaled medications respondent had prescribed to treat Patient C's chronic obstructive pulmonary disease. Respondent declined in October 2015 to prescribe more codeine for Patient C, and documented in Patient C's medical record that no one from the practice should prescribe codeine to her. Patient C made several more efforts in late 2015 to persuade respondent and other providers to prescribe codeine cough syrup to her, however.

85. In 2015, respondent or a colleague saw Patient C in person on January 26, March 19, May 14, June 18, July 27, September 14, October 12, October 30, and November 6. Some of these visits were for acute concerns, and others were to follow up on Patient C's chronic conditions, including pain. Respondent refilled Patient C's morphine prescriptions regularly throughout this year, but her notes regarding pain control state only that Patient C's pain is "stable."

86. After November 6, 2015, Patient C's next in-person visit to respondent's office was seven months later, on June 6, 2016. Patient C arranged opioid medication refills between these visits by telephone or email. On June 6, 2016, respondent's notes state that respondent informed Patient C that the practice would begin doing "some random urine drug testing," but respondent did not obtain a urine sample for drug testing from Patient C on that date.

87. Respondent saw Patient C again in person on July 11, 2016, and then not again until November 14, 2016. Patient C returned on December 19, 2016, complaining about back pain despite her opioid drug regimen, and respondent prescribed lidocaine patches to her. Respondent did not obtain urine samples for drug testing from Patient C on any of these dates.

88. In 2017, Patient C saw respondent without an appointment in February; skipped an appointment in April; and saw respondent in May to have sutures removed after a finger injury. Respondent's notes from that May 2017 visit state that Patient C had experienced "increased pain control needs" because of the finger injury and because of further pain in her right shoulder, and that respondent refilled Patient C's morphine early for this reason. In addition, despite the matters stated above in Findings 83 and 84, respondent resumed prescribing codeine-containing cough syrup to Patient C.

89. Respondent saw Patient C several times in June and July 2017, because Patient C was preparing to have surgery for a bunion. Patient C had this surgery in early September 2017, after which she missed several follow-up appointments with her podiatric surgeon and refused to follow his post-surgery instructions. The surgery did not reduce Patient C's stated need for opioid pain medication, and respondent continued prescribing morphine to Patient C in the same amounts.

90. At their next in-person visit, on December 7, 2017, Patient C reported to respondent that she had "taken a few extra [morphine] pills here and there even though she knows she shouldn't" and needed an early refill. She also stated that all activities were difficult because of intractable pain. Respondent's plan to address these

concerns was to continue prescribing morphine, and to add fentanyl[13] patches to Patient C's morphine regimen. Respondent also prescribed Narcan to Patient C, but Patient C did not fill this prescription.

91. Respondent did not obtain urine samples for drug testing from Patient C at any office visit during 2017. On December 7, respondent did give Patient C a written pain policy, although the evidence does not show that she asked Patient C to sign it. Respondent also asked Patient C to provide a urine sample on that date, but Patient C said that she had urinated just before her appointment and could not provide one.

92. Patient C was hospitalized for a few days in late December 2017 for a gastrointestinal problem. She saw respondent for a follow-up visit on January 4, 2018, and gave a urine sample for drug screening. Patient C also reported that she had begun using the 25-microgram-per-hour fentanyl patches respondent had prescribed, but experienced "no difference at all in pain."

93. Patient C's January 4, 2018, urine sample showed that Patient C recently had used methamphetamine. (Respondent did not order testing on that date that might have shown whether Patient C had taken the drugs respondent prescribed to her.) Respondent spoke with Patient C about this test result on January 18, and Patient C denied having used methamphetamine. Respondent's note regarding their telephone conversation states that Patient C agreed to give urine samples for drug testing at every subsequent office visit.

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[13] Fentanyl is an opioid drug used for pain control. Fentanyl is a controlled substance (Health & Saf. Code, § 11055, subd. (c)(8)) and a dangerous drug (Bus. & Prof. Code, § 4022).

94. Patient C skipped her next appointment on February 12, 2018, however, after respondent had approved Patient C's morphine and fentanyl patch refills on February 8. Respondent also increased Patient C's fentanyl patch prescription on February 8 from patches delivering 25 micrograms per hour to patches delivering 50 micrograms per hour.

95. Patient C returned to the office on March 1, 2018. She gave another urine sample for drug screening, which again showed her recently to have used methamphetamine. According to respondent's notes from this appointment, respondent explained "strictly" to Patient C that further methamphetamine use would "result in our not being able to prescribe opiates," and would cause respondent instead to recommend "a rehab program."

96. Patient C received refills on her morphine and fentanyl prescriptions in early March 2018, soon after her March 1 office visit. She gave further urine samples in March 2018 that showed methamphetamine use, but gave a sample on April 3, 2018, that was negative for methamphetamine. Respondent recommended substance use disorder treatment, but Patient C balked, stating that she could not afford it. Respondent continued prescribing morphine and fentanyl to Patient C.

97. At an appointment with Patient C on April 19, 2018, respondent approved a further refill of fentanyl patches for Patient C. She told Patient C that the practice would continue prescribing opioid medications to Patient C as long as she gave weekly urine samples for drug screening that showed no methamphetamine use. Respondent consulted the CURES system after Patient C had left and learned that Patient C had received hydrocodone in an emergency room that Patient C had not reported to respondent; this information did not change respondent's plan.

98. Patient C skipped her scheduled appointment on April 26. She gave urine samples on later dates that did not show methamphetamine, and respondent continued Patient C's morphine and fentanyl prescriptions. By late May 2018, however, staff members in respondent's practice began to suspect that Patient C was providing urine for testing that was not her own. A sample Patient C provided on May 24, 2018, for example, was tested for fentanyl, but did not show any despite respondent's regular refills of prescribed fentanyl patches. Nevertheless, Patient C received a further morphine refill on May 31.

99. On June 15, 2018, Patient C provided a urine sample that practice staff members believed to be adulterated. On June 18, 2018, she provided a sample from a person who had taken none of Patient C's prescribed medications. On June 21, she skipped an appointment with respondent. Respondent then informed Patient C by telephone and email that respondent would not prescribe further to her, and again recommended chemical dependency programs.

Benzodiazepine Prescribing

100. Respondent also prescribed clonazepam (Klonopin),[14] a benzodiazepine drug, for Patient C. In October 2012 Patient C was prescribed up to 4 milligrams of clonazepam per day, along with the morphine described above in Finding 77. She continued to receive this amount of clonazepam each month until respondent stopped seeing Patient C in 2018.

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[14] Klonopin is a brand name for clonazepam, a benzodiazepine anti-anxiety drug. It is a controlled substance (Health & Saf. Code, § 11057, subd. (d)(7)) and a dangerous drug (Bus. & Prof. Code, § 4022).

101. Respondent advised Patient C regularly that psychotherapy would likely benefit her, but Patient C declined this recommendation.

EXPERT OPINIONS REGARDING CARE

102. Dr. Huang's opinions regarding respondent's care for Patient C reflect a reasonably accurate understanding of Patient C's treatment history.

103. Dr. Huang opines that respondent departed from the standard of care by failing to try "safer non-addictive pharmacotherapy" for Patient C. This opinion is not persuasive, because Patient C's records reflect not only that her opioid use long preceded the time period Dr. Huang reviewed (as summarized in Findings 76 and 77) but also that Patient C took other "non-addictive" anti-inflammatory and anti-pain medications in addition to morphine, oxycodone, and fentanyl. Also, Patient C underwent several surgeries for undoubtedly painful conditions (as summarized in Findings 81, 82, and 89). The evidence does not establish that short-term prescriptions for opioid pain medications to address these injuries and to treat post-surgical pain departed from the standard of care.

104. Dr. Huang opines further that respondent departed from the standard of care by failing to assess Patient C's opioid use risks "properly." He explains this opinion by stating that Patient C's "major depression, tobacco addiction, anxiety, alcohol usage, and history of amphetamine abuse," in combination with her stated experience of extreme, unmanageable pain, should have led respondent to refer Patient C to a pain management or addiction specialist rather than attempting to manage Patient C's pain herself. In his view, reliance solely on opioid therapy for Patient C was a simple departure from the standard of care for a primary care physician.

105. Dr. Polston calls Dr. Huang's opinion erroneous, but declines to explain why except to refer to his own opinions regarding Patients A and B. Unlike Patient A, however, Patient C was in observably poor mental health,[15] had a strongly relevant addiction history involving both legal (nicotine) and illegal (methamphetamine) drugs, repeatedly reported extreme pain despite large morphine doses and despite surgical interventions that her surgeons deemed medically successful, and (as described in Finding 76) had experienced adverse consequences from opioid intoxication. Unlike Patient B, Patient C had a history of diagnostically confirmed complex medical problems, including problems that usually do cause pain. In light of his failure to address these relevant aspects of Patient C's history, none of Dr. Polston's opinions about Patient C's care are persuasive. In contrast, Dr. Huang's opinion that respondent departed from the standard of care by attempting to treat Patient C's pain herself rather than referring Patient C to a specialist is persuasive.

106. Dr. Huang also opines that respondent departed from the standard of care by having failed to recognize Patient C's "opioid hyperalgesia syndrome." Although Dr. Huang's suspicion that Patient C had this condition (in which opioid use paradoxically increases rather than decreases a person's pain perception) is reasonable, the matters stated in Findings 77 through 99 do not establish that this syndrome explains Patient C's experience. This opinion is not persuasive.

107. Dr. Huang opines that respondent departed from the standard of care by prescribing such large amounts of morphine, oxycodone, and fentanyl to a patient who already was at respiratory risk because of chronic obstructive pulmonary disease.

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[15] According to respondent's notes, Patient C cried frequently during their office visits.

He notes that Patient C was on a daily opioid dose that was nearly ten times the dose the Board's 2014 Guidelines identify as a "yellow flag warning" justifying specialist referral, yet continued to complain of unrelieved pain, which Dr. Huang believes indicates that she was receiving "little functional benefits" to offset her overdose risk. In light of all matters summarized in Findings 76, 77, 79 through 82, 89, 90, 92, and 94, this opinion is persuasive.

108. Dr. Huang opines that respondent's documentation regarding her monitoring of Patient C was "insufficient." The records do not support this opinion, because they reflect extensive discussion of Patient C's condition and medication use. The judgment failures summarized in Findings 104, 105, and 107 occurred despite, not because of, respondent's observation and documentation.

109. Dr. Huang opines that respondent departed from the standard of care by failing to try "non-addictive medications" to replace clonazepam as a treatment for Patient C's anxiety. Patient C's medical records show, however, that over the entire period for which records are in evidence, Patient C used several different anti-depressant and anti-anxiety medications in addition to clonazepam (including fluoxetine, citalopram, and paroxetine). Respondent never attempted to help Patient C reduce her clonazepam consumption, but Dr. Huang's opinion regarding alternative anxiety medications is not persuasive.

110. Dr. Huang opines that respondent departed from the standard of care between 2015 and 2018 by continuing to prescribe both morphine and clonazepam concurrently to Patient C. He notes that the Board, the Centers for Disease Control, and the federal Food and Drug Administration by 2016 all had warned providers not to co-prescribe opioid and benzodiazepine drugs. His opinion does not establish, however, that a primary care physician with a patient who already used both classes of

drug in 2016 would have departed from the standard of care by continuing to prescribe them. For this reason, his opinion regarding this issue with respect to Patient C is not persuasive.

111. Finally, Dr. Huang opines that respondent departed from the standard of care by failing to have Patient C sign a pain management agreement. As for Patients A and B, his analysis demonstrates neither that a signature is necessary to meet the standard of care nor that respondent failed to explain clearly to Patient C what she should do to use pain medication safely. This opinion is not persuasive.

Patient D

112. Patient D is a man who was in his middle 50s between 2015 and 2018. As a young adult, he had experienced a traumatic accident that resulted in amputation of his right leg below the knee and in removal of one kidney. In 2010, Patient D had left total knee replacement. Patient D was in recovery from addiction to methamphetamine and to alcohol.

COURSE OF TREATMENT

113. Patient D established care with respondent in 2010. He experienced chronic pain in his amputated limb, as well as in his back because of an awkward gait. He used morphine to control this pain; at the end of 2012, for example, he was using 500 milligrams of long-acting morphine plus up to 6 30-milligram short-acting morphine tablets per day.

114. Patient D tapered down his morphine use during 2013, and used none in November 2013. In December 2013, however, he resumed using it because he found his untreated pain debilitating.

115. Patient D also relapsed into drinking alcohol in December 2013. In January 2014, he checked himself into a treatment program. During his stay there, his treating psychiatrist diagnosed Patient D with bipolar disorder and started him on medication (valproic acid, or Depakote) to treat this mental illness. Respondent conferred by telephone at least once with the psychiatrist after Patient D's discharge from this treatment program.

116. At an office visit with respondent in early June 2014, Patient D reported that he had been sleeping in a parking lot and that he was experiencing hallucinations. Respondent recommended that he go to a hospital, which he agreed to do. He was admitted for psychiatric treatment.

117. Patient D again stopped using opioid drugs during this hospitalization. After his discharge in late June 2014, however, Patient D reported to respondent that his pain was severe and that he worried it would provoke him again into drinking alcohol or using methamphetamine. Respondent concluded that prescription opioid medications would be safer for Patient D and would pose less risk to his ongoing sobriety than untreated severe pain, and re-prescribed morphine to him.

118. In October 2014, Patient D stopped using valproic acid because he believed that it increased his joint pain.[16] In November 2014, respondent re-prescribed clonazepam to Patient D. Her records state that he had used benzodiazepines previously, but that she had hoped to avoid returning him to them because of interactions with his other medications and potential effects on his mood. Patient D

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[16] In mid-2015, Patient D began taking a new medication to treat his bipolar disorder (lamotrigine, or Lamictal), which he found very effective.

persuaded respondent, however, that improving his impulse control and reducing his anger would help him maintain his sobriety as well as his transitional supportive living arrangement.[17]

119. Patient D often experienced muscle spasms in his back during the night. Respondent prescribed the muscle relaxant carisoprodol (Soma) to Patient D in March 2015 to address this problem. He took it for about six months, and then discontinued it because he did not like its sedating effect.

120. In June 2016, Patient D had a colonoscopy, using propofol for sedation. This anesthetic drug led to significant anxiety and agitation after the procedure, for which the treating physician prescribed diazepam (Valium),[18] a benzodiazepine drug. Patient D observed that in addition to its anti-anxiety effects, diazepam was an effective muscle relaxant for his back spasms. He asked respondent to prescribe it for him instead of clonazepam, and this substitution enabled him to reduce his morphine consumption as well.

121. Patient D informed respondent in late 2016 that he had begun using cannabis before bed to help him sleep. She advised him to discuss the matter with his psychiatrist, and advised him that mixing cannabis with his opioid and benzodiazepine

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[17] After his discharge from psychiatric hospitalization, Patient D lived for several months in a transitional supportive housing setting for people who had both major mental illnesses and substance use disorders.

[18] Valium is a brand name for diazepam, a benzodiazepine anti-anxiety drug. It is a controlled substance (Health & Saf. Code, § 11057, subd. (d)(9)) and a dangerous drug (Bus. & Prof. Code, § 4022).

medications would be risky. Patient D continued using cannabis, however, and discussed using it as a sleep aid several times with respondent over the next few years.

122. Respondent saw Patient D in person monthly or sometimes bimonthly between 2015 and 2019. At each visit, they discussed Patient D's pain and daily function, as well as his psychiatric treatment. Patient D was an active participant in his own care; he made and kept referral appointments and monitored his own controlled substance use carefully. Patient D walked and bicycled for exercise and attended 12-step groups to reinforce his sobriety from alcohol and methamphetamine.

123. In February 2015, respondent had Patient D sign a pain management agreement, which they reviewed together annually thereafter. In early 2017, respondent began checking the CURES database regularly to monitor Patient D's controlled substance use. She identified no prescription activity that was in any way inconsistent with her prescriptions or instructions. Respondent also began in early 2017 conducting regular quarterly or more frequent urine drug screens for Patient D, again without identifying any drugs that were not consistent with her prescriptions or with Patient D's reports to her. Respondent prescribed naloxone to Patient D in late 2017, and he kept it on hand (but never used it) thereafter.

124. With slight variations to address acute pain resulting from problems such as a tooth abscess and a collision between his bicycle and a car, Patient D remained on similar doses of opioid and benzodiazepine medications between 2015 and 2018. After switching from clonazepam to diazepam, Patient D's usual regimen was to use 200 milligrams of morphine and 30 milligrams of diazepam per day.

125. Patient D had quarterly visits with his outpatient treating psychiatrists, which he described to respondent as cursory, generally lasting about 5 minutes. In

August 2014, Patient D reported to respondent at an office visit that his treating psychiatrist disapproved of his opioid use. In July 2016, he reported that a different treating psychiatrist had said that the psychiatrist would prefer that he not use benzodiazepine drugs. No evidence shows that either psychiatrist ever contacted respondent to discuss these concerns, however. Respondent's records do state that respondent attempted unsuccessfully several times to contact Patient D's outpatient psychiatrists by telephone and email to confer regarding their mutual patient.

126. Patient D moved from the transitional housing referenced in Finding 118 to an independent apartment in late 2016. He continued to live in this apartment thereafter. He did not resume using alcohol or methamphetamine.

127. Repeatedly throughout his treatment with respondent, Patient D stated his intent eventually to stop using opioids and benzodiazepines, because he did not like being physically dependent on these drugs. In late 2019, after having been in stable mental health for about four years and in secure housing for three, he began tapering his benzodiazepine and opioid use. In late 2020, after having significantly reduced his daily dose of both types of drug, Patient D substituted buprenorphine with naloxone (Suboxone) for morphine.

EXPERT OPINIONS REGARDING CARE

128. Dr. Huang's opinions regarding respondent's care for Patient D reflect a reasonably accurate understanding of Patient D's treatment history.

129. Dr. Huang opines that respondent departed from the standard of care by failing to try "various other safer non-opiate medications" for Patient D. This opinion is not persuasive, because Patient D's records reflect chronic pain dating back many years, and opioid use long predating Dr. Huang's analysis. In light of Patient D's many

other challenges, the evidence does not show respondent's decision to keep Patient D on a pain management regimen that seemed to work for him to have departed from the standard of care.

130. Dr. Huang opines further that respondent departed from the standard of care by failing to assess Patient D's opioid use risks "properly," and by failing to recognize his "opioid addiction." As summarized in Findings 112, 117, and 118, however, respondent was aware of Patient D's substance abuse history, and took that history into account while making treatment decisions for Patient D. Moreover, although the matters summarized in Finding 127 show Patient D to have been physically dependent on opioid drugs, the matters summarized all together in Findings 117 through 126 do not show him to have abused these drugs. Dr. Huang's opinion on this topic is not persuasive.

131. Dr. Huang believes that respondent should have used "multi-disciplinary management" for Patient D, including an addiction specialist, a chiropractor, and an acupuncturist. This opinion ignores Patient D's reality: He was on Medi-Cal; was in regular psychiatric care with overburdened providers (as summarized in Finding 125); was temporarily homeless (as summarized in Finding 116); lived for several months in a dual-diagnosis supportive housing setting (as summarized in Finding 118); and prioritized his sobriety from alcohol and methamphetamine, drugs that previously had caused harm to him and to other people in his life. Patient D cooperated with respondent's care, including specialist referrals; reported regularly that his pain-control regimen was effective; and showed no evidence of drug misuse or diversion. Under these circumstances, the evidence does not show that respondent departed from the standard of care by continuing to manage Patient D's pain.

132. Dr. Huang opines that respondent departed from the standard of care by failing to use urine drug screens frequently enough to monitor Patient D's opioid use. In light of the matters summarized in Findings 122 and 123, this opinion is not persuasive.

133. Dr. Huang believes that Patient D was an "active user of marijuana therapy for many years," and that respondent departed from the standard of care by continuing to prescribe controlled substances to Patient D while he used cannabis. The matters summarized in Finding 121 show Patient D to have used cannabis regularly but not casually or recreationally. Respondent advised Patient D against cannabis use, but maintained her prescribing relationship with Patient D despite it. In light of the other benefits Patient D received from respondent's care, the evidence does not show her tolerance for cannabis use to have been a departure from the standard of care.

134. Dr. Huang opines that respondent's documentation regarding her monitoring of Patient D was inadequate. The records do not support this opinion, because (as summarized in Findings 117, 118, and 120 through 122) they reflect extensive discussion of Patient D's condition and medication use. This opinion is not persuasive.

135. According to Dr. Huang, respondent departed from the standard of care by prescribing carisoprodol to Patient D in mid-2015, both because she did not offer Patient D other muscle relaxant medications before carisoprodol and because Patient D already was using opioids and benzodiazepines. He supports this opinion with reference to current views about the combination of these drugs, but not with reference to how responsible primary care physicians commonly prescribed them in 2015. For this reason, his opinion is not persuasive.

136. Dr. Huang believes that Patient D's psychiatrists "repeatedly advised" that he not use benzodiazepines, and that for this reason respondent departed from the standard of care by continuing to prescribe them. The records do not support Dr. Huang's belief. Rather, as summarized in Finding 125, the records show only that on two occasions respondent paraphrased Patient D's reports from his psychiatrists; these records show further that neither psychiatrist ever communicated directly with respondent regarding Patient D's care. Moreover, the records summarized in Findings 118 and 120 show respondent to have considered how benzodiazepine drugs would affect Patient D's other concerns, and to have chosen them as a harm reduction strategy. In light of these facts, Dr. Huang's opinion is not persuasive.

137. Dr. Huang opines that respondent departed from the standard of care between 2015 and 2018 by continuing to prescribe both morphine and clonazepam or diazepam concurrently to Patient D. As for Patient C, as summarized in Finding 110, this opinion is not persuasive.

Costs

138. Since January 1, 2022, the Board has incurred $80,082.75 in costs for legal services provided to complainant by the California Department of Justice in this matter. Complainant's claim for reimbursement of these costs is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivisions (b)(2) and (b)(3), with respect to the amount actually incurred. These costs are unreasonable, however, because they reflect considerable repetition and duplication of effort. A reasonable amount for legal services from the Department of Justice for this matter is $40,000.

139. Complainant also presented evidence showing that the Board incurred $14,900 in costs for expert evaluation of this matter, supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(2). Although the records Dr. Huang reviewed in this matter were voluminous, his report and testimony showed him not to have reviewed them thoroughly. A reasonable amount for the services Dr. Huang provided is $10,000.

140. Finally, complainant presented evidence showing that the Board incurred $3,989.50 in costs for investigative services in January and February 2022. The total is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(1), with respect to the amount actually incurred. These costs are reasonable.

LEGAL CONCLUSIONS

1. The Board may take disciplinary action against respondent only if clear and convincing evidence establishes cause for such action. The factual findings above rest on clear and convincing evidence.

Alleged Causes for Discipline

2. The Board may suspend or revoke respondent's physician's and surgeon's certificate if she has engaged in unprofessional conduct. (Bus. & Prof. Code, §§ 2227, 2234.) Unprofessional conduct includes repeated acts constituting ordinary negligence in medical practice. (*Id.*, § 2234, subd. (b).) Unprofessional conduct also includes maintenance of medical records that are inaccurate or inadequate, with reference to the standard of care for such records. (*Id.*, §§ 2234, subd. (a), 2266.) Complainant alleges that respondent committed repeated acts of negligence in her

treatment of Patients A, B, C, and D; and that respondent also maintained inadequate medical records for Patients A, C, and D.

FIRST CAUSE FOR DISCIPLINE (PATIENT A)

3. The matters stated in Findings 26 through 31 do not constitute cause for discipline against respondent arising either from respondent's treatment of Patient A or from her documentation of that treatment.

SECOND CAUSE FOR DISCIPLINE (PATIENT B)

4. The matters stated in Findings 64 through 66, 69 through 71, and 72 constitute cause for discipline against respondent arising from her treatment of Patient B, and specifically from respondent's decision to prescribe opioid medication rather than non-opioid treatments to Patient B in February 2016, from her decision to prescribe more and more oxycodone to Patient B despite mounting evidence of either misuse or diversion, and from her decision to prescribe zolpidem to Patient B along with oxycodone.

5. The matters stated in Findings 62, 63, 67, 68, and 73 do not constitute cause for discipline against respondent arising from her initial examination of Patient B, from her initial referrals for Patient B, from her risk assessment for Patient B, from her decision to use oxycodone rather than another opioid drug, or from her failure to have Patient B sign a pain management agreement.

THIRD CAUSE FOR DISCIPLINE (PATIENT C)

6. The matters stated in Findings 104, 105, and 107 constitute cause for discipline against respondent arising from her treatment of Patient C, and specifically from her decisions to prescribe very high doses of opioid drugs to Patient C despite no

evidence that they controlled pain and to manage Patient C's pain medications herself rather than referring Patient C to a pain management or addiction specialist.

7. The matters stated in Findings 103, 106, and 108 through 111 do not constitute cause for discipline against respondent arising from her failure to prescribe "non-addictive pain medication" to Patient C, from her failure to recognize "opioid-induced hyperalgesia syndrome" in Patient C, from inadequate documentation of Patient C's care, from prescribing benzodiazepine drugs to Patient C, or from her failure to have Patient C sign a pain management agreement.

FOURTH CAUSE FOR DISCIPLINE (PATIENT D)

8. The matters stated in Findings 129 through 137 do not constitute cause for discipline against respondent arising either from respondent's treatment of Patient D or from her documentation of that treatment.

Disciplinary Considerations

9. Patients A, C, and D were complex patients. Each had many physical causes for chronic pain, and many circumstances challenging their and respondent's ability to address those pain-causing conditions. Complainant failed to establish through expert testimony that respondent departed in any respect from the standard of care in treating Patients A and D, and established only some of the departures complainant alleged regarding Patient C. In light of this complexity, respondent's position that she provided the best care she could for each of these patients, without departing from the standard of care even as to Patient C, is not unreasonable.

10. With respect to Patient B, however, respondent's confidence that she did not depart in any respect from the standard of care is inexplicable. As summarized in

Findings 33, 35 through 42, 49, 50, and 56, Patient B displayed far more interest in procuring oxycodone than in investigating or addressing any physical causes for the debilitating back pain she professed to experience. Moreover, as summarized in Findings 45 and 47, respondent's colleagues advised her not to continue prescribing oxycodone to Patient B. Respondent's failure to recognize her departures from the standard of care with respect to Patient B, even in hindsight, is unreasonable.

11. Complainant argues that respondent's failure to acknowledge any departures from the standard of care with respect to any patient justifies an order placing respondent on probation. In light of all circumstances, however, and particularly in light of the matters stated in Findings 5 through 7, an order placing respondent on probation would impose costs on both her and the Board that would be unlikely to improve public safety for the future.

12. The Board may reprimand respondent, and may as part of its reprimand require her to take remedial medical education. (Bus. & Prof. Code, § 2227, subd. (a)(4).) A reprimand, with a requirement to take a prescribing practices course, is appropriate in this matter to demonstrate the Board's disapproval of respondent's negligence with respect to Patients B and C, and to ensure that such negligence does not recur.

Costs

13. A physician who has committed a violation of the laws governing medical practice in California may be required to pay the Board the reasonable costs of the investigation and enforcement of the case, but only as incurred on and after January 1, 2022. (Bus. & Prof. Code, § 125.3.) The matters stated in Findings 138 through 140 establish that these costs for this matter total $53,989.50.

14. In *Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the standards by which a licensing board or bureau must exercise its discretion to reduce or eliminate cost awards to ensure that the board or bureau does not deter licensees with potentially meritorious claims from exercising their administrative hearing rights. The court held that a licensing board requesting reimbursement for costs relating to a hearing must consider the licensee's "subjective good faith belief" in the merits of his position and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Id.*, at p. 45.) The board also must consider whether the licensee will be "financially able to make later payments." (*Ibid.*) Last, the board may not assess full costs of investigation and enforcement when it has conducted a "disproportionately large investigation." (*Ibid.*)

15. Respondent raised a successful defense to complainant's allegations regarding Patients A and D, and to some allegations regarding Patient C. An order directing her to pay the Board $30,000 in cost reimbursement is appropriate.

ORDER

1. Physician's and Surgeon's Certificate No. A 77883, held by respondent Michele Allegra Gomez, M.D., is hereby publicly reprimanded.

2. Respondent must pay $30,000 to the Board, to reimburse the Board for its enforcement costs in this matter, within 30 days after the effective date of this order.

3. Within 60 calendar days after 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education 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.

DATE: 08/05/2025

Juliet E. Cox

JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings