

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

In the Matter of the Second Amended)
Accusation Against:)
)
)
RUDOLPHO J. ALEGRIA, M.D.) **Case No. 09-2009-203411**
)**OAH No. 2013010754**
Physician's and Surgeon's)
Certificate No. A37049)
)
)
Respondent.)
_____)

DECISION

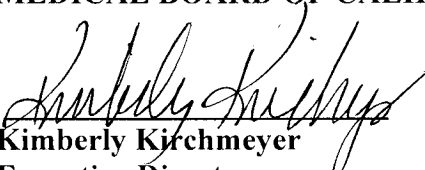
**The attached Stipulated Surrender of License and Disciplinary Order
is hereby adopted as the Decision and Order of the Medical Board of
California, Department of Consumer Affairs, State of California.**

This Decision shall become effective at 5:00 p.m. on December 31, 2014.

IT IS SO ORDERED July 14, 2014.

MEDICAL BOARD OF CALIFORNIA

By:


**Kimberly Kirchmeyer
Executive Director**

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 MARTIN W. HAGAN
Deputy Attorney General
4 State Bar No. 155553
110 West "A" Street, Suite 1100
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
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7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

9
10 **BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

12 In the Matter of the Second Amended
13 Accusation Against:

14 **RUDOLPHO J. ALEGRIA, M.D.
82-420 Miles Avenue
Indio, CA 92201**

15
16 **Physician's and Surgeon's Certificate No.
A37049**

17 Respondent.

Case No. 09-2009-203411
OAH No. 2013010754

**STIPULATED SURRENDER OF
LICENSE AND DISCIPLINARY ORDER**

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

21 **PARTIES**

22 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
23 of California and is represented in this matter by Kamala D. Harris, Attorney General of the State
24 of California, by Martin W. Hagan, Deputy Attorney General.

25 2. RUDOLPHO J. ALEGRIA, M.D. (Respondent) is represented in this proceeding by
26 attorney Peter R. Osinoff, Esq., of Bonne Bridges Mueller O'Keefe and Nicholls whose address is
27 3699, Wilshire Boulevard, Tenth Floor, Los Angeles, CA 90010-2719.

28 *////*

3. On July 15, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate No. A37049 to RUDOLPHO J. ALEGRIA, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought in Second Amended Accusation No. 09-2009-203411 and will expire on March 31, 2015, unless renewed.

JURISDICTION

4. On June 4, 2012, Accusation No. 09-2009-203411 was filed against Respondent before the Medical Board of California (Board), Department of Consumer Affairs. On June 4, 2012, Respondent was properly served with a true and correct copy of Accusation No. 09-2009-203411, together with true and correct copies of all other statutorily required documents, at his address of record on file with the Board which was and is: 84-420 Miles Avenue, Indio, CA, 92201. On or about June 8, 2012, a Notice of Defense was filed on Respondent's behalf by his then attorney of record, Tracy Green, Esq.

5. On May 28, 2013, First Amended Accusation No. 09-2009-203411 was filed against Respondent before the Board. On May 28, 2013, a true and correct copy of the First Amended Accusation, along with true and correct copies of a Supplemental Statement to Respondent and further Request for Discovery, were properly served on Respondent at his address of record on file with the Board which was and is: 84-420 Miles Avenue, Indio, CA, 92201.

6. On April 29, 2014, Second Amended Accusation No. 09-2009-203411 was filed before the Board and is currently pending against Respondent. On April 29, 2014, a true and correct copy of the Second Amended Accusation, along with true and correct copy of a Supplemental Statement to Respondent, were properly served on Respondent at his address of record on file with the Board which was and is: 84-420 Miles Avenue, Indio, CA, 92201. A true and correct copy of Second Amended Accusation No. 09-2009-203411 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

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12. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A37049 without further notice or opportunity to be heard.

CONTINGENCY

13. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board “shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license.”

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it

1 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
2 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
3 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
4 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
5 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
6 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
7 of any matter or matters related hereto.

8 **ADDITIONAL PROVISIONS**

9 16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties
10 herein to be an integrated writing representing the complete, final and exclusive embodiment of
11 the agreements of the parties in the above-entitled matter.

12 17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary
13 Order, including signatures of the parties, may be used in lieu of original documents and
14 signatures and, further, that such copies shall have the same force and effect as originals.

15 18. In consideration of the foregoing admissions and stipulations, the parties agree the
16 Executive Director of the Medical Board may, without further notice to or opportunity to be heard
17 by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

18 **DISCIPLINARY ORDER**

19 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A37049, issued
20 to Respondent RUDOLPHO J. ALEGRIA, M.D., is surrendered and accepted by the Medical
21 Board of California.

22 1. The effective date of this Decision and Disciplinary Order shall be December 31,
23 2014.

24 2. The surrender of Respondent's Physician's and Surgeon's Certificate No. A37049 and
25 the acceptance of the surrendered license by the Board shall constitute the imposition of
26 discipline against Respondent. This stipulation constitutes a record of the discipline and shall
27 become a part of Respondent's license history with the Medical Board of California.

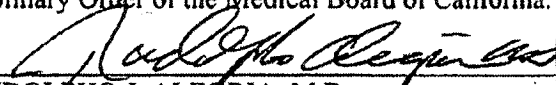
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- 1 3. Respondent shall lose all rights and privileges as a physician and surgeon in
2 California as of the effective date of the Board's Decision and Order.
- 3 4. Respondent shall cause to be delivered to the Board his pocket license and, if one was
4 issued, his wall certificate on or before the effective date of the Decision and Order.
- 5 5. If Respondent ever applies for licensure or petitions for reinstatement in the State of
6 California, the Board shall treat it as a petition for reinstatement. Respondent must comply with
7 all the laws, regulations and procedures for licensure in effect at the time the application or
8 petition is filed, and all of the charges and allegations contained in Second Amended Accusation
9 No. 09-2009-203411 shall be deemed to be true, correct and fully admitted by Respondent when
10 the Board determines whether to grant or deny the application or petition.
- 11 6. If Respondent should ever apply or reapply for a new license or certification, or
12 petition for reinstatement of a license, by any other health care licensing agency in the State of
13 California or elsewhere, all of the charges and allegations contained in Second Amended
14 Accusation No. 09-2009-203411 shall be deemed to be true, correct, and fully admitted by
15 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
16 restrict licensure.
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1 ACCEPTANCE

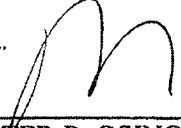
2 I have carefully read the above Stipulated Surrender of License and Disciplinary Order and
3 have fully discussed it with my attorney, Peter R. Osinoff, Esq. I understand the stipulation and
4 the effect it will have on my Physician's and Surgeon's Certificate No. A37049. I enter into this
5 Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently,
6 and agree to be bound by the Decision and Disciplinary Order of the Medical Board of California.

7 DATED: 5/16/14


8 RUDOLPHO J. ALEGRIA, M.D.
Respondent

9 I have read and fully discussed with Respondent RUDOLPHO J. ALEGRIA, M.D., the
10 terms and conditions and other matters contained in this Stipulated Surrender of License and
11 Disciplinary Order. I approve its form and content.

12 DATED: 5/16/14


13 PETER R. OSINOFF, ESQ.
14 Attorney for Respondent

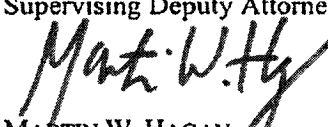
15 ENDORSEMENT

16 The foregoing Stipulated Surrender of License and Disciplinary Order is hereby
17 respectfully submitted for consideration by the Medical Board of California of the Department of
18 Consumer Affairs.

19 DATED: 5-16-2014

Respectfully submitted,

20 KAMALA D. HARRIS
Attorney General of California
21 THOMAS S. LAZAR
Supervising Deputy Attorney General


22 MARTIN W. HAGAN
23 Deputy Attorney General
24 Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 09-2009-203411

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Supervising Deputy Attorney General
3 MARTIN W. HAGAN
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8 *Attorneys for Complainant*

9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12 In the Matter of the Second Amended
13 Accusation Against:

14 **RUDOLPHO J. ALEGRIA, M.D.**
15 **82-420 Miles Avenue**
Indio, CA 92201

16 **Physician's and Surgeon's Certificate**
17 **No. A37049**

18 Respondent.

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 29, 2014
BY: [Signature] ANALYST

Case No. 09-2009-203411

SECOND AMENDED ACCUSATION

19
20 Complainant alleges:

21 **PARTIES**

22 1. Kimberley Kirchmeyer (Complainant) brings this Second Amended Accusation
23 solely in her official capacity as the Executive Director of the Medical Board of California,
24 Department of Consumer Affairs.

25 2. On or about July 15, 1981, the Medical Board of California issued Physician's and
26 Surgeon's Certificate Number A37049 to RUDOLPHO J. ALEGRIA, M.D. (Respondent). The
27 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
28 charges brought herein and will expire on March 31, 2015, unless renewed.

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1 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
2 licensee's conduct departs from the applicable standard of care, each departure
3 constitutes a separate and distinct breach of the standard of care.

4 "(d) Incompetence.

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

8 "(f) Any action or conduct which would have warranted the denial of a
9 certificate.

10 "...."

11 6. Section 2238 of the Code states:

12 "A violation of any federal statute or federal regulation or any of the statutes or
13 regulations of this state regulating dangerous drugs or controlled substances constitutes
14 unprofessional conduct."

15 7. Section 2261 of the Code states:

16 "Knowingly making or signing any certificate or other document directly or
17 indirectly related to the practice of medicine or podiatry which falsely represents the
18 existence or nonexistence of a state of facts, constitutes unprofessional conduct."

19 8. Section 2242 of the Code states:

20 "(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in
21 Section 4022 without an appropriate prior examination and a medical indication,
22 constitutes unprofessional conduct.

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

26 "(1) The licensee was a designated physician and surgeon or podiatrist
27 serving in the absence of the patient's physician and surgeon or podiatrist, as the
28 case may be, and if the drugs were prescribed, dispensed, or furnished only as

1 necessary to maintain the patient until the return of his or her practitioner, but in
2 any case no longer than 72 hours.

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

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

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

10 “(3) The licensee was a designated practitioner serving in the absence of
11 the patient's physician and surgeon or podiatrist, as the case may be, and was in
12 possession of or had utilized the patient's records and ordered the renewal of a
13 medically indicated prescription for an amount not exceeding the original
14 prescription in strength or amount or for more than one refill.

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

17 9. Section 725 of the Code states:

18 “(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or
19 administering of drugs or treatment, repeated acts of clearly excessive use of
20 diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or
21 treatment facilities as determined by the standard of the community of licensees is
22 unprofessional conduct for a physician and surgeon...

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

1 “(c) A practitioner who has a medical basis for prescribing, furnishing,
2 dispensing, or administering dangerous drugs or prescription controlled substances
3 shall not be subject to disciplinary action or prosecution under this section.
4 “(d) No physician and surgeon shall be subject to disciplinary action pursuant
5 to this section for treating intractable pain in compliance with Section 2241.5.”
6 10. Section 2266 of the Code states:
7 “The failure of a physician and surgeon to maintain adequate and accurate records
8 relating to the provision of services to their patients constitutes unprofessional conduct.”
9 11. Section 2241 of the Code states:
10 “(a) A physician and surgeon may prescribe, dispense, or administer
11 prescription drugs, including prescription controlled substances, to an addict under
12 his or her treatment for a purpose other than maintenance on, or detoxification
13 from, prescription drugs or controlled substances.
14 “(b) A physician and surgeon may prescribe, dispense, or administer
15 prescription drugs or prescription controlled substances to an addict for purposes of
16 maintenance on, or detoxification from, prescription drugs or controlled substances
17 only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218,
18 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall
19 authorize a physician and surgeon to prescribe, dispense, or administer dangerous
20 drugs or controlled substances to a person he or she knows or reasonably believes
21 is using or will use the drugs or substances for a nonmedical purpose.
22 “...”
23 ////
24 ////
25 ////
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INTRODUCTION

12. On or about December 17, 2008, the United States Department of Drug Enforcement Administration, Office of Diversion Control, Riverside District Office (DEA), received information that an individual identified as Rudolpho J. Alegria, M.D., "would prescribe anything to anyone without a medical examination." The DEA received a subsequent tip from a Source of Information indicating that "Dr. Alegria would prescribe methadone² in tablet form to opiate addicted patients." A review was conducted of respondent's prescribing history, by using a Controlled Substance Utilization Review and Evaluation System (CURES) report for the period November 1, 2007, through May 14, 2008. This review indicated that respondent wrote approximately 4,398 prescriptions for patients during this six-month period. The DEA initiated an investigation against respondent on or about April 30, 2009, which was assigned to DEA Diversion Investigator A.A., as the lead investigator. Further investigation, as discussed more fully herein, revealed additional serious concerns over respondent's prescribing of controlled substances and dangerous drugs.

13. On or about June 9, 2009, S.B., a licensed vocational nurse (LVN) at a methadone clinic reported that respondent was prescribing methadone tablets to opiate addicted patients for "pain management." S.B. stated that several patients of the methadone clinic, while still participating in the program and receiving daily doses of methadone, obtained prescriptions from respondent which put the patients at high risk of overdosing.³ S.B. reported the clinic made

² Methadone (Dolophine Hydrochloride) is a Schedule II Controlled Substance under Health and Safety Code section 11055(c) (14) and a dangerous drug under Code section 4022 (a). On November 27, 2006, the United States Federal Drug Administration (FDA) issued "Public Health Advisory: Methadone Use for Pain Control May Result in Death and Life-Threatening Changes in Breathing and Heart Beat." The public health advisory warned, in pertinent part, that "FDA has received reports of death and life-threatening side effects in patients taking methadone for pain control and in patients who have switched to methadone after being treated for pain with other strong narcotic pain relievers. Methadone can cause slow or shallow breathing and dangerous changes in heart beat that may not be felt by the patient."

³ "Between 1999 and 2009, the rate of fatal overdoses involving methadone increased more than fivefold as its prescribed use for treatment of pain increased" and "[r]ecent analyses have shown that methadone was involved in one in three opioid-related deaths in 2008." (Vital Signs: Risk of Overdose from Methadone Used for Pain Relief – United States, 1999-2010, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR) Volume 61, No. 26, dated July 6, 2012.)

1 several attempts to contact respondent regarding this practice without any success due to a lack of
2 cooperation by respondent and his staff.

3 14. On or about June 29, 2009, DEA Diversion Investigator A.A. obtained a patient
4 profile history for A.M., who at the time was 29 years old. According to the profile, A.M. filled
5 prescriptions from respondent for 390 tablets of methadone 10 mg on a consistent monthly basis
6 with a prescription for Oxycodone 15 mg being filled on June 22, 2009.⁴ Shortly thereafter, A.M.
7 was interviewed and stated, among other things, that she obtained the Methadone and Oxycodone
8 from respondent. A.M. further stated respondent never instructed her on how to take the
9 medications, never warned her of the long term effects of taking pain medication, and never
10 discussed any type of treatment plan to wean her off the medications. According to A.M., the
11 first and only time she was examined by respondent was May 27, 2009.

12 15. On or about July 30, 2009, agents from the DEA Riverside Diversion Unit obtained
13 additional information from a source associated with a narcotic treatment program (NTP) in Palm
14 Springs, California, who advised them respondent was known to prescribe methadone for "pain"
15 to addicts without valid justification or medical indication. DEA Diversion Investigator A.A.
16 conducted a subsequent interview with the source who indicated that when NTP patients find a
17 physician who will prescribe methadone outside of the NTP they typically will not return to the
18 NTP. The source identified at least ten (10) patients that the NTP had lost to respondent. The
19 source also stated several patients, prior to initiating treatment at the NTP had tested positive for
20 methadone which indicated methadone in tablet form was available for purchase on the street.

21 16. On or about August 18, 2009, DEA Diversion Investigator A.A. interviewed a clinic
22 director of another NTP located in Palm Springs, California. This source indicated, among other
23 things, that she was aware of respondent through several of her patients who reported respondent
24 prescribed methadone for "pain." The source provided information on patients who had been
25 terminated from her NTP who were possibly patients of respondent. Further investigation
26

27 ⁴ The patient profile for A.M. indicated that Methadone 10 mg prescriptions from
28 respondent being filled on October 21, 2008, November 11, 2008, January 9, 2009, February 9,
2009, March 12, 2009 and April 8, 2009.

1 revealed that some of the patients were, in fact, receiving methadone and other controlled
2 substances and dangerous drugs from respondent.

3 17. On or about September 2009 through December 2009, DEA Diversion Investigator
4 A.A. obtained information and documents from the Riverside County Coroner concerning patient
5 deaths for patients who had received controlled substances from respondent:

6 (a) Patient J.M. died in 2008 from a suspected overdose. Respondent
7 prescribed J.M. hydrocodone and alprazolam (Xanax).⁵ The Deputy Coroner later
8 confirmed J.M. died of natural causes unrelated to the controlled substances.
9 However, the Deputy Coroner, indicated respondent had, on occasion, prescribed
10 hydrocodone and alprazolam to J.M. at inappropriate intervals.

11 (b) Patient J.O. died on May 18, 2009, from acute alprazolam and
12 morphine intoxication.⁶ J.O. was last seen by respondent on March 13, 2009. A
13 review of the CURES report for J.O. indicated he began filling prescriptions from
14 respondent for alprazolam, morphine and other controlled substances on
15 September 3, 2008, for approximately nine months; with additional prescriptions
16 for alprazolam and morphine sulfate being filled in March and May 2009. Prior to
17 his death on May 18, 2009, J.O. received a prescription for 90 tablets of
18 alprazolam 90 mg and 90 tablets of morphine sulfate 15 mg from respondent.
19 These prescriptions were filled on May 13, 2009 (five days before J.O. died).

20 (c) Patient C.C. died of acute methadone intoxication on August 25, 2009.
21 Respondent prescribed C.C. methadone and alprazolam (Xanax). According to
22 DEA Diversion Investigator A.A.'s report of investigation, the inventory of the

23 ⁵ Alprazolam (Xanax), a benzodiazepine, is a Schedule IV Controlled Substance under
24 Health and Safety Code section 11057(d)(1) and a dangerous drug under Code section 4022 (a).

25 ⁶ As noted by the CDC, in one of their weekly Morbidity and Mortality Reports, there is a
26 distinct risk in prescribing methadone and alprazolam (Xanax), an antianxiety agent. The
27 "primary disadvantages [of methadone] are its long and unpredictable half-life and associated risk
28 for accumulating toxic levels leading to severe respiratory depression; its multiple interactions
with other drugs, including frequently abused drugs such as antianxiety agents; and its ability to
cause major disturbances of cardiac rhythm." (*Id.*, Vital Signs: Risk of Overdose from
Methadone Used for Pain Relief – United States, 1999-2010, at p. 494.)

1 controlled substances taken by the Deputy Coroner revealed the levels of use were
2 inappropriate. On August 18, 2009 (five days before C.C. died), respondent
3 prescribed C.C. 150 tablets of methadone 10 mg; and 90 tablets of alprazolam
4 (Xanax). There were 23 tablets of methadone and 54 tablets of alprazolam
5 remaining at the time of C.C.'s death.

6 (d) Patient H.A. was involved in an early morning traffic accident on
7 December 24, 2009, and was pronounced dead at the scene of the accident.
8 Respondent prescribed patient H.A. 180 tablets of methadone 10 mg which H.A.
9 filled on December 17, 2009.⁷ A subsequent autopsy listed the cause of death for
10 patient H.A. as acute methadone and alcohol intoxication and accident.

11 18. On or about April 2, 2010, DEA Diversion Investigator A.A. obtained information
12 from the Palm Springs Police Department concerning B.W. and the death of his friend which
13 involved alcohol and drugs. B.W. reported to a Palm Springs Detective that he started taking
14 Vicodin, Xanax, Ecstasy and Oxycontin in approximately 2007 when he was fifteen (15) years
15 old. In approximately 2009, B.W.'s friend took him to a physician in Indio "who gives out
16 prescriptions with no questions asked."⁸ B.W. identified the doctor as respondent who would
17 prescribe Methadone and Xanax without running any tests and without obtaining a complete
18 medical history.

19 19. On or about September 29, 2009 through June 17, 2010, the DEA ran five (5)
20 undercover operations against respondent which are discussed more fully herein.

21 20. On or about October 13, 2011, representatives from the Inland Empire Health Plan
22 (IEHP), a State health care provider, conducted an in-office medical audit on a random sample of
23 thirteen (13) of respondent's patient files. The "Narcotic Drug Review" memorandum regarding
24

25 ⁷ The Deputy Coroner's inventory of controlled substances also included other methadone
prescriptions from a Dr. T. that had been filled in September, October and November 2009.

26 ⁸ A cross-reference with a CURES report for the period of November 1, 2008, to February
27 1, 2010, indicates B.W. filled the following prescriptions from respondent: alprazolam, 20 mg
28 (#90) and methadone hydrochloride, 10 mg (#180) on December 14, 2009; and alprazolam, 20
mg (#90) and methadone hydrochloride, 10 mg (#210) on February 14, 2010.

1 the audit identified respondent as being "on the top 10 narcotic prescriber report [for the] last
2 several years." The summary section of the "Narcotic Drug Review" memorandum stated:

3 "After reviewing 13 patient records, it is clear that Dr. Alegria provided
4 excessive narcotic prescriptions for his patients. In most cases, no pain related issues
5 were identified. When [a] pain condition was documented, no evaluation was
6 recorded such as pain scale, examination, evaluation and treatment plan. It was
unclear why the treatment was initiated and continued for the condition. High
potency narcotics were used without valid diagnoses. Poor documentation was also
noted for non-pain chronic issues."

7 21. On or about October 13, 2010, the DEA served respondent with an Order to Show
8 Cause and Immediate Suspension of Registration which suspended respondent's DEA
9 Registration No. AA1285318.

10 22. On or about January 11, 2011, respondent voluntarily surrendered his DEA
11 Registration No. AA1285318 in lieu of an Administrative Hearing for an Order to Show Cause to
12 revoke his DEA registration.⁹

13 **FIRST CAUSE FOR DISCIPLINE**

14 **(Gross Negligence)**

15 23. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
16 by section 2234, subsection (b) of the Code, in that respondent committed gross negligence as
17 more particularly alleged below:

18 ////

19 ⁹ Shortly after respondent surrendered his DEA certificate, DEA Diversion Investigator
20 A.A. received a report prepared by Dr. J.G., identified as a Diplomat of the American Boards of
21 Internal Medicine, Addiction Medicine and Pain Medicine, which set forth the results of his
22 review of ten (10) of respondent's patient's files. This report noted, in pertinent part, "Dr.
23 Alegria's medical records for the ten patients I reviewed share the following characteristics: [¶]
24 His handwriting is extremely difficult to read and often completely illegible. [¶] He virtually
25 never records sufficient information in the medical history or physical examination to provide a
26 basis for the diagnosis or treatment of any condition. His notes are extremely skeletal and
27 inadequate. Only in one patient, [A.M.], was there an adequate basis to evaluate and treat her
28 chronic pain, and that came solely from an outside pain management specialty clinic. [¶] His
stated diagnoses are most often just statements of symptoms, e.g., low back pain. A symptom is
not a medical diagnosis. The role of a physician is to find and treat the cause of symptoms. [¶]
He prescribed controlled drugs for patients who are addicts, even when he recorded "substance
abuse" as a diagnosis. Seven of the ten patients I reviewed were definite or probable addicts: [list
of names]. [¶] In two other patients, [patient names], Dr. Alegria provided the opiates and
sedatives most prized by addicts without any evidence their use was warranted. [¶] For those
reasons, and with the exception of [A.M.], Dr. Alegria prescribed controlled drugs to these
patients without legitimate medical indication, and outside the usual course of medical practice."

1 DEA AGENT B.S.

2 24. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
3 by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his
4 care and treatment of B.S. as more particularly alleged hereinafter:

5 25. On or about September 29, 2009, DEA agent B.S. acting as an undercover operative
6 under the undercover name "Brian Lowman," presented at respondent's medical offices located at
7 82-420 Miles Avenue in Indio. B.S. paid \$80.00 for the visit. B.S. was initially attended to by a
8 physician assistant (PA) who took his blood pressure, weight and height and sent him to the
9 treatment room. In the treatment room, B.S. told respondent he wanted a prescription for
10 Methadone, Oxycontin¹⁰ and Xanax for his back pain. B.S. stated he hurt his back from an
11 automobile accident a year earlier and that the injury was aggravated when he slipped and fell on
12 some stairs. Respondent asked B.S. how much Methadone and Oxycontin he was taking. B.S.
13 stated he was taking 100 milligrams of Methadone and 80 milligrams of Oxycontin a day, and
14 that the drugs had been prescribed for him by a "Dr. Lister." Respondent told B.S. he could not
15 prescribe Oxycontin without reviewing Dr. Lister's records, and in any case, would not prescribe
16 Oxycontin and Xanax together for a patient of B.S.'s age because the state authorities were
17 specifically "looking for Oxycontin and Xanax prescriptions given to younger people." B.S. told
18 respondent he could examine his back to justify the prescription if he wished, but respondent said
19 he did not need to. Respondent agreed to prescribe Methadone and Xanax but told B.S. he should
20 bring Dr. Lister's records with him on the next visit. Respondent wrote a prescription for 300
21 Methadone 10 mg and 90 tablets of Xanax 1 mg for B.S. and recommended that B.S. could fill
22 the prescription at a nearby pharmacy known as McIntosh Pharmacy. Respondent failed to
23 provide adequate informed consent regarding, among other things, the risks and benefits of the
24 use of controlled substances and other possible treatment modalities. B.S. had the prescriptions
25 filled at McIntosh Pharmacy.

26
27 ¹⁰ Oxycontin (Oxycodone) is a Schedule II Controlled Substance under Health and Safety
28 Code section 11055(b)(1)(L) and a dangerous drug under Code section 4022 (a).

1 26. In his chart note of the September 29, 2009 visit,¹¹ respondent noted he performed a
2 physical exam which showed B.S. had "Tender Post Neck" and "Back/Spine-L4-5 para-spinal
3 areas." Respondent listed diagnoses for B.S. which included "Chronic Cervical strain due to
4 whiplash" and "Anxiety/Stress." Respondent's medical documentation was false because
5 respondent did not perform any physical examination, B.S. never complained of "whiplash" or
6 that he was suffering from any stress and/or anxiety, the diagnoses were not based on any
7 physical examination or any diagnostic tests and there was no reasonable justification for charting
8 B.S. suffered from these conditions.

9 27. On or about November 10, 2009, B.S. made a return visit to respondent's offices in
10 his undercover capacity. He paid \$50.00 for the visit. B.S. was initially attended to by a PA who
11 took his blood pressure, weight and height. At one point, the PA asked B.S. "are you always
12 high?" B.S. informed the PA he was not in pain but wanted his prescription refilled. Respondent
13 attended to B.S. Respondent told B.S. he had not received the medical records from Dr. Lister.
14 B.S. stated he thought the medical records were only necessary if he wanted a prescription for
15 Oxycontin. Among other things, respondent stated he could not prescribe Methadone to B.S.
16 without "some records," that the 300 tablets of Methadone was an "extremely high dose" for a
17 patient of B.S.'s age and that he was required to follow the state prescribing guidelines.
18 However, respondent agreed to prescribe Methadone and Xanax for B.S. "one more time." He
19 advised B.S. to have "lab work" done before the next visit. Respondent wrote a prescription for
20 300 tablets of Methadone 10 mg and 90 tablets of Xanax 2 mg. Respondent failed to provide
21 adequate informed consent regarding, among other things, the risks and benefits of the use of
22 controlled substances and other possible treatment modalities. B.S. filled the prescriptions at
23 McIntosh Pharmacy.

24 28. In his chart note for the November 10, 2009 visit, respondent falsely documented that
25 B.S. complained of "continued back pain" and that he performed a physical examination which
26 was unremarkable. Respondent diagnosed B.S. as suffering from low back pain. Respondent's

27 ¹¹ Respondent incorrectly noted September 26, 2009 as the date of service in his
28 typewritten chart note.

1 medical documentation was false because B.S. did not complain of continued back pain,
2 respondent did not perform any physical examination, and the diagnosis of low back pain was not
3 based on any physical examination or any diagnostic tests and there was no reasonable
4 justification for charting B.S. suffered from this condition.

5 29. On or about March 25, 2010, B.S. made a return visit to respondent's offices in his
6 undercover capacity. He paid \$50.00 for the visit. The receptionist told B.S. there was a "big
7 note" in his medical file stating respondent wanted "labs done." B.S. showed the receptionist an
8 x-ray he brought with him but the receptionist said respondent's instructions were that B.S.
9 should not be scheduled for an appointment without "records or labs." Subsequently, B.S. was
10 seen by a PA who also told B.S. respondent would not see him without his medical records or
11 "lab work." However, the PA told B.S. to wait while he checked with respondent. When he
12 returned, the PA told B.S. respondent would prescribe medications for him but a urine sample
13 would have to be obtained. The PA took B.S.'s blood pressure, weight, height and urine sample¹²
14 and sent him to the waiting room to be seen by respondent. When respondent entered the waiting
15 room, he asked B.S. how he was doing and B.S. responded he was doing "alright" and he had
16 "been better." B.S. also stated he had not been able to find Dr. Lister, that he had been to a
17 "methadone clinic" but did not complete the "paper work" for enrollment because he did not feel
18 comfortable at the clinic. B.S. told respondent that he was able to get an X-ray "from one of my
19 friends who was with Dr. Lister and that's all I could get." After further discussion, respondent
20 prescribed 300 tablets of Methadone 10 mg, 90 tablets of Xanax 2 mg and a blood pressure
21 medication for B.S. Respondent failed to provide adequate informed consent regarding, among
22 other things, the risks and benefits of the use of controlled substances and other possible
23 treatment modalities and during the course of treatment failed to seek consultation from and/or
24 provide a referral to the appropriate medical specialist(s).

25 30. In his chart note for the March 25, 2010 visit, respondent falsely indicated B.S.
26 complained of "increased low back pain, still with anxiety" and that he performed a physical
27

28 ¹² There were no urine screen results contained in the medical records for B.S.

1 examination which was unremarkable during the visit. Among other things, respondent
2 diagnosed B.S. as suffering from "chronic back pain." Respondent's chart notes were false
3 because B.S. did not complain of increased back pain or anxiety/stress, respondent did not
4 perform any physical examination, and the diagnoses of "chronic back pain" and anxiety were not
5 based on any physical examination or any diagnostic tests and there was no reasonable
6 justification for charting B.S. suffered from these conditions.

7 31. Respondent committed gross negligence in his care and treatment of B.S., which
8 included, but was not limited to, the following:

9 (a) Respondent repeatedly prescribed large amounts of Methadone and
10 Xanax medications to B.S. without adequate justification and without an adequate
11 history and physical examination including, but not limited to, obtaining a more
12 detailed history, reviewing and verifying prior medical treatment, conducting a
13 more thorough review of symptoms and/or more accurately assessing the patient's
14 actual condition;

15 (b) Respondent repeatedly prescribed large amounts of Methadone and
16 Xanax medications to B.S. without adequate justification and without clearly
17 documenting an adequate treatment plan with stated objectives for the patient's
18 care and treatment in regard to the narcotics and controlled substances that were
19 prescribed;

20 (c) Respondent repeatedly prescribed large amounts of Methadone and
21 Xanax medications to B.S. without adequate justification and without adequate
22 informed consent of the various risks associated with the narcotics and controlled
23 substances that were being prescribed and the possibility of alternative non-
24 narcotic therapies;

25 (d) Respondent repeatedly prescribed large amounts of Methadone and
26 Xanax medications to B.S. without seeking appropriate consultation from, or
27 referring the patient to, the appropriate medical specialists;

28 ////

1 (e) Respondent repeatedly prescribed large amounts of Methadone and
2 Xanax medications to B.S. without utilizing urine drug screens and/or other risk
3 screening tools.

4 (f) Respondent failed to maintain, in whole or part, legible, complete,
5 adequate, and/or accurate medical records concerning, among other things, B.S.'s
6 medical history and physical examination, other evaluations and/or treatments,
7 treatment plan objectives, informed consent, treatments, medications, rationale for
8 changes in the treatment plan or medications, agreements with the patient and/or
9 periodic reviews of the treatment plan;

10 (g) Respondent made false medical record entries for patient B.S.'s visit of
11 September 29, 2009, when he, among other things, documented he performed a
12 physical examination of the patient pain, documented pain associated with "Tender
13 Post Neck" and "Back/Spine-L4-5 para-spinal areas" and documented impressions
14 of "Chronic Cervical strain due to whiplash" and "Anxiety/Stress." Respondent's
15 medical record entries were false because, among other things, respondent did not
16 perform a physical examination and there was no reasonable justification for
17 documenting the aforementioned conditions and diagnoses;

18 (h) Respondent made false medical record entries for patient B.S.'s visit of
19 November 10, 2009, when he, among other things, documented the patient
20 complained of back pain during the visit and listed his diagnosis of back pain.
21 Respondent's medical record entries were false because, among other things, B.S.
22 did not complain of continued back pain, respondent did not perform a physical
23 examination, and there was no reasonable justification for documenting the
24 aforementioned condition and diagnosis; and

25 (i) Respondent made false medical record entries for patient B.S.'s visit of
26 March 25, 2010, when he, among other things, documented B.S. complained of
27 "increased low back pain, still with anxiety" during the visit and when he
28 diagnosed B.S. as suffering from chronic back pain. Respondent's medical record

1 entries were false because, among other things, B.S. did not complain of increased
2 back pain or anxiety, respondent did not perform a physical examination, and there
3 was no reasonable justification for documenting the aforementioned conditions and
4 diagnosis.

5 DEA AGENT M.J.

6 32. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
7 by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his
8 care and treatment of M.J. as more particularly alleged hereinafter:

9 33. On or about May 11, 2010, DEA agent M.J. acting as an undercover operative under
10 the undercover name Michael Lopez, presented at respondent's offices located at 82-420 Miles
11 avenue in Indio.¹³ M.J. requested to see the "doctor" because he needed a prescription for
12 Methadone. He was initially attended to by a female medical assistant who took his temperature,
13 blood pressure, weight and height. M.J. gave a "medical history" that included heroin use "on
14 and off" for seven to eight years, smoking a pack of cigarettes a day, and Methadone and
15 Valium¹⁴ use. M.J. denied experiencing any pain and stated he wanted Methadone because he
16 was "just jonesin."¹⁵ M.J. paid \$80.00 for the visit. Respondent attended to M.J. and asked M.J.
17 why he needed Methadone "right now." M.J. told respondent that he was "just jonesin" and had
18 been using Methadone he obtained from friends, that he had not seen a doctor in awhile because
19 he had no money and that he was not in pain, but was "jonesin." Respondent placed two fingers
20 on M.J.'s left upper chest and listened to his breathing. Respondent stated, among other things,
21 that he could only prescribe Methadone for pain and asked M.J. if he had any kind of pain. M.J.
22 asked if "jonesin" counted as pain. Respondent said "No, cause that is just withdrawals."
23 Respondent again asked M.J. if he had any pain such as lower back pain or joint pain. M.J. did

24 ¹³ M.J. was accompanied by another DEA Agent.

25 ¹⁴ Valium (Diazepam) is a Schedule IV Controlled Substance under Health and Safety
26 Code section 11057(d)(9) and a dangerous drug under Code section 4022 (a).

27 ¹⁵ "Jonesin" or "jonesing" was originally used to describe withdrawal symptoms caused
28 by addiction. It is defined as an intense withdrawal or craving for a drug.

1 not respond to the inquiries about lower back pain and joint pain and asked "does a headache
2 count?" Respondent replied "Well, I guess - that is not a good reason to give Methadone for
3 though [followed by laughter]."¹⁶ Respondent then prescribed 270 tablets of Methadone 10 mg
4 for M.J. Respondent failed to provide adequate informed consent regarding, among other things,
5 the risks and benefits of the use of controlled substances and other possible treatment modalities.

6 34. In his chart note for the May 11, 2010 visit, respondent noted M.J.'s "Back/Spine-
7 Tender" on examination and "Paraspinal once." Respondent charted that M.J. "c/o [complained
8 of] chronic LBP [low back pain] x 5 years" and listed one of his impressions as "chronic low
9 back pain" despite the fact that M.J. reported several times that he was just "jonesin," failed to
10 report any "problems" with his "muscles and bones" or lower back on his Adult History Health
11 Questionnaire and never subjectively complained of any low back pain or "chronic low back
12 pain" during the course of his visit with respondent. Respondent's medical documentation was
13 false because respondent did not perform any physical examination, M.J. never complained of
14 suffering from low back pain, the diagnoses were not based on any physical examination or any
15 diagnostic tests and there was no reasonable justification for charting M.J. suffered from this
16 condition.

17 35. On or about June 17, 2010, M.J. made a return visit to respondent's offices in his
18 undercover capacity. M.J. requested a refill of his Methadone. He was initially attended to by a
19 male attendant who took his temperature, blood pressure, weight and height. In response to the
20 question whether he had any pain, M.J. stated he was "beginning to get sick." M.J. declined an
21 invitation to provide a urine sample. Respondent attended to M.J. in the treatment room. M.J.
22 told respondent he had run out of Methadone and wanted another prescription. Respondent
23 advised M.J. to reduce his use of Methadone or he would have to obtain his Methadone
24 medications from a "methadone maintenance clinic." He told M.J. the purpose of the Methadone
25 prescriptions was to allow M.J. to reduce his dependence on heroin. Respondent asked M.J. if he

26 ¹⁶ "For chronic noncancer pain, methadone should not be considered a drug of first choice.
27 This is especially true for conditions for which the benefits of opioids have not been
28 demonstrated, *such as headache or low back pain*. (*Id.*, Vital Signs: Risk of Overdose from
Methadone Used for Pain Relief - United States, 1999-2010, at p. 495, emphasis added.)

1 needed anti-anxiety and sleeping medications and M.J. said he did. Respondent wrote a
2 prescription for 270 tablets of Methadone 10 mg, 90 tablets of Xanax 2 mg and Restoril 30 mg for
3 M.J. Respondent failed to provide adequate informed consent regarding, among other things, the
4 risks and benefits of the use of controlled substances and other possible treatment modalities and
5 during the course of treatment failed to seek consultation from and/or provide a referral to the
6 appropriate medical specialist(s).

7 36. In his chart note for the June 17, 2010 visit, respondent indicated that M.J.
8 complained of low back pain, decreased sleep and excessive anxiety. Respondent also
9 documented that he performed a physical exam that was unremarkable and his diagnoses included
10 chronic low back pain and anxiety/stress. Respondent's medical documentation was false
11 because respondent did not perform any physical examination, M.J. never complained of
12 suffering from low back pain, decreased sleep and/or anxiety, the diagnoses were not based on
13 any physical examination or any diagnostic tests; and, there was no reasonable justification for
14 charting M.J. suffered from these conditions.

15 37. Respondent committed gross negligence in his care and treatment of M.J., which
16 included, but was not limited to, the following:

17 (a) Respondent repeatedly prescribed large amounts of Methadone and
18 Xanax on one occasion to M.J. without adequate justification and without an
19 adequate history and physical examination including, but not limited to, obtaining a
20 more detailed history, reviewing and verifying prior medical treatment, conducting
21 a more thorough review of symptoms and/or more accurately assessing the patient's
22 actual condition;

23 (b) Respondent repeatedly prescribed large amounts of Methadone and
24 Xanax on one occasion to M.J. without adequate justification and without clearly
25 documenting an adequate treatment plan with stated objectives for the patient's care
26 and treatment in regard to the narcotics and controlled substances that were
27 prescribed;

28 ////

1 (c) Respondent repeatedly prescribed large amounts of Methadone and
2 Xanax on one occasion to M.J. without adequate justification and without adequate
3 informed consent of the various risks associated with the narcotics and controlled
4 substances that were being prescribed and the possibility of alternative non-narcotic
5 therapies;

6 (d) Respondent repeatedly prescribed large amounts of Methadone and
7 Xanax on one occasion to M.J. without seeking appropriate consultation from, or
8 referring the patient to, the appropriate medical specialists;

9 (e) Respondent repeatedly prescribed large amounts of Methadone and
10 Xanax on one occasion to M.J. without utilizing urine drug screens and/or other risk
11 screening tools;

12 (f) Respondent failed to maintain, in whole or part, legible, complete,
13 adequate, and/or accurate medical records concerning, among other things, M.J.'s
14 medical history and physical examination, other evaluations and/or treatments,
15 treatment plan objectives, informed consent, treatments, medications, rationale for
16 changes in the treatment plan or medications, agreements with the patient and/or
17 periodic reviews of the treatment plan;

18 (g) Respondent made false medical record entries for M.J.'s visit of May
19 11, 2010, when he, among other things, documented M.J.'s "Back/Spine was tender"
20 on examination, "Paraspinal once," that M.J. "c/o [complained of] chronic LBP [low
21 back pain] x 5 years" and documented his impressions as "chronic low back pain"
22 Respondent's medical record entries were false because, among other things, M.J.
23 did not complain of back pain or chronic back pain, respondent did not perform a
24 physical examination, and there was no reasonable justification for documenting the
25 aforementioned conditions and diagnosis; and

26 (h) Respondent made false medical record entries for M.J.'s visit of June
27 27, 2010, when he, among other things, documented that M.J. complained of low
28 back pain, decreased sleep and excessive anxiety and diagnosed M.J. as suffering

1 from "chronic low back pain" and "Anxiety/Stress." Respondent's medical record
2 entries were false because, among other things, M.J. did not complain of back pain,
3 decreased sleep and/or excessive anxiety respondent did not perform a physical
4 examination, and there was no reasonable justification for documenting the
5 aforementioned conditions and diagnoses.

6 PATIENT R.C.

7 38. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
8 by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his
9 care and treatment of R.C. as more particularly alleged hereinafter:

10 39. On or about January 2, 2008, R.C., a male patient then 20 years old, made a visit to
11 respondent's offices with complaints of back, hand and neck pain. On this visit, respondent noted
12 patient R.C.'s medical history included "ADD on Adderall," two surgeries on the right hand in
13 2005 and 2006, and knee pain from snowboarding. Respondent also noted the patient's
14 medications included Oxycontin he received from the "ER." However, respondent failed to note
15 the nature and severity of the patient's back, hand and neck pain, and failed to note the patient's
16 history of Oxycontin use. On physical examination, respondent noted tenderness in the knees and
17 decreased range of motion (DROM) in the right 5th metacarpal. However, respondent failed to
18 perform a physical examination and/or note a physical examination of the patient's back and
19 neck. Respondent's assessment was "ADD," post traumatic osteoarthritis (PTOA) of the knees
20 and hands, tachycardia and lipidemia. Respondent prescribed 100 tablets of Percocet 325/5 mg¹⁷
21 and 60 tablets of Xanax 1 mg for patient R.C. Respondent failed to note any medical justification
22 for the Percocet and Xanax medications he prescribed for patient R.C. on this visit.

23 40. On or about February 4, 2008, respondent prescribed 90 tablets of Oxycontin 20 mg
24 and 90 tablets of Xanax 1 mg for patient R.C. Also on or about March 3, 2008, respondent

25
26 ¹⁷ Percocet, oxycodone and acetaminophen, is a Schedule II Controlled Substance under
27 Health and Safety Code section 11055(b)(1)(M) and a dangerous drug under Code section 4022.
28 It is indicated for relief of moderate to moderately severe pain when a continuous, around the
clock analgesic is needed for an extended period of time. It has the potential for abuse similar to
morphine.

1 prescribed another 90 of Oxycontin and 60 tablets of Xanax 1 mg for patient R.C. There are no
2 recorded visits on any of these dates, and respondent failed to note any medical justification for
3 these prescriptions. On or about March 21, 2008, patient R.C. made a visit with a request for
4 refills, among other things. Respondent noted the patient continued to have "hand pain with
5 movement." Respondent's assessment included Tachycardia, ADD, PTOA and hyperlipidemia.
6 On this visit, respondent prescribed Oxycontin and Xanax for patient R.C., however, he failed to
7 note these prescriptions in his chart note for the patient.¹⁸ Respondent also failed to note any
8 medical justification for these prescriptions.

9 41. On or about May 3, 2008, respondent prescribed 90 tablets of Xanax 1 mg for patient
10 R.C. There is no recorded visit on this date and there is no notation of the medical justification
11 for this prescription. On or about May 19, 2008, patient R.C. made an office visit requesting
12 refill and change of his medications. He reported he was "withdrawing" from Oxycontin and had
13 been "started on Methadone." Respondent failed to inquire and/or note he inquired into the
14 history of the patient's "withdrawal" or of a history of the patient's Methadone use. Respondent
15 also failed to obtain any history and/or note any history of the patient's addiction to and/or abuse
16 of controlled substances including Oxycontin and Xanax. On this visit, respondent prescribed 90
17 tablets of Methadone 10 mg for the patient. Respondent failed to note any medical justification
18 for these prescriptions.

19 42. On or about May 22, 2008, patient R.C.'s mother telephoned respondent's office and
20 spoke to a "nurse" called Carol. The patient's mother told Carol that patient R.C. did not have a
21 legitimate pain and was addicted to prescription medications. Carol assured the patient's mother
22 that respondent would no longer provide treatment or prescribe medication for patient R.C.

23 43. On or about June 13, 2008, patient R.C. made an office visit requesting refills. On
24 this visit, patient R.C. reported he had severe panic attacks and had been seen at a hospital and
25 was treated with Xanax. Respondent failed to note any history of the panic attacks and again
26 failed to note the patient's history of drug addiction and/or drug abuse. He prescribed 90 tablets

27 ¹⁸ According to the pharmacy records, patient R.C. filled the Xanax medication on
28 March 21, 2008 and filled the Oxycontin on March 22, 2008.

1 of Methadone 10 mg and 90 tablets of Xanax 1 mg for the patient. There is no notation of the
2 medical justification for these prescriptions. Respondent also failed to refer patient R.C. to a
3 specialist for treatment of his anxiety attacks.

4 44. Patient R.C. made an office visit on or about July 7, 2008 with a request for refill of
5 his medications. On this visit, respondent noted patient R.C. reported he had been seen at the
6 "ER" a month earlier for "anxiety attacks." Respondent again failed to note any history of the
7 patient's "anxiety attacks" or of the results of the patient's visit to the "ER." Respondent
8 prescribed 90 tablets of Oxycontin 40 mg and 90 tablets of Xanax 2 mg for the patient. There is
9 no notation of the medical justification for these prescriptions. On this visit, respondent noted he
10 instructed patient R.C. to seek follow-up care with Kaiser Permanente because he would no
11 longer prescribe medications for patient R.C.

12 45. Nonetheless, patient R.C. made an office visit on or about September 29, 2008, with a
13 complaint of lower back pain. On this visit, respondent noted that the patient reported he was
14 enrolled in the Kaiser Permanente "pain management program" for his lower back pain. Despite
15 this information, respondent prescribed 90 tablets of Oxycontin 40 mg and 30 tablets of
16 Clonazepam 2 mg¹⁹ for the patient. There is no notation of the medical justification for these
17 prescriptions.

18 46. Thereafter, patient R.C. was treated for drug addiction at Kaiser Permanente. On or
19 about September 4, 2009, patient R.C. died from drug toxicity.

20 47. Respondent committed gross negligence in his care and treatment of R.C., which
21 included, but was not limited to, the following:

22 (a) Between about January 2, 2008 and September 29, 2008, respondent
23 repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone without
24 adequate justification and without an adequate history and physical examination
25 including, but not limited to, obtaining a more detailed history, reviewing and
26

27 ¹⁹ Clonazepam (Klonopin) is a Schedule IV Controlled Substance under Health and Safety
28 Code section 11057(d)(7) and a dangerous drug under Code section 4022 (a).

1 verifying prior medical treatment, conducting a more thorough review of symptoms
2 and/or more accurately assessing the patient's actual condition;

3 (b) Between about January 2, 2008 and September 29, 2008, respondent
4 repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C.
5 without adequate justification and without clearly documenting an adequate
6 treatment plan with stated objectives for the patient's care and treatment in regard to
7 the narcotics and controlled substances that were prescribed;

8 (c) Between about January 2, 2008 and September 29, 2008, respondent
9 repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C.
10 without adequate justification and without adequate informed consent of the various
11 risks associated with the narcotics and controlled substances that were being
12 prescribed and the possibility of alternative non-narcotic therapies;

13 (d) Respondent repeatedly prescribed large amounts of Oxycontin, Xanax
14 and Methadone to R.C. without seeking appropriate consultation from, or referring
15 the patient to, the appropriate medical specialists;

16 (e) Respondent repeatedly prescribed large amounts of Oxycontin, Xanax
17 and Methadone to R.C. without utilizing urine drug screens and/or other risk
18 screening tools.

19 (f) Respondent failed to maintain, in whole or part, legible, complete,
20 adequate, and/or accurate medical records concerning, among other things, R.C.'s
21 medical history and physical examination, other evaluations and/or treatments,
22 treatment plan objectives, informed consent, treatments, medications, rationale for
23 changes in the treatment plan or medications, agreements with the patient and/or
24 periodic reviews of the treatment plan;

25 (g) On or about February 4, 2008, March 3, 2008 and May 3, 2008,
26 respondent prescribed Oxycontin and Xanax for patient R.C. without any recorded
27 office visit and without any notation of a medical justification for the prescriptions;
28 and

1 (h) Between about June 13, 2008 and September 29, 2008, respondent
2 prescribed Oxycontin, Methadone and Xanax to patient R.C. for treatment of R.C.'s
3 back pain and anxiety even though respondent knew or should have known that
4 patient R.C. did not have a legitimate pain, was addicted to prescription medications
5 and was drug seeking.

6 PATIENT C.W.

7 48. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
8 by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his
9 care and treatment of C.W. as more particularly alleged hereinafter:

10 49. On or about July 30, 2008, C.W., a male patient then 57 years old, made a visit to
11 respondent's offices for "follow up and medication." The patient was 6 feet 6 inches tall,
12 weighed 309 pounds, and his B/P was 144/73. On this visit, respondent noted patient C.W.
13 complained of problems related to the lower extremities.²⁰ As history, respondent noted the
14 patient had an "old fracture of the foot," a history of "past use of cocaine and PCP," and a family
15 history that included his father's death from coronary artery disease. On physical examination,
16 respondent noted the patient's feet were tender with "decreased range of motion due to pain."
17 Respondent ordered labs including EKG, echocardiogram and peripheral vascular studies and
18 nerve conduction velocity study of the lower extremities.²¹ His diagnosis included "possible
19 chronic obstructive pulmonary disease (COPD)." Respondent's prescriptions included Spivira,
20 Percocet 5/325, and Phenergan Expectorant with Codeine. Thereafter, patient C.W. made periodic
21 visits until about September 12, 2011.

22 50. During the period of treatment, patient C.W. repeatedly complained of pain in his
23 lower back, shoulders, hands, legs and knees. Respondent repeatedly failed to obtain and/or
24 document a history of the patient's complaint; failed to perform and/or document a thorough

25
26 ²⁰ At the physician's interview on January 25, 2012, respondent admitted he was unable
27 read his notation related to the patient's complaints on July 30, 2008.

28 ²¹ At the physician's interview, respondent stated he was unsure why he ordered the EKG
and echocardiogram but could because he heard a "heart murmur" which he failed to document.

1 physical examination related to the patient's pain complaints; failed to order appropriate
2 diagnostic tests in order to arrive at a diagnosis for the patient's pain; and failed to note a
3 diagnosis for the patient's pain complaints. However, respondent repeatedly prescribed narcotic
4 analgesics for management of the patient's pain. On patient C.W.'s visits on or about September
5 8, 2008, November 10, 2008 and December 10, 2008, respondent prescribed 120 tablets of
6 Percocet on each visit, for management of the patient's pain complaints. Respondent failed to
7 perform and/or document a physical examination of patient C.W. on any of these visits.

8 51. Patient C.W. repeatedly complained of pain in his lower back, legs, hands and knees
9 during visits in 2009. On the visit of January 12, 2009, respondent noted patient C.W.
10 complained of "increased knee pain." On the visits of on or about February 6 and March 16,
11 2009, respondent noted the patient complained of "bilateral leg and knee pain and stiffness,"
12 among other things. Respondent noted that patient C.W. complained of "continual pain in the
13 knees" on the visit of June 9, 2009; complained of "pain in both legs" on the visit on or about July
14 29, 2009, and complained of knee pain on the visit on or about November 2, 2009. Despite
15 patient C.W.'s repeated complaints of pain, respondent failed to obtain and/or document a history
16 of the pain complaints and failed to perform and/or document a thorough physical examination
17 related to the patient's pain complaints. Moreover, respondent failed to order appropriate
18 diagnostic tests in order to determine the cause of the patient's pain and failed to note a diagnosis
19 for the patient's pain complaints.

20 52. Beginning in about January 2009, respondent commenced prescribing MS Contin ²²
21 for management of patient C.W.'s complaints of pain in his lower back, legs, hands and knees.
22 This was in addition to the Percocet medication respondent prescribed each month for the patient.
23 There is no explanation for the addition of MS Contin in respondent's chart notes for the patient.
24 According to the Controlled Substances Utilization and Review Evaluations (CURES) report for
25 the year 2009, respondent prescribed 120 tablets of Percocet and 90 tablets of MS Contin 30 mg

26 ²² MS Contin (Morphine Sulphate Controlled release) is a Schedule II Controlled
27 Substance under Health and Safety Code section 11055(b)(1)(L) and a dangerous drug under
28 Code section 4022. It is indicated for relief of moderate to moderately severe pain.

1 each month for patient C.W. These include prescriptions for Percocet and MS Contin respondent
2 wrote for the patient on April 13, 2009, May 26, 2009, August 31, 2009 and September 29, 2009,
3 even though the patient did not make office visits on these dates. Despite patient C.W.'s repeated
4 complaints of pain in his lower back, legs, hands and knees, respondent failed to refer the patient
5 to a pain management specialist for appropriate management of his pain.²³

6 53. Patient C.W. repeatedly complained of pain in his lower back legs, hands and knees
7 during visits in 2010. According to respondent's chart, patient C.W. complained of "increased
8 low back pain" on the visit on or about April 12, 2010; complained of "knee and lower back pain"
9 on the visit on or about July 9, 2010; complained of "knee and low back pain without change" on
10 the visit on about August 2, 2010; complained of "excess joint pain, especially knees, and ankles"
11 on the visit of October 20, 2010; and complained of "knee and ankle pain" and "continued low
12 and joint pains, especially at night" on the visit on or about December 9, 2010. Respondent failed
13 to obtain and/or document a history of the pain complaints and failed to perform and/or document
14 a thorough physical examination related to the patient's pain complaints on any of these visits.
15 Respondent also failed to arrive at and/or note a diagnosis for the patient's pains on any of these
16 visits.

17 54. In about January 2010, respondent commenced prescribing Vicodin ES²⁴ instead of
18 MS Contin for management of C.W.'s complaints of pain in his lower back, legs, hands and
19 knees. This was in addition to the Percocet respondent prescribed each month for the patient.
20 There is no documentation of the medical justification for the addition of Vicodin ES to the
21 patient's medications. According to the CURES report for the year 2010, respondent prescribed

22
23 ²³ At the physician's interview, respondent explained his custom and practice of referring
24 patients to specialists this way: "...Usually, when a person tells me [he has pain] I usually ask
25 them...do you want to have something done about the knee...[to be] sent to a surgeon, to ortho...
then that's when I order an MRI, because now we need to get something to send to ortho. But as
long as they tell me they just want the pain medication then I don't order any tests until -- and
there is something to send to ortho."

26 ²⁴ Vicodin ES, Hydrocodone Bitartrate 7.5 mg and Acetaminophen 750 mg, is a Schedule
27 III controlled substance as defined by Section 11056(c) of the Health and Safety Code and a
28 dangerous drug under Code section 4022. It is indicated for relief of moderate to moderately
severe pain.

1 approximately 1,380 tablets of Percocet for patient C.W. between January 4, 2010 and October 1,
2 2010. During this same period, respondent prescribed approximately 1,080 tablets of Vicodin for
3 patient C.W. These prescriptions included prescriptions for 120 tablets of Percocet and 90 tablets
4 of Vicodin ES respondent wrote for patient C.W. on January 4, 2010, although the patient did not
5 make an office visit on this date.

6 55. Despite the large amounts of Percocet and Vicodin respondent prescribed for patient
7 C.W. during 2010, respondent failed to note the dosages of these medications in the patient's
8 chart; failed to inquire and document the number of these medications patient C.W. was taking
9 daily; failed to note the patient's response to the medications; and failed to note how the patient
10 was functioning on these medications. Moreover, respondent failed to calculate the amount of
11 acetaminophen patient C.W. was consuming daily from the combined use of Percocet and
12 Vicodin ES., and failed to discuss or to note he discussed the risk of acetaminophen toxicity with
13 patient C.W. Furthermore, respondent failed to assess patient C.W. for the risk of addiction and
14 failed to make any inquiry and/or note he inquired into whether patient C.W. was abusing the
15 medications he was prescribing. Respondent also failed to refer patient C.W. to a pain
16 management specialist.

17 56. On or about October 20, 2010, respondent ordered a series of MRI's including MRI
18 of left knee, left and right ankles and right wrist. The results indicated, among other things, that
19 patient C.W. had had previous left knee surgery, and there was evidence of deterioration of the
20 medial meniscus and instability of the anterior cruciate. Despite these findings, respondent failed
21 to refer patient C.W. to an orthopedist.²⁵

22 57. Patient C.W. made an office visit on or about March 1, 2011 with a complaint of
23 "pain in the right hand," among other things. Respondent noted he referred the patient to a pain
24 management specialist on this date.²⁶ On or about March 31, 2011, patient C.W. made a visit

25 ²⁵ At the physician's interview on January 25, 2012, respondent stated that patient C.W.
26 "probably" refused a referral to an orthopedist during the visit on December 9, 2010. He
27 admitted he failed to note the discussion about the referral or the patient's refusal in the chart note
of the visit of December 9, 2010.

28 ²⁶ Respondent's DEA certificate was suspended on or about October 13, 2010.

1 during which he complained of "pain in the right wrist for six months getting worse" and
2 continuing pain in his left shoulder. Respondent noted he referred patient C.W. to an orthopedist
3 on this date.

4 58. During the period of treatment, patient C.W. repeatedly complained of shortness of
5 breath. Respondent noted patient C.W. complained of shortness of breath on the visits of
6 September 8, 2008, November 10, 2008, February 2, 2009, March 16, 2009, June 29, 2009, July
7 29, 2009 and November 2, 2009. Despite patient C.W.'s repeated complaints respondent failed to
8 obtain and/or document a history of the complaints, and failed to perform and/or document a
9 thorough physical examination related to the patient's complaints of shortness of breath.
10 Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause
11 of the patient's shortness of breath and failed to arrive at and/or note a diagnosis for the patient's
12 shortness of breath. Furthermore, respondent failed to refer patient C.W. to a cardiologist for
13 evaluation of the patient's complaints of shortness of breath.

14 59. On or about July 9, 2010, patient C.W. made an office visit with complaints that
15 included "shortness of breath for two years" and his inability to walk for more than 30 feet
16 without getting out of breath. On this visit, respondent ordered a chest x-ray, an echocardiogram,
17 and an EKG. The echocardiogram revealed the patient had mild mitral tricuspid, pulmonary
18 regurgitation and aortic sclerosis, among other things. Patient C.W. continued to complain of
19 shortness of breath on the visits on or about August 2, 2010, and October 20, 2010. Despite the
20 findings of the echocardiogram the patient's continuing complaints of shortness of breath,
21 respondent failed to refer patient C.W. to a cardiologist.

22 60. During the period of treatment, patient C.W. repeatedly complained of anxiety,
23 "increased worry," stress and insomnia. Patient C.W. complained of either stress, "worry,"
24 anxiety or insomnia on the visits on or about June 29, 2009, July 29, 2009, November 2, 2009,
25 and February 11, 2011. Despite patient C.W.'s repeated complaints, respondent failed to obtain
26 and/or document a history of the complaints and failed to perform and/or document a thorough
27 physical examination related to the patient's complaints of stress, "worry," anxiety or insomnia.
28 Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause

1 of the patient's stress, "worry," anxiety or insomnia, and failed to note a diagnosis for the
2 patient's complaints. Furthermore, respondent failed to refer patient C.W. to a psychiatrist or a
3 psychologist for evaluation of the patient's complaints of stress, "worry," anxiety or insomnia.

4 61. Patient C.W. complained of abdominal or epigastric pain on the visits of February 3,
5 2010 and April 14, 2010. Respondent failed to obtain and/or document a history of the
6 abdominal pain and failed to perform and/or document a thorough physical examination related to
7 the patient's abdominal pain. Moreover, respondent failed to order appropriate diagnostic tests in
8 order to arrive at a diagnosis for the patient's abdominal pain, and failed to properly treat the
9 patient's abdominal pain.

10 62. Respondent committed gross negligence in his care and treatment of C.W., which
11 included, but was not limited to, the following:

12 (a) From approximately July 30, 2008, to October 2010, respondent, on
13 occasion, prescribed various controlled substances, including, but not limited to,
14 Percocet, MS Contin and Vicodin to C.W., without adequate justification and
15 without examining the patient in a timely fashion and without adequate periodic
16 review to assess the appropriateness of the course of treatment and the continued
17 use of the various controlled substances, including, but not limited to, Percocet, MS
18 Contin and Vicodin;

19 (b) From approximately July 30, 2008, to October 2010, respondent
20 prescribed various controlled substances, including, but not limited to, Percocet,
21 MS Contin and Vicodin to C.W., without adequate justification and without seeking
22 appropriate consultation from, or referring the patient to, the appropriate medical
23 specialists; and

24 (c) On or about April 13, 2009, May 26, 2009, August 31, 2009 and
25 January 4, 2010, respondent prescribed Percocet, MS Contin and Vicodin for
26 patient C.W. without any recorded office visit and without any notation of a
27 medical justification for the prescriptions.

28 ////

PATIENT N.A.

63. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his care and treatment of N.A., as more particularly alleged hereinafter:

64. On or about September 20, 2006, N.A., a female patient then 43 years old, made a visit to respondent's offices with complaints of frequent urination which "was getting worse." On this visit, respondent noted that the patient's medical history included a "bladder problem for two years" and that the patient had been prescribed Ibuprofen 800 mg for pain by her previous care provider. Respondent performed a physical examination, however, with the exception of the word "fingers" under "Extremities," respondent failed to note any other findings upon physical examination. Respondent ordered laboratory tests. His impression included bilateral carpal tunnel syndrome and osteoarthritis of the hand, obesity elevated blood pressure, sleep apnea and possible urinary tract infection. His recommendation included referral to an urologist, wrist splint for the carpal tunnel syndrome. He prescribed Ketoprofen 75 mg²⁷ for the patient. On or about October 23, 2006, patient N.A. made a follow up visit for her laboratory results. On this date, respondent noted the patient complained of "right upper extremity pain, especially the right elbow." However, respondent failed to perform and/or note a physical examination related to the patient's "right upper extremity pain" complaint. Respondent's prescriptions for the patient on this visit included Naprosyn 500 mg²⁸ and 30 tablets of Vicodin. Respondent failed to note any medical justification for the combination of Naprosyn and Vicodin medications he prescribed for the patient.

65. Thereafter, patient N.A. made periodic visits to respondent's offices with various complaints until about March 8, 2011. These included four (4) visits in 2007 (on or about January 17, June 27, July 30 and November 9, 2007), one (1) visit in 2008 (on or about April 25,

²⁷ Ketoprofen is a nonsteroidal anti-inflammatory drug. It is indicated for management of the signs and symptoms of rheumatoid arthritis and osteoarthritis.

²⁸ Naprosyn is a nonsteroidal anti-inflammatory drug. It is indicted for the treatment of rheumatoid arthritis and osteoarthritis.

1 2008), six (6) visits in 2009 (on or about February 27, May 27, July 15, August 21, October 1,
2 and December 22, 2009) and five (5) visits in 2010 (on or about January 18, April 19, July 2,
3 October 4 and October 26, 2010). During the period of treatment, patient N.A. repeatedly
4 complained of pain in the right upper extremities, including pain in the shoulders and elbows,
5 pain in the left arm, pain in the hands and pain in both legs. Patient N.A. complained of pain in
6 the shoulders, elbows, hands and legs on the visits on or about October 23, 2006, June 27, 2007,
7 April 28, 2008 and February 27, 2009. Despite these complaints, respondent failed to obtain
8 and/or note a history of the patient's pain complaints and failed to perform and/or note an
9 examination related to the patient's pain complaints at anytime during the period of treatment.
10 However, on nearly every visit, respondent's assessment of the patient included osteoporosis.
11 There is no medical justification noted for the assessment of osteoporosis. Respondent prescribed
12 pain medications including controlled substances, for patient N.A. throughout the period of
13 treatment.

14 66. On or about March 15, 2007, respondent prescribed 30 tablets of Vicodin to treat
15 patient N.A.'s pain even though the patient did not make an office visit on this date. On about
16 July 30, 2007, respondent prescribed 100 tablets of Percocet for management of patient N.A.'s
17 osteoarthritis. However, beginning on the visit on or about November 9, 2007, respondent
18 increased the dosage and variety of pain medications he prescribed for treatment of patient N.A.'s
19 osteoporosis. On this visit, respondent prescribed 200 tablets of Percocet and 30 tablets of
20 Avinza 60 mg²⁹ for the patient. Respondent also prescribed another 200 tablets of Percocet and
21 30 tablets of Avinza 60 mg for the patient on or about January 7, 2008. Respondent failed to note
22 any medical justification for increase in dosage and variety of the controlled substances he
23 prescribed for the patient. On or about February 21, 2008, respondent prescribed 200 tablets of
24 Vicodin for patient N.A. even though the patient did not make an office visit on this date. On
25 patient N.A.'s visit on or about April 25, 2008, respondent prescribed 200 tablets of Percocet and

26
27 ²⁹ Avinza, a brand name for Morphine Sulphate, is a Schedule II Controlled Substance
28 under Health and Safety Code section 11055(b)(1)(L) and a dangerous drug under Code section
4022. It is indicated for relief of moderate to moderately severe pain.

1 90 tablets of Oxycodone 20 mg for the patient. Respondent failed to note any medical
2 justification for prescribing a combination of Percocet and Oxycodone for the patient on this visit.

3 67. On or about February 27, 2009, (seven months after the patient's previous visit),
4 patient N.A. made a return visit with complaints that included "pain in the left arm." On this
5 visit, respondent noted the patient reported a history that included "right wrist and hand pain
6 getting worse." Respondent failed to perform and/or note he performed a physical examination
7 related to the patient's left arm pain complaint. Respondent also failed to inquire and/or note he
8 inquired into the reason(s) for the seven-month interval between the patient's visits, and failed to
9 inquire and/or note he inquired into whether the patient was obtaining pain medications from
10 other sources. Respondent's assessment included carpal tunnel syndrome and osteoarthritis of the
11 right hand. Respondent's prescriptions for the patient included 200 tablets of Roxicet 5/325 mg³⁰
12 Respondent failed to note any medical justification for prescribing the Roxicet medication.
13 Respondent also failed to refer patient N.A. to an orthopedist.

14 68. According to CURES report for the year 2009, respondent prescribed approximately
15 200 tablets of Percocet, 630 tablets of Oxycontin and 480 tablets of Norco 7.5 for management of
16 the patient's pain between about May 27, 2009 and December 31, 2009. Also, according to the
17 CURES report for the year 2010, between about January 12, 2010 and October 8, 2010,
18 respondent prescribed approximately 1,000 tablets of Norco, 360 tablets of Oxycontin and 180
19 tablets of Morphine Sulphate for the management of patient N.A.'s pain. This was in addition to
20 the many prescriptions for Ambien³¹ or Temazepam³² respondent wrote for the patient during this

21 ³⁰ Roxicet, oxycodone and acetaminophen, is a Schedule II Controlled Substance under
22 Health and Safety Code section 11055(b)(1)(M) and a dangerous drug under Code section 4022.
It is indicated for relief of moderate to moderately severe pain.

23 ³¹ Ambien, a brand name for zolpidem tartrate, is a Schedule IV controlled substance
24 under Health and Safety Code section 11075(d)(32) and a dangerous drug under Business and
25 Professions Code section 4022. It is a non-benzodiazepam hypnotic indicated for short-term
26 treatment of insomnia. Use of Ambien comes with the following WARNING "Since sleep
27 disturbances may be the presenting manifestation of a physical and/or psychiatric disorder,
28 symptomatic treatment of insomnia should initiated only after a careful evaluation of the patient.
The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of
primary psychiatric and/or medical illness which should be evaluated."

1 period. Despite the large amounts of Norco, Oxycontin and Percocet respondent prescribed for
2 patient N.A. during 2009 and 2010, respondent failed to note the dosages of these medications in
3 the patient's chart; failed to inquire and document the number of these medications patient N.A.
4 was taking daily; failed to note the patient's response to the medications; and failed to note how
5 the patient was functioning on these medications. Moreover, respondent failed to assess patient
6 N.A. for the risk of addiction and failed to make any inquiry and/or note he inquired into whether
7 patient N.A. was abusing the medications. Respondent also failed to refer patient N.A. to a pain
8 management specialist at any time during the period of treatment.

9 69. During the period of treatment, patient N.A. repeatedly complained of shortness of
10 breath, dizziness and chest pain. Respondent noted patient N.A. complained of dizziness,
11 shortness of breath and chest pain on the visits of July 15, 2009, December 22, 2009 and April 19,
12 2010. Despite the repeated complaints, respondent failed to obtain and/or document a history of
13 the complaints and failed to perform and/or document a thorough physical examination related to
14 the patient's complaints of shortness of breath, dizziness and chest pain. Moreover, respondent
15 failed to order appropriate diagnostic tests in order to determine the cause of the patient's
16 complaints and failed to note a diagnosis for the patient's shortness of breath, dizziness and chest
17 pain. Furthermore, respondent failed to refer patient N. A. to a cardiologist for evaluation of the
18 patient's complaints of shortness of breath, chest pain and dizziness.

19 70. During the period of treatment, patient N.A. repeatedly complained of anxiety,
20 "excess worry" stress and insomnia. On the visits on or about May 27, 2009, August 21, 2009,
21 July 2, 2010 and October 4, 2010, respondent noted Patient N.A. complained of stress, "excess
22 worry," anxiety or insomnia. Despite patient N.A.'s repeated complaints, respondent failed to
23 obtain and/or document a history of the complaints and failed to perform and/or document a
24 thorough physical examination related to the patient's complaints of stress, "excess worry,"
25 anxiety or insomnia. Moreover, respondent failed to order appropriate diagnostic tests in order to
26 determine the cause of the patient's stress, "excess worry," anxiety or insomnia, and failed to

27 ³² Temazepam is a Schedule IV controlled substance under Health and Safety Code
28 section 11075(d)(29) and dangerous drugs under Business and Professions Code section 4022.

1 arrive at and/or note a diagnosis for the patient's complaints. Beginning on or about July 17,
2 2009, and continuing to about September 28, 2010, respondent prescribed approximately 30
3 tablets of Ambien each month for management of patient N.A.'s stress, "excess worry," anxiety
4 or insomnia. There is no medical justification noted for the monthly prescription of Ambien for
5 patient N.A. At no time during the period of treatment did respondent refer patient N.A. to a
6 psychiatrist or a psychologist for evaluation of the patient's complaints of stress, "worry," anxiety
7 or insomnia.

8 71. Respondent committed gross negligence in his care and treatment of N.A., which
9 included, but was not limited to, the following:

10 (a) During his course of treatment, respondent, on occasion, prescribed
11 various controlled substances, including, but not limited to, Percocet, Norco,
12 Oxycontin and/or Ambien to N.A., without adequate justification and without
13 examining the patient in a timely fashion and without adequate periodic review to
14 assess the appropriateness of the course of treatment and the continued use of the
15 various controlled substances, including, but not limited to, Percocet, Norco,
16 Oxycontin and/or Ambien.

17 SECOND CAUSE FOR DISCIPLINE

18 (Repeated Negligent Acts)

19 DEA AGENT B.S.

20 72. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
21 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
22 acts in his care and treatment of B.S., as more particularly alleged hereinafter:

23 (a) Paragraphs 24 through 31, above, are hereby incorporated by reference
24 and realleged as if fully set forth herein;

25 (b) Respondent repeatedly prescribed large amounts of Methadone and
26 Xanax medications to B.S. without adequate justification and without an adequate
27 history and physical examination including, but not limited to, obtaining a more
28 detailed history, reviewing and verifying prior medical treatment, conducting a

1 more thorough review of symptoms and/or more accurately assessing the patient's
2 actual condition;

3 (c) Respondent repeatedly prescribed large amounts of Methadone and
4 Xanax medications to B.S. without adequate justification and without clearly
5 documenting an adequate treatment plan with stated objectives for the patient's
6 care and treatment in regard to the narcotics and controlled substances that were
7 prescribed;

8 (d) Respondent repeatedly prescribed large amounts of Methadone and
9 Xanax medications to B.S. without adequate justification and without adequate
10 informed consent of the various risks associated with the narcotics and controlled
11 substances that were being prescribed and the possibility of alternative non-
12 narcotic therapies;

13 (e) Respondent repeatedly prescribed large amounts of Methadone and
14 Xanax medications to B.S. without seeking appropriate consultation from, or
15 referring the patient to, the appropriate medical specialists;

16 (f) Respondent repeatedly prescribed large amounts of Methadone and
17 Xanax medications to B.S. without utilizing urine drug screens and/or other risk
18 screening tools;

19 (g) Respondent failed to maintain, in whole or part, legible, complete,
20 adequate, and/or accurate medical records concerning, among other things, B.S.'s
21 medical history and physical examination, other evaluations and/or treatments,
22 treatment plan objectives, informed consent, treatments, medications, rationale for
23 changes in the treatment plan or medications, agreements with the patient and/or
24 periodic reviews of the treatment plan;

25 (h) Respondent made false medical record entries for patient B.S.'s visit of
26 September 29, 2009, when he, among other things, documented he performed a
27 physical examination of the patient's pain, documented pain associated with
28 "Tender Post Neck" and "Back/Spine-L4-5 para-spinal areas" and documented

1 impressions of "Chronic Cervical strain due to whiplash" and "Anxiety/Stress."
2 Respondent's medical record entries were false because, among other things,
3 respondent did not perform a physical examination and there was no reasonable
4 justification for documenting the aforementioned conditions and diagnoses;

5 (i) Respondent made false medical record entries for patient B.S.'s visit of
6 November 10, 2009, when he, among other things, documented the patient
7 complained of back pain during the visit and listed his diagnosis of back pain.
8 Respondent's medical record entries were false because, among other things, B.S.
9 did not complain of continued back pain, respondent did not perform a physical
10 examination, and there was no reasonable justification for documenting the
11 aforementioned condition and diagnosis; and

12 (j) Respondent made false medical record entries for patient B.S.'s visit of March
13 25, 2010, when he, among other things, documented B.S. complained of "increased low
14 back pain, still with anxiety" during the visit and when he diagnosed B.S. as suffering from
15 chronic back pain. Respondent's medical record entries were false because, among other
16 things, B.S. did not complain of increased back pain or anxiety, respondent did not perform
17 a physical examination, and there was no reasonable justification for documenting the
18 aforementioned conditions and diagnosis.

19 DEA AGENT M.J.

20 73. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
21 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
22 acts in his care and treatment of M.J., as more particularly alleged hereinafter:

23 (a) Paragraphs 32 through 37, above, are hereby incorporated by reference
24 and realleged as if fully set forth herein;

25 (b) Respondent repeatedly prescribed large amounts of Methadone and
26 Xanax on one occasion to M.J. without adequate justification and without an
27 adequate history and physical examination including, but not limited to, obtaining
28 a more detailed history, reviewing and verifying prior medical treatment,

1 conducting a more thorough review of symptoms and/or more accurately assessing
2 the patient's actual condition;

3 (c) Respondent repeatedly prescribed large amounts of Methadone and
4 Xanax on one occasion to M.J. without adequate justification and without clearly
5 documenting an adequate treatment plan with stated objectives for the patient's
6 care and treatment in regard to the narcotics and controlled substances that were
7 prescribed;

8 (d) Respondent repeatedly prescribed large amounts of Methadone and
9 Xanax on one occasion to M.J. without adequate justification and without adequate
10 informed consent of the various risks associated with the narcotics and controlled
11 substances that were being prescribed and the possibility of alternative non-
12 narcotic therapies;

13 (e) Respondent repeatedly prescribed large amounts of Methadone and
14 Xanax on one occasion to M.J. without seeking appropriate consultation from, or
15 referring the patient to, the appropriate medical specialists;

16 (f) Respondent repeatedly prescribed large amounts of Methadone and
17 Xanax on one occasion to M.J. without utilizing urine drug screens and/or other
18 risk screening tools;

19 (g) Respondent failed to maintain, in whole or part, legible, complete,
20 adequate, and/or accurate medical records concerning, among other things, M.J.'s
21 medical history and physical examination, other evaluations and/or treatments,
22 treatment plan objectives, informed consent, treatments, medications, rationale for
23 changes in the treatment plan or medications, agreements with the patient and/or
24 periodic reviews of the treatment plan;

25 (h) Respondent made false medical record entries for M.J.'s visit of May
26 11, 2010, when he, among other things, documented M.J.'s "Back/Spine was
27 tender" on examination, "Paraspinal once," that M.J. "c/o [complained of] chronic
28 LBP [low back pain] x 5 years" and documented his impressions as "chronic low

1 back pain" Respondent's medical record entries were false because, among other
2 things, M.J. did not complain of back pain or chronic back pain respondent did not
3 perform a physical examination, and there was no reasonable justification for
4 documenting the aforementioned conditions and diagnosis; and

5 (i) Respondent made false medical record entries for M.J.'s visit of June
6 27, 2010, when he, among other things, documented that M.J. complained of low
7 back pain, decreased sleep and excessive anxiety and diagnosed M.J. as suffering
8 from "chronic low back pain" and "Anxiety/Stress." Respondent's medical record
9 entries were false because, among other things, M.J. did not complain of back
10 pain, decreased sleep and/or excessive anxiety respondent did not perform a
11 physical examination, and there was no reasonable justification for documenting
12 the aforementioned conditions and diagnoses.

13 PATIENT R.C.

14 74. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
15 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
16 acts in his care and treatment of R.C., as more particularly alleged hereinafter:

17 (a) Paragraphs 38 through 47, above, are hereby incorporated by reference
18 and realleged as if fully set forth herein;

19 (b) Between about January 2, 2008 and September 29, 2008, respondent
20 repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone without
21 adequate justification and without an adequate history and physical examination
22 including, but not limited to, obtaining a more detailed history, reviewing and
23 verifying prior medical treatment, conducting a more thorough review of
24 symptoms and/or more accurately assessing the patient's actual condition;

25 (c) Between about January 2, 2008 and September 29, 2008, respondent
26 repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C.
27 without adequate justification and without clearly documenting an adequate
28

1 treatment plan with stated objectives for the patient's care and treatment in regard
2 to the narcotics and controlled substances that were prescribed;

3 (d) Between about January 2, 2008 and September 29, 2008, respondent
4 repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C.
5 without adequate justification and without adequate informed consent of the
6 various risks associated with the narcotics and controlled substances that were
7 being prescribed and the possibility of alternative non-narcotic therapies;

8 (e) Respondent repeatedly prescribed large amounts of Oxycontin, Xanax
9 and Methadone to R.C. without utilizing urine drug screens and/or other risk
10 screening tools;

11 (f) Respondent failed to maintain, in whole or part, legible, complete,
12 adequate, and/or accurate medical records concerning, among other things, R.C.'s
13 medical history and physical examination, other evaluations and/or treatments,
14 treatment plan objectives, informed consent, treatments, medications, rationale for
15 changes in the treatment plan or medications, agreements with the patient and/or
16 periodic reviews of the treatment plan;

17 (g) On or about February 4, 2008, March 3, 2008 and May 3, 2008,
18 respondent prescribed Oxycontin and Xanax for patient R.C. without any recorded
19 office visit and without any notation of a medical justification for the prescriptions;

20 (h) Between about June 13, 2008 and September 29, 2008, respondent
21 prescribed Oxycontin, Methadone and Xanax to patient R.C. for treatment of
22 R.C.'s back pain and anxiety even though respondent knew or should have known
23 that patient R.C. did not have a legitimate pain, was addicted to prescription
24 medications and was drug seeking.

25 PATIENT C.W.

26 75. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
27 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
28 acts in his care and treatment of C.W, as more particularly alleged hereinafter:

1 (a) Paragraphs 48 through 62, above, are hereby incorporated by reference
2 and realleged as if fully set forth herein;

3 (b) From approximately July 30, 2008, to October 2010, respondent, on
4 occasion, prescribed various controlled substances, including, but not limited to,
5 Percocet, MS Contin and Vicodin to C.W., without adequate justification and
6 without examining the patient in a timely fashion and without adequate periodic
7 review to assess the appropriateness of the course of treatment and the continued
8 use of the various controlled substances;

9 (c) From approximately July 30, 2008, to October 2010, respondent
10 prescribed various controlled substances, including, but not limited to, Percocet,
11 MS Contin and Vicodin to C.W., without adequate justification and without an
12 adequate history and physical examination including, but not limited to, obtaining
13 a more detailed history, reviewing and verifying prior medical treatment,
14 conducting a more thorough review of symptoms and more accurately assessing
15 the patient's actual condition;

16 (d) From approximately July 30, 2008, to October 2010, respondent
17 prescribed various controlled substances, including, but not limited to, Percocet,
18 MS Contin and Vicodin to C.W., without adequate justification and without clearly
19 documenting an adequate treatment plan with stated objectives for the patient's
20 care and treatment in regard to the narcotics and/or controlled substances that were
21 prescribed;

22 (e) From approximately July 30, 2008, to October 2010, respondent
23 prescribed various controlled substances, including, but not limited to, Percocet,
24 MS Contin and Vicodin to C.W., without adequate justification and without
25 adequate informed consent of the various risks associated with the narcotics and
26 controlled substances that were being prescribed and the possibility of alternative
27 non-narcotic therapies;

28 ////

1 (f) From approximately July 30, 2008, to October 2010, respondent
2 prescribed various controlled substances, including, but not limited to, Percocet,
3 MS Contin and Vicodin to C.W., without adequate justification and without
4 seeking appropriate consultation from, or referring the patient to, the appropriate
5 medical specialists;

6 (g) From approximately July 30, 2008, to October 2010, respondent
7 prescribed various controlled substances to C.W., including, but not limited to,
8 Percocet, MS Contin and Vicodin, without adequate justification and without
9 utilizing urine drug screens and/or other risk screening tools;

10 (h) On or about April 13, 2009, May 26, 2009, August 31, 2009 and
11 January 4, 2010, respondent prescribed Percocet, MS Contin and Vicodin for
12 patient C.W. without any recorded office visit and without any notation of a
13 medical justification for the prescriptions;

14 (i) Between September 8, 2008 and March 30, 2011, respondent failed to
15 refer patient C.W. to an orthopedist for evaluation despite the patient's repeated
16 complaints of lower back, legs, hands and knee pain; and

17 (j) Respondent failed to maintain, in whole or part, legible, complete,
18 adequate, and/or accurate medical records concerning, among other things, M.J.'s
19 medical history and physical examination, other evaluations and/or treatments,
20 treatment plan objectives, informed consent, treatments, medications, rationale for
21 changes in the treatment plan or medications, agreements with the patient and/or
22 periodic reviews of the treatment plan.

23 PATIENT N.A.

24 76. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
25 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
26 acts in his care and treatment of N.A., as more particularly alleged hereinafter:

27 (a) Paragraphs 63 through 71, above, are hereby incorporated by reference
28 and realleged as if fully set forth herein;

1 (b) During his course of treatment, respondent, on occasion, prescribed
2 various controlled substances, including, but not limited to, Percocet, Norco,
3 Oxycontin and/or Ambien to N.A., without adequate justification, and without
4 examining the patient in a timely fashion and without adequate periodic review to
5 assess the appropriateness of the course of treatment and the continued use of the
6 various controlled substances;

7 (c) During his course of treatment, respondent, prescribed various
8 controlled substances to N.A., including, but not limited to, Percocet, Norco,
9 Oxycontin and/or Ambien without adequate justification and without an adequate
10 history and physical examination including, but not limited to, obtaining a more
11 detailed history, reviewing and verifying prior medical treatment, conducting a
12 more thorough review of symptoms and more accurately assessing the patient's
13 actual condition;

14 (d) During his course of treatment, respondent, prescribed various
15 controlled substances to N.A., including, but not limited to, Percocet, Norco,
16 Oxycontin and/or Ambien without adequate justification and without clearly
17 documenting an adequate treatment plan with stated objectives for the patient's
18 care and treatment in regard to the narcotics and controlled substances that were
19 prescribed;

20 (e) During his course of treatment, respondent, prescribed various
21 controlled substances to N.A., including, but not limited to, Percocet, Norco,
22 Oxycontin and/or Ambien without adequate justification and without adequate
23 informed consent of the various risks associated with the narcotics and controlled
24 substances that were being prescribed and the possibility of alternative non-
25 narcotic therapies;

26 (f) During his course of treatment, respondent, prescribed various
27 controlled substances to N.A., including, but not limited to, Percocet, Norco,
28 Oxycontin and/or Ambien without adequate justification and without seeking

1 appropriate consultation from, or referring the patient to, the appropriate medical
2 specialists;

3 (g) From approximately July 30, 2008, to October 2010, respondent
4 prescribed various controlled substances to C.W., including, but not limited to,
5 Percocet, MS Contin and Vicodin, without adequate justification and without
6 utilizing urine drug screens and/or other risk screening tools; and

7 (h) Respondent failed to maintain in whole or part complete, adequate,
8 and/or accurate medical records concerning, among other things, N.A.'s medical
9 history and physical examination, other evaluations and/or treatments, treatment
10 plan objectives, informed consent, treatments, medications, rationale for changes
11 in the treatment plan or medications, agreements with the patient and/or periodic
12 reviews of the treatment plan.

13 THIRD CAUSE FOR DISCIPLINE

14 (Incompetence)

15 77. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
16 defined by section 2234, subdivisions (d), of the Code, in that respondent has demonstrated
17 incompetence and lack of knowledge regarding the guidelines and proper protocol for the
18 prescribing of narcotics and controlled substances as to B.S., M.J., J.C., C.W. and N.A., as more
19 particularly alleged in paragraphs 24 through 76, above, which are hereby incorporated by
20 reference as if fully set forth herein.

21 FOURTH CAUSE FOR DISCIPLINE

22 (Acts of Dishonesty or Corruption)

23 78. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
24 defined by section 2234, subdivisions (e), of the Code, in that respondent committed an act or acts
25 of dishonesty or corruption when he made false medical record entries for B.S. and M.J. as more
26 particularly alleged in paragraphs 24 through 37, above, which are hereby incorporated by
27 reference as if fully set forth herein.

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1 **FIFTH CAUSE FOR DISCIPLINE**

2 **(Violation of Statutes Regulating Drugs)**

3 79. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
4 defined by section 2238, of the Code, in that respondent has violated a federal or state statute or
5 regulation regulating dangerous drugs or controlled substances, as more particularly alleged in
6 paragraphs 24 through 76, above, which are hereby incorporated by reference as if fully set forth
7 herein.

8 **SIXTH CAUSE FOR DISCIPLINE**

9 **(Furnishing Dangerous Drugs Without Examination)**

10 80. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
11 defined by section 2242, of the Code, in that respondent prescribed dangerous drugs to B.S., M.J.,
12 R.C., C.W. and N.A. without an appropriate prior examination and medical indication, as more
13 particularly alleged in paragraphs 24 through 76, above, which are hereby incorporated by
14 reference and realleged as if fully set forth herein.

15 **SEVENTH CAUSE FOR DISCIPLINE**

16 **(Repeated Acts of Clearly Excessive Prescribing)**

17 81. Respondent is further subject to disciplinary action under sections 2227 and 725 of
18 the Code in that respondent engaged in repeated acts of clearly excessive prescribing or
19 administering of drugs or treatment as determined by the standard of the community of licensees
20 in his care and treatment of B.S., M.J., R.C., C.W. and N.A. as more particularly alleged in
21 paragraphs 24 through 76, above, which are hereby incorporated by reference and realleged as if
22 fully set forth herein.

23 **EIGHTH CAUSE FOR DISCIPLINE**

24 **(Furnishing Drugs to Addict)**

25 82. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
26 defined by section 2241 of the Code, in that respondent prescribed controlled substances and
27 dangerous drugs to M.J., B.S. and R.C., whom he knew or reasonably should have known were
28 using or would be using the controlled substances and dangerous drugs for a nonmedical purpose,

1 as more particularly alleged in paragraphs 24 through 47, above, which are hereby incorporated
2 by reference and realleged as if fully set forth herein.

3 **NINTH CAUSE FOR DISCIPLINE**

4 **(Signing a Document that Falsely Represents the Existence**
5 **or Non-Existence of a State of Facts)**

6 83. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
7 defined by sections 2261 of the Code, in that respondent signed documents for B.S. and M.J. that
8 falsely represented the existence or non-existence of a state of facts, as more particularly alleged
9 in paragraphs 24 through 37, above, which are incorporated by reference and realleged as if fully
10 set forth herein.

11 **TENTH CAUSE FOR DISCIPLINE**

12 **(Creation of False Medical Record)**

13 84. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
14 defined by section 2262, of the Code, in that respondent created false medical records for B.S.
15 and M.J., as more particularly alleged in paragraphs 24 through 37, above, which are incorporated
16 by reference and realleged as if fully set forth herein.

17 **ELEVENTH CAUSE FOR DISCIPLINE**

18 **(Failure to Maintain Adequate and Accurate Medical Record)**

19 85. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
20 defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate
21 records regarding his care and treatment of B.S., M.J., R.C., C.W. and N.A., as more fully
22 particularly alleged in paragraphs 24 through 76, above, which are incorporated by reference and
23 realleged as if fully set forth herein.

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1 TWELVE CAUSE FOR DISCIPLINE

2 (General Unprofessional Conduct)

3 86. Respondent has further subjected his license to disciplinary action under sections
4 2227 and 2234 of the Code, in that he has engaged in conduct which breached the rules or ethical
5 code of the medical profession or which was unbecoming a member in good standing of the
6 medical profession, and which demonstrates an unfitness to practice medicine, in his care of
7 B.S., M.J., J.C., C.W. and N.A., as more particularly alleged in paragraphs 12 through 85, above,
8 which are incorporated herein by reference and realleged as if fully set forth herein.

9 PRAYER

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

- 12 1. Revoking or suspending Physician's and Surgeon's Certificate Number A37049,
13 issued to respondent RUDOLPHO J. ALEGRIA, M.D;
14 2. Revoking, suspending or denying approval of respondent RUDOLPHO J. ALEGRIA,
15 M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;
16 3. Ordering respondent RUDOLPHO J. ALEGRIA, M.D. to pay the Medical Board of
17 California to pay the costs of probation if placed on probation; and
18 4. Taking such other and further action as deemed necessary and proper.

19 DATED: April 29, 2014

20 
21 KIMBERLY KIRCHMEYER
22 Executive Director
23 Medical Board of California
24 Department of Consumer Affairs
25 State of California
26 Complainant
27
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