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

In the Matter of the Accusation Against: **Gary Gursharan Sandhu, M.D.** **Physician's and Surgeon's Certificate No. A 93748** **Respondent.**	**Case No.: 800-2022-087453**

ORDER CORRECTING NUNC PRO TUNC
CLERICAL ERROR IN RESPONDENT'S NAME ON PAGE 4 LINE 6 OF THE STIPULATION SETTLEMENT AND DISCIPLINARY ORDER

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the Respondent's name on Page 4, line 6 of the Stipulated Settlement and Disciplinary Order in the above-titled matter and that such clerical error should be corrected so that the name will conform to the Board's issued license.

IT IS HEREBY ORDERED that the Respondent's name contained on Page 4, line 6 of the Stipulated Settlement and Disciplinary Order in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "Gary Gursharan Sandhu."

October 10, 2025

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

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

In the Matter of the Accusation Against: Gary Gursharan Sandhu, M.D. Physician's and Surgeon's Certificate No. A 93748 Respondent.	Case No.: 800-2022-087453

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 October 10, 2025.

IT IS SO ORDERED: September 12, 2025.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
E-mail: Rebecca.Smith@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **GARY GURSHARAN SANDHU, M.D.** **840 Towne Center Drive** **Pomona, CA 91767-5900** **Physician's and Surgeon's Certificate No. A 93748,** Respondent.	Case No. 800-2022-087453 OAH No. 2025010262 **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. Gary Gursharan Sandhu, M.D. (Respondent) is represented in this proceeding by attorneys Peter R. Osinoff and Derek F. O'Reilly-Jones, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071.

3. On or about January 6, 2006, the Board issued Physician's and Surgeon's Certificate No. A 93748 to Respondent. That license was in full force and effect at all times relevant to the

charges brought in Accusation No. 800-2022-087453, and will expire on January 31, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2022-087453 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 November 21, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2022-087453 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. 800-2022-087453. 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. 800-2022-087453, 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-

2022-087453, 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 93748 to disciplinary action.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and 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. 800-2022-087453 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 Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 93748 issued to Respondent Gary Gusharan Sandhu, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years 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 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 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. 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 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.

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

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 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 not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (60) calendar days of the practice setting change,

Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

6. PROHIBITED PRACTICE. During probation, Respondent is prohibited from practicing as a hospice medical director at any medical facilities or for any hospice agencies. After the effective date of this Decision, all patients receiving hospice, end-of-life, and palliative care while being treated by Respondent shall be notified that Respondent is prohibited from practicing as a hospice medical director at any medical facilities or for any hospice agencies. Any new hospice, end-of-life, and palliative care patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, 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 $28,804.40 (twenty-eight thousand eight hundred four dollars and forty 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 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 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. 800-2022-087453 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

///

///

///

///

///

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Peter R. Osinoff and 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: 7/30/25

GARY GURSHARAN SANDHU, M.D.
Respondent

I have read and fully discussed with Respondent Gary Gursharan Sandhu, 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: 07/30/2025

Derek O'Reilly-Jones

PETER R. OSINOFF
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: July 30, 2025

Respectfully submitted,

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

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

LA2024603720/67790402

Exhibit A

Accusation No. 800-2022-087453

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
E-mail: Rebecca.Smith@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **GARY GURSHARAN SANDHU, M.D.** **840 Towne Center Drive** **Pomona, CA 91767-5900** **Physician's and Surgeon's Certificate No. A 93748,** Respondent.	Case No. 800-2022-087453 **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 January 6, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 93748 to Gary Gursharan Sandhu, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2026, unless renewed.

///

///

///

JURISDICTION

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

4. Section 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.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

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 2262 of the Code states:

Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section.

11. 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

12. 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.

13. 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

14. Section 125.3 of the Code states:

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

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

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

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

///

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

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

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

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

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

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

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

DRUG DEFINITIONS

15. 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.

"Buspirone," also known by the brand name Buspar, is used to treat anxiety. It belongs to a classification of drugs called anxiolytics. It works by balancing the levels of dopamine and serotonin to help regulate mood. It is a dangerous drug as

defined in Code section 4022.

"Depakote" is a brand name for sodium valproate or divalproex sodium which is an anticonvulsant mood stabilizer drug that can be used to treat bipolar disorder and seizures. It can also help prevent migraine headaches. It is a dangerous drug as defined in Code section 4022.

"Fentanyl" is a potent, synthetic narcotic analgesic with a rapid onset and short duration of action. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), 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.

"Lorazepam," also known by the brand name Ativan, is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Code section 4022.

"Mirtazapine" is an antidepressant primarily used to treat depression. It is often used to treat depression complicated by anxiety or trouble sleeping. It is a dangerous drug pursuant to Code section 4022.

"Morphine" is an analgesic and narcotic drug obtained from opium and used medicinally to relieve moderate to severe pain. It can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), 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.

"Quetiapine," also known by the brand name Seroquel, is an atypical antipsychotic drug used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. It is a dangerous drug pursuant to Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. 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)

16. 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, 2, and 3.[1] The circumstances are as follows:

Patient 1:

17. In approximately 2011, Patient 1, a then 60-year-old male, suffered a left-sided cerebrovascular accident (CVA) with right hemiparesis. He had right hand contracture, underlying atrial fibrillation, Stage III chronic kidney disease, Grade II diastolic dysfunction with pulmonary hypertension, right pleural effusion with prior right pneumothorax, gout, and anemia. In addition, he was taking hydrocodone-acetaminophen 10 mg/325 mg three times a day at baseline for chronic low back pain. Patient 1 was cared for at home by his spouse.[2]

18. Approximately 10 years later, in January of 2021, Patient 1 was hospitalized with sepsis, severe C. difficile infection with acute renal failure. He required temporary dialysis but had renal recovery by the time he was discharged from the hospital.

19. In February 2021, Patient 1 developed persistent or recurrent C. difficile, requiring a second hospital admission. An echocardiogram was performed during the hospitalization. It revealed a Grade II diastolic dysfunction and moderate pulmonary hypertension.

20. On March 14, 2021, Patient 1 had a third hospital admission following complaints of generalized weakness and diarrhea. It was noted that at the time of admission, Patient 1 had a code status discussion with Dr. H.L. and that Patient 1 requested Do Not Resuscitate (DNR)/Do Not Intubate (DNI). Dr. H.L. noted that he updated Patient 1's spouse regarding Patient 1's DNR/DNI decision. Patient 1 was diagnosed with an active bacterial infection in addition to the C. difficile infection. Patient 1's primary diagnosis was hypertensive heart and kidney disease without heart failure. In addition, Patient 1 had pulmonary hypertension, unstageable pressure

[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1, 2, and 3.

[2] This information is provided for historical purposes only.

ulcers of bilateral heels, stage III pressure ulcer of the sacrum, and stage II pressure ulcers of the upper back and right ankle. Orders were issued for home health and hospice evaluations.

21. On March 25, 2021, Patient 1, at 70 years of age, was admitted to hospice at home, under the care of Respondent and H.C. Hospice. Patient 1's spouse signed the admissions paperwork, including a Physician Orders for Life Sustaining Treatment (POLST) for DNR/DNI, and comfort measures form, the selection of Respondent as Patient 1's hospice and primary care physician, and an acknowledgment that care would not be directed towards cure, but only to relieve pain and symptoms related to the terminal condition.

22. That same day, a comprehensive hospice admission nursing assessment was completed as part of the Interdisciplinary Group (IDG) hospice documentation. Patient 1's primary diagnosis was noted to be unspecified cerebrovascular disease with a secondary diagnosis of heart disease. Patient 1 was noted to have 2+ pitting bilateral lower extremity edema, no dyspnea with clear lung sounds, and oxygen saturation of 98% on room air. It was also documented that Patient 1 had weight loss, poor appetite, inadequate fluid intake, and decreased food and fluid intake. On the psychological assessment, Patient 1 answered "No" when asked, "are you uncomfortable because of pain?"

23. Patient 1 was noted to have a Karnofsky Performance Scale (KPS) score of 40,[3] Palliative Performance Score (PPS) of 40,[4] and a Functional Assessment Staging Tool (FAST) score of 7A (severe dementia).[5] Patient 1 did not carry a diagnosis of dementia from his hospitalizations. The neurological/mental/sensory check box section of the IDG hospice documentation regarding orientation (i.e., time, place, person, disoriented) was not completed.

---

[3] KPS classifies patients by functional impairment. The scores range from 0 to 100. A higher score means that the patient is better able to carry out daily activities. A score of 40 is disabled, requiring special care and help.

[4] PPS measures the progressive decline of a palliative patient. It has five functional dimensions: ambulation, activity level and evidence of disease, self-care, oral intake, and level of consciousness. The scores range from 0 (death) to 100 (full ambulation). A higher score means that the patient is better able to carry out daily activities. A score of 40 is mainly in bed and unable to do most activity.

[5] FAST is a tool that tracks the progression of Alzheimer's disease. It has seven stages, ranging from normal functioning to severe cognitive decline. A score of 7A indicates severe dementia in the final stages of the disease, with very limited speech of less than 6 intelligible words, as a result of the disease.

24. Patient 1 was noted to be taking Norco 10 mg/325 mg, three times a day. Patient 1's hospital records reflect that Patient 1 was taking Norco for lower back pain and possibly pain related to Patient 1's prior CVA. Patient 1 did not have a terminal diagnosis that was expected to cause severe pain. Patient 1's additional initial medications were documented as ciprofloxacin and metronidazole for C. difficile, prednisone taper for colitis, loperamide as needed for diarrhea, bumetanide 1 mg twice a day for edema, mirtazapine nightly for sleep, and cyclobenzaprine twice a day for muscle spasm pain and stiffness.

25. On March 25, 2021, Respondent documented that Patient 1 was an 88-year-old male[6] diagnosed with unspecified cerebrovascular disease. Respondent documented that Patient 1 was classified as FAST 7A (severe dementia). Patient 1's medical records do not set forth a diagnosis of dementia. Respondent also documented that Patient 1 had New York Heart Association (NYHA) Class IV[7] heart failure. Patient 1's medical records do not set forth a diagnosis of heart failure. Patient 1 did not have documented symptoms of heart failure. Patient 1's physical assessment on March 25, 2021 reflected that he had no dyspnea, no crackles, and normal oxygen saturation on room air. Respondent also documented that Patient 1 was at high risk for hypo/hyperglycemia due to diabetes. Patient 1 was not prescribed hypoglycemic medications and his hemoglobin A1C in the hospital was normal at 5.3.

26. The Physician's Certification for Hospice Benefit dated March 25, 2021, and signed March 26, 2021, by Respondent documented FAST 7A (severe dementia) and NYHA Class IV. Respondent documented a terminal diagnosis of unspecified cerebrovascular disease.[8]

27. On March 29, 2021, nursing noted on the IDG hospice documentation that Patient 1 was sleeping most of the time. Patient 1's pain goal was noted to be a reduction in pain score to 2

---

[6] Respondent incorrectly documented Patient 1's age. On the same page, Patient 1's date of birth is noted and in the nursing portion of the note, the nurse documents that the patient is 70 years old.

[7] NYHA classifies congestive heart failure patients based on their symptoms. It has four classifications. Class I is no symptoms of heart failure; Class II is symptoms of heart failure with moderate exertion; Class III is symptoms of heart failure with minimal exertion; and Class IV is symptoms of heart failure at rest.

[8] Respondent's physician narrative again erroneously documented Patient 1's age as 88 despite the correct date of birth documented on same page.

within 1 to 2 hours after medication. Respondent signed off on the note that same day.

28. On April 1, 2021, the hospice nurse noted on the IDG hospice documentation that Patient 1's pain was not controlled. Patient 1 had a pain score of 3 out of 10. There was no documentation of the time of Patient 1's last Norco dose in relation to the assessment of the pain score. Patient 1's plan indicated that pain should be assessed for medication efficacy one to two hours after dose. Patient 1's blood pressure was 130/72 and heart rate was 108. He was documented to have "easy breathing," no abnormal lung sounds, and oxygen saturation at 97% on two liters nasal cannula, as needed. Patient 1 was incorrectly noted to be independent with all activities of daily living (ADLs) and not to be imminently dying. The nurse noted that Patient 1 was awake and alert with periods of forgetfulness. There was continued documentation that Patient 1 had poor oral intake but no documentation that he was unable to take oral medications. Patient 1's pain was documented as 3 out of 10 after his spouse gave him Norco, but there was no documentation of time elapsed since dose.

29. The IDG hospice documentation reflected that Patient 1's family requested a fentanyl patch. The nurse documented that Respondent was notified of Patient 1's pain and an order was received for a fentanyl 25 mcg/hour patch. There was no documentation that Norco was discontinued, nor that Patient 1's spouse was advised to avoid using Norco in combination with fentanyl. The fentanyl dose increased Patient 1's baseline opioid dose by at least 50%. The general recommendation is to decrease total dose initially for safety when rotating opioids.

30. On April 3, 2021, Patient 1 was seen by the hospice nurse for "patient decline." He had a decreased level of consciousness and increased respiratory distress. Patient 1's pain was noted to be controlled. He was documented as "obtunded" and unable to take any oral intake. There was no documentation of any assessment of Patient 1's opioid response or the possibility that opioid overdose might be causing Patient 1's new obtundation and impaired respirations.

31. Patient 1's spouse was informed that Patient 1 was imminently dying. Patient 1's spouse was encouraged to start comfort medications and continuous care was initiated. It was documented that Respondent was notified of Patient 1's condition.

///

32. Patient 1 was initiated on comfort medications, including 0.5 mL sublingual morphine (10 mg dose) as needed.

33. Patient 1 expired in the early morning on April 4, 2021. Patient 1's death certificate, signed by Respondent, documented that Patient 1's immediate cause of death was respiratory failure from end stage CVA.

Excessive Prescribing of Opioids.

34. The standard of care requires an examination and an appropriate medical indication for prescribing opioids to a patient. When prescribing opioid medications, the physician must perform ongoing assessments for efficacy and possible adverse effects.

35. Prescribing fentanyl was excessive for Patient 1's level of opioid use, tolerance, and level of reported pain. Respondent failed to document a conversion calculation or rationale for the dose selection. Respondent failed to discontinue the scheduled Norco with initiation of fentanyl patch. Respondent failed to recognize that opioid overdose may be responsible for Patient 1's rapid decline one to two days after initiation of the fentanyl patch, coinciding with maximal blood levels of fentanyl. Rather than attempting treatment of an unintentional opioid overdose to reverse rapid decline, Respondent ordered morphine, an additional opioid. Though Patient 1 was terminal, Respondent failed to document an indication for terminal sedation or a discussion with Patient 1's spouse regarding terminal sedation. Patient 1's respiratory failure was likely secondary to the opioid overdose. Respondent's inappropriate prescribing caused harm to Patient 1. This is an extreme departure from the standard of care.

Patient 2:

36. Patient 2, a 74-year-old male, had a history of Parkinson's disease, dementia, hypothyroid, and seizure disorder. On August 20, 2021, Patient 2 was hospitalized secondary to poor oral intake and weakness. He was dehydrated and had a urinary tract infection (UTI). His admitting laboratory studies were also consistent with severe hypothyroid. Patient 2 was given ceftriaxone for UTI and his levothyroxine dose was increased from 25 mcg daily to 100 mcg daily to address the severe hypothyroid.

///

37. During the hospitalization, Patient 2 was evaluated by a physical therapist who noted that Patient 2 denied any complaints and stated "I feel good!" Patient 2 told the physical therapist that he lived at home with his wife and children and that he was normally able to care for himself. This statement was noted to conflict with family reports that Patient 2 requires increased assistance. The physical therapist noted that Patient 2 was oriented to person, place, and situation but mildly impulsive.

38. During the hospitalization, Patient 2 was also noted to be ambulatory and able to transfer independently to and from bed. He was able to feed himself and attend to his own toileting needs. His physical health status was documented as "good." Patient 2's dementia was documented to be sufficiently advanced that he required assistance with his medication and treatment, as well as with dressing and bathing.

39. The plan was for Patient 2 to be discharged to a board and care facility due to his dementia. Patient 2 did not qualify for skilled rehabilitation because he was able to ambulate more than 250 feet and was too functional. Patient 2's attending physician did not make any recommendations regarding hospice.

40. On August 28, 2021, Patient 2 was discharged to a board and care facility. Patient 2's son executed a consent for Respondent, the hospice medical director, to be Patient 2's attending and primary care physician. Patient 2's son signed a Hospice Informed Consent and Treatment Authorization and Election of Medicare Hospice Benefit form. It was noted that Patient 2's son signed in lieu of Patient 2 because Patient 2 had dementia.

41. With respect to life saving efforts, Patient 2's son requested full code and full treatment with a trial of artificial nutrition if needed for Patient 2.

42. On August 28, 2021, a comprehensive hospice nursing assessment was completed. Patient 2 was noted to be ambulatory with supervision and required minimal assistance with ADLs. He had no psychiatric history and there were no reports of delirium, agitation, or anxiety from the hospital. Patient 2 was noted to be "peaceful," calm, and cooperative. Patient 2 was alert and oriented to person, with disorganized speech and tremors. He was noted to be "able only sometimes [to] engage in meaningful conversation." A Mini-Mental State Examination

(MMSE) score was documented to be 12 out of 30.[9] There was no record of the actual MMSE assessment, who performed it, where it was completed, or when it was completed. Patient 2 was noted to have a KPS score of 40 (disabled, requiring special care and help), a PPS of 40 (mainly in bed and unable to do most activity), and a FAST score of 7A (severe dementia). There was no record of who performed the KPS, PPS and FAST assessments. It was noted that Patient 2's disease trajectory reflected "a slow, steady decline, as directly related to the diagnosis of Alzheimer's Disease, qualifying [Patient 2] for hospice services."

43. Respondent's narrative portion of the August 28, 2021 IDG hospice documentation noted that Patient 2 "meets criteria for hospice and no longer seeks aggressive treatment." Respondent also noted a KPS score of 40 and a FAST score of 7A. Respondent prescribed lorazepam, 0.5 mg every 4 hours, as needed, for "anxiety/agitation." Respondent continued Patient 2's levothyroxine at 100 mcg daily and pantoprazole for management of his Parkinson's symptoms. Without documenting a reason, Respondent discontinued the primidone, which was also being used to manage Patient 2's Parkinson's symptoms.

44. There was no Certification of Terminal Illness in Patient 2's medical records.

45. On September 7, 2021, the visiting hospice nurse documented that Patient 2 was anxious and agitated during the night (sundowning). Per the report of the caregiver at the board and care facility, the use of lorazepam, as needed, was ineffective.

46. On September 8, 2021, Respondent prescribed quetiapine, twice daily.

47. The next IDG hospice documentation dated September 14, 2021 did not address the addition of quetiapine to Patient 2's medication regimen and there was no assessment as to the effectiveness of quetiapine. Additionally, Respondent did not assess Patient 2's response to the high dose of levothyroxine he was receiving.[10]

48. On October 12, 2021, the IDG hospice documentation reflected that Patient 2 was "confused and disoriented, unable to maintain meaningful conversation." Patient 2 was noted to

[9] An MMSE score of 12 reflects clear impairments, possibly indicating middle-stage to moderate dementia and may require 24-hour supervision of day-to-day functioning.

[10] Indications that levothyroxine dose may be too high include anxiety, diarrhea, weight loss, and trouble sleeping.

have intermittent bowel and bladder incontinence. Again, there was no documentation reflecting an assessment of Patient 2's response to the significant levothyroxine dose increase.

49. The hospice nursing notes from August 29, 2021 through October 15, 2021, repeatedly noted that Patient 2 had normal speech and normal intake. After the initial few assessments of moderate confusion, Patient 2 was documented as having no confusion or mild confusion.

50. On October 15, 2021, Respondent was removed as Patient 2's attending physician.

51. On May 18, 2022, Patient 2 was discharged from hospice due to "extended prognosis."

Inappropriate Hospice Admission.

52. The standard of care requires that the hospice physician certify the presence of terminal illness with life expectancy of less than six months if disease follows its usual course. The hospice physician should consider the terminal diagnosis, other diagnoses, and current available information regarding the patient. For hospice admission, the patient and/or patient's family should be aligned with the hospice philosophy of care of palliation of symptoms rather than curative treatment.

53. Patient 2 did not have a terminal diagnosis and there was no certification of terminal illness in Patient 2's medical records. Patient 2 did not meet the criteria to be scored as having 7A on the FAST scale. Patient 2 was documented to be ambulatory with supervision and required minimal assistance with ADLs. He was documented to be conversant while in the hospital and hospice frequently documented no confusion and normal speech. Patient 2's overall good physical health did not support a terminal prognosis of less than six months due to Alzheimer's disease. Patient 2's severe hypothyroidism was a reversible medical condition and was not considered as being a factor in his cognitive decline. Respondent failed to address and correct the severe hypothyroidism.

54. Respondent admitted Patient 2 to hospice without a hospice qualifying diagnosis. If Respondent had documented a request for all aggressive interventions and appropriate management of Patient 2's Parkinson's disease and hypothyroid, rather than palliative care, he

may have improved Patient 2's quality and quantity of life. This is an extreme departure from standard of care.

Patient 3:

55. On January 8, 2020, Patient 3, a then 75-year-old woman with dementia, hypertension, arthritis, and osteoporosis, sustained a right hip fracture after a fall at home. She was hospitalized for an open intramedullary nailing of her right hip. In early February 2020, Patient 3 was discharged to a skilled nursing facility (SNF) for rehabilitation and then to hospice.

56. On February 6, 2020, Patient 3 was re-hospitalized due to a severely altered mental status and hypotension. Patient 3's outpatient medications at that time included tramadol. Patient 3's family revoked hospice so that Patient 3 could receive more aggressive treatment. Patient 3 had severe acute renal failure and was thought to have severe dehydration. Patient 3's renal status improved during the hospitalization, but she remained confused. She was confirmed as DNR and was discharged to a skilled nursing facility.

57. On February 28, 2020, Patient 3 was discharged from the skilled nursing facility to a board and care facility. At that time, Patient 3 began receiving care from Respondent and H.C. Hospice. Respondent was both the hospice medical director and Patient 3's physician. Patient 3's daughter completed the election of hospice benefit and a POLST that specified DNR, comfort measures. Respondent signed off on the POLST. Patient 3's daughter also completed a "Patient Consent for Primary Care Physician," indicating that she prefers that Respondent, as H.C. Hospice Medical Director, attend to Patient 3's primary care needs. There was no initial certification of terminal illness and no IDG hospice documentation in Patient 3's medical records.

58. The first available hospice nursing note is dated January 3, 2021. At that time, the hospice nurse noted that Patient 3 had a primary diagnosis of heart disease with NYHA classification of IV. Patient 3 was noted as having no shortness of breath in the last 48 hours, easy breathing, and no edema. Patient 3 did not have documented symptoms of heart disease nor did she carry over a diagnosis of heart disease from her prior hospitalizations. A FAST score was documented to be 7C (severe dementia, cannot sit up on own without assistance). It was also documented that there was no confusion or speech impairment, and that Patient 3 was able to

stand unaided, all of which is inconsistent with a FAST score of 7C.

59. Between January 2021 and October 2021, Patient 3 had multiple hospice nurse visits. Hospice recertification assessments took place on January 17, 2021, March 22, 2021, and May 18, 2021. The documentation repeatedly reflected that Patient 3 had heart disease, NYHA classification of IV, and a FAST score of 7C, without documentation of symptoms to support these diagnoses. Patient 3 was repeatedly documented as having easy breathing, clear lung sounds, and no edema. Patient 3 was also consistently documented as only having mild to no confusion and normal speech. The documentation also reflected that Patient 3 was hard of hearing, potentially impeding her ability to converse or follow instructions appropriately. Patient 3's mobility issues began after her hip fracture and there is no indication that the mobility issues were attributable to dementia.

60. During her hospice admission, Patient 3 was continued on tramadol, 50 mg, every six hours as needed. On March 16, 2020, Patient 3 was placed on lorazepam (1 mg), every 6 hours as needed, for anxiety/agitation. On June 1, 2020, Patient 3 was placed on Depakote (125 mg) three times a day, for behavioral management. On June 26, 2020, Patient 3 was placed on mirtazapine (30 mg) nightly, for depression/appetite stimulation. On September 8, 2021, Patient 3 was eventually started on buspirone (5 mg) twice a day for depression/appetite stimulation.

61. Between January 2021 and October 2021, it was repeatedly documented that Patient 3 was under the services of Respondent but there was no documentation of any assessments by Respondent. The only document signed by Respondent was the POLST dated March 2, 2020.

62. On October 15, 2021, hospice nursing records reflect that Patient 3's hospice physician changed from Respondent to Dr. J.A.

63. On May 17, 2022, Patient 3 was discharged from hospice due to her extended prognosis.

64. On February 9, 2023, Patient 3 passed away. On Patient 3's death certificate, Dr. J.A. listed the immediate cause of death as respiratory failure due to congestive heart failure.

///

///

Inappropriate Hospice Admission.

65. Respondent was responsible for ensuring that Patient 3 met hospice admission criteria. Patient 3 did not exhibit signs or symptoms of a terminal illness at the time Respondent admitted her to hospice. Admitting Patient 3 to hospice without a terminal diagnosis deprived her of medical, psychological, and rehabilitative care that may have improved her quality of life. Respondent failed to recognize that Patient 3 was not terminally ill and failed to adjust her care plan accordingly. This is an extreme departure from the standard of care.

Failure to Accurately Diagnose Patient 3.

66. Patient 3 was documented as having a primary diagnosis of heart disease with NYHA classification of IV during her hospice care with Respondent though she did not have documented signs or symptoms of heart failure. Respondent failed to ensure an accurate diagnosis and allowed a plan to be developed, without correction, around an inaccurate diagnosis. This was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

67. 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, 2, and 3. The circumstances are as follows:

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

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

70. Respondent committed the following additional repeated acts of negligence:

Patient 1:

Erroneous Documentation of Hospice Diagnosis.

71. The standard of care requires that physicians maintain accurate and adequate medical records. When certifying the terminal illness that qualifies a patient for hospice, the certifying physician should make a good faith effort to verify the accuracy and internal consistence of the

information provided by hospice staff and available in the medical records.

72. Respondent documented a terminal diagnosis of "cerebrovascular accident, unspecified" for Patient 1's certification of terminal illness. On Patient 1's death certificate, Respondent certified that the immediate cause of Patient 1's death was respiratory failure due to "end stage cerebrovascular accident." Patient 1's medical records do not reflect that the CVA that occurred 10 years prior to his death was a direct contributor to his terminal decline or death. Patient 1's medical records reflect that his hospital admission for sepsis and C. difficile infection in January 2021 precipitated the terminal spiral from which he became increasingly unlikely to recover given his multiple underlying medical comorbidities. Patient 1 was appropriate for hospice given his failure to recover from a severe and recurrent C. difficile infection leading to worsened renal failure, severe malnutrition, anasarca, and multiple severe decubitus wounds complicated by his underlying disability from prior CVA and Stage III chronic kidney disease.

73. Respondent failed to document Patient 1's correct terminal diagnosis. This is a simple departure from the standard of care.

Inaccurate Patient Assessments.

74. The standard of care requires that physicians maintain accurate and adequate medical records.

75. Respondent repeatedly endorsed hospice documentation with erroneous facts, specifically the recurrent documentation of FAST 7A and NYHA Class IV. Patient 1 did not have a diagnosis of dementia or symptoms of heart failure. Both the FAST 7A and NYHA Class IV are not supported by the symptoms documented in Patient 1's medical records. As Patient 1's hospice physician, Respondent had a responsibility to correct Patient 1's hospice records prior to endorsing the records with his signature.

76. Respondent failed to accurately document Patient 1's diagnoses and severity of illness. This is a simple departure from standard of care.

///

///

///

Patient 2:

Inappropriate Prescribing of Lorazepam.

77. The standard of care requires that there be an appropriate clinical indication for prescribing dangerous drugs. Lorazepam is generally used as part of a comfort kit for urgent intervention in hospice; however, a medical indication is necessary and the dose should be tailored to the specific patient. Lorazepam can increase the risk of falls and contribute to confusion in the elderly. Its use in elderly patients is contraindicated in the absence of a benefit that outweighs those risks.

78. Respondent failed to establish a clinical indication for prescribing lorazepam for Patient 2 and the dose prescribed for Patient 2 was excessive. This is a simple department from the standard of care.

Inappropriate Prescribing of Quetiapine.

79. Quetiapine is an atypical antipsychotic that is frequently used to control behavioral issues associated with anxiety and agitation at night (sundowning).

80. Respondent failed to reassess the need for quetiapine once it was prescribed. Respondent failed to establish a clear indication for prescribing a morning dose of quetiapine given that Patient 2's anxiety and agitation occurred at night. This is a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

81. 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:

82. The allegations of the First and Second Causes for Discipline, 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.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

83. 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:

84. The allegations of the First, Second, and Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

85. Respondent is subject to disciplinary action under Code sections 2266, in that he failed to maintain adequate and accurate records for Patients 1, 2, and 3. The circumstances are as follows:

86. The allegations in the First and Second Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

87. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 6, 2020, in a prior disciplinary action entitled *In the Matter of the First Amended Accusation Against: Gary Gursharan Sandhu, M.D.*, before the Medical Board of California, Case No. 800-2015-014639, Respondent's license was revoked for being convicted of a crime, being under the influence at work, and use of alcohol in a dangerous manner. However, the revocation of Respondent's license was stayed and Respondent was placed on four (4) years of probation with the requirement that he abstain from use of controlled substances and alcohol, undergo a psychiatric evaluation, undergo psychotherapy, and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

///

///

///

///

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 93748, issued to Respondent Gary Gursharan Sandhu, M.D.;

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

3. Ordering Respondent Gary Gursharan Sandhu, 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: NOV 21 2024

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

LA2024603720
67202252.docx