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

In the Matter of the Accusation Against:	)	
Kishwar R. Gill, M.D.	)	**Case No. 08-2013-229894**
Physician's and Surgeon's Certificate No. A 52697	)	
Respondent	)	

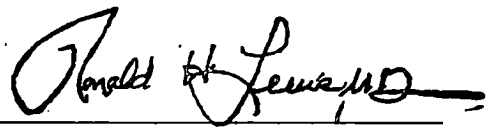
DECISION

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

This Decision shall become effective at 5:00 p.m. on December 13, 2017.

IT IS SO ORDERED: November 13, 2017.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **KISHWAR R. GILL, M.D.** 6250 W Vine Ct. Visalia, CA 93291 **Physician's and Surgeon's Certificate No. A52697** Respondent.	Case No. 08-2013-229894 OAH No. 2015060376.1 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Steve Diehl, Deputy Attorney General.

2. Respondent Kishwar R. Gill, M.D. (Respondent) is represented in this proceeding by attorney Andrew Weiss, Esq., whose address is: 7108 North Fresno St., Suite 250, Fresno, CA 93720

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3. On or about December 22, 1993, the Board issued Physician's and Surgeon's Certificate No. A52697 to Kishwar R. Gill, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 08-2013-229894, and will expire on July 31, 2019, unless renewed.

JURISDICTION

4. Accusation No. 08-2013-229894 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 27, 2015. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 08-2013-229894 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 08-2013-229894. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 08-2013-229894, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges and allegations in the Accusation and that she has thereby subjected her license to disciplinary action. Respondent hereby gives up her right to contest that cause for discipline exists based on those charges and allegations. Respondent agrees that in any future proceeding involving her professional license, all of the charges and allegations contained in Accusation No. 08-2013-229894 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

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

CONTINGENCY

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

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A52697 issued to Respondent Kishwar R. Gill, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules IV and V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use

of marijuana.

Upon successful completion of a Prescribing Practices Course, as described in Condition 3, below, as well as successful completion of a Medical Recordkeeping Course, as described in Condition 4, below, and upon notification by the Board or its designee in writing of successful completion of these courses, this condition shall be lifted.

2. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. PRESCRIBING PRACTICES COURSE. Within 120 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

4. MEDICAL RECORD KEEPING COURSE. Within 120 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standard of practice of medicine, and whether Respondent is practicing medicine

safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 180 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The

program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

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

If Respondent fails to establish a practice with another physician or secure employment in

an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

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

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

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

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

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

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

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations.

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

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

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Andrew Weiss Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10/6/2017

KISHWAR R. GILL, M.D.
Respondent

I have read and fully discussed with Respondent Kishwar R. Gill, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 10/06/17

ANDREW WEISS ESQ
Attorney for Respondent

ENDORSEMENT

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

Dated: 10/6/17

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

STEVE DIEHL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 08-2013-229894

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 27 20 15
BY K. Voong ANALYST

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

In the Matter of the Accusation Against: **KISHWAR R. GILL, M.D.** **5943 W. Elowin Dr.** **Visalia, CA 93291** **Physician's and Surgeon's Certificate No. A52697,** Respondent.	Case No. 08-2013-229894 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 22, 1993, the Medical Board of California issued Physician's and Surgeon's Certificate Number A52697 to Kishwar R. Gill, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2015, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

"(b) The administration and hearing of disciplinary actions.

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

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

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

"(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

6. Section 2234 of the Code, states, in pertinent part:

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

"...

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

"...."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that she engaged in acts amounting to gross negligence. The circumstances are as follows:

Circumstances Related to Patient H.I. [1]

9. Between May 18, 2009, and January 11, 2013, Patient H.I., a woman in her forties, visited the Mountain View Medical Clinic a total of 68 times for treatment of a variety of complaints, including chronic pain. During this period, Respondent authored 59 handwritten progress notes for in-person visits with H.I., on standardized one-page SOAP (Subjective Objective Assessment Plan) forms. These forms contain sections for vital signs, chief complaint, problems from last visit, subjective, objective, assessment, and treatment plan.

10. On or about September 9, 2007, H.I. first presented at the Mountain View Medical Clinic, and documented on a patient intake form the following medical problems: high blood pressure, headaches, and depression/anxiety. She listed the medications she was on as Norco[2], Soma[3], Fioricet[4], lorazepam[5], and the hypertension drug lisinopril. She was not seen by Respondent on this visit.

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[1] In this Accusation, patients are identified by initial to protect their privacy.

[2] Norco, Vicodin, and Lortab are combinations of the short-acting opiate hydrocodone and the analgesic/antipyretic acetaminophen. The formulation 5/500 signifies 5 mg hydrocodone and 500 mg acetaminophen.

[3] Soma (carisoprodol) is a centrally-acting muscle relaxant with potent sedative side-effects. It is indicated for the short-term treatment of muscle spasm. In combination with opiate medications, it carries the risk of additive central nervous system depression.

[4] Fioricet is a combination of the barbiturate butalbital, acetaminophen, and caffeine. It is indicated for the treatment of tension headaches.

11. On or about May 18, 2009, H.I. first presented to Respondent. Her chief complaint was noted as "hemorrhoids x3 day." Respondent noted "bad cramps" with menstruation, and hemorrhoids. No physical examination was noted. Respondent's assessment was "(1) Menorrhagic after tubal ligation" and "(2) Headache Migraine." Respondent prescribed hemorrhoid medication and Vicodin 5/500 three times per day as needed. Respondent failed to note any objectives for this treatment plan.

12. On or about January 29, 2010, H.I. presented at the Mountain View Medical Clinic and was diagnosed with a possible urinary tract infection.

13. On or about March 8, 2010, H.I. again presented to Respondent. Her chief complaint was noted as "patient here for lab results." Respondent noted "(1) Urination back to normal; (2) Periods regular but heavy with abdominal cramps; (3) Migraine headaches so bad, vascular, throbbing, goes to E.R. for relief; (4) Involved in 2 M.V.A. [motor vehicle accidents] spine was injured, both drunk drivers hit patient. One was hit [illegible]; (5) has an appointment for colonoscopy from [Dr. K.]" Respondent noted "was sent to neurologist, was inconclusive." No other information was noted regarding this referral. Respondent noted the results of a physical examination. Respondent's assessment was "(1) Back injury, bulging discs and thoracic; (2) Menorrhagia." Respondent prescribed a variety of medications including Vicodin 5/500 #60, Fioricet #60, and lorazepam 2mg #30, but again failed to note any objectives for her treatment plan. Respondent ordered an ultrasound of the abdomen and x-ray studies of the thoracic and lumbar spine.

14. On or about April 5, 2010, H.I. presented again to Respondent. The chief complaint was noted as "patient here for refill on meds." The subjective and objective sections of the note were left entirely blank. Respondent's assessment was simply "Back injury; bulging discs; Menorrhagia." Respondent made no mention of H.I.'s prior complaint of severe headache.

(...continued)

[5] Lorazepam is a high-potency, intermediate-duration, 3-hydroxy benzodiazepine drug, often used to treat anxiety disorders.

Respondent's plan was simply a list of seven prescriptions, including refills of Vicodin, Fioricet, and lorazepam. Respondent made no mention of the radiological studies she had ordered.

15. On or about May 3, 2010, H.I. presented again to Respondent. The chief complaint was noted as "patient here for refill on meds." The subjective and objective sections of the note were left entirely blank. Respondent's assessment was "Headaches; Back injury after M.V.A.; Bulging disc; Menorrhagia, Scoliosis." Respondent failed to note whether any of these conditions were improving as a result of her treatment, and Respondent failed to note any basis for the diagnosis of scoliosis. Her plan was noted as simply "Meds given same as given on 4/5/10." Respondent noted that she expected to receive ultrasound results "Monday."

16. On or about June 14, 2010, H.I. presented again to Respondent. The chief complaint was noted as "patient here for refill on meds." The subjective section noted simply "Headaches persisting." She noted the results of the abdominal ultrasound were "negative," but noted "fibroid uterus and heavy periods." Respondent's assessment was noted as "(1) Headaches, migraine; (2) Pain in abdomen, peptic ulcer disease." No basis was given for the diagnosis of peptic ulcer, and Respondent made no mention of her earlier assessments of back injury, bulging discs, or scoliosis. Her plan was noted as a list of now eight different medications, including Vicodin 5/500 #60, lorazepam 2 mg #30, and promethazine[6] 25 mg #50. Again, no objectives were stated for this treatment plan.

17. On or about July 12, 2010, H.I. presented again to Respondent. The chief complaint was noted as "here for pap smear" and "refill on meds." The subjective and objective sections of the note were left entirely blank. Respondent noted H.I.'s menstruation issues, fibroid uterus, and migraine headaches, but failed to mention the status of H.I.'s back pain, scoliosis, or peptic ulcer. Respondent ordered a pap smear and sexually transmitted disease (S.T.D.) panel, and a positive test for Gardnerella vaginalis was noted. Respondent's plan was noted simply as "all refills same as written on 6/14/10."

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[6] Promethazine is an antihistamine with strong sedative effects.

18. On or about July 15, 2010, H.I. returned for follow-up, and Respondent treated a Gardnerella vaginitis infection with antibiotics. Respondent did not note any examination or treatment related to any other complaint at this visit.

19. On or about August 12, 2010, H.I. presented again to Respondent. The chief complaint was noted as "patient here for refill on meds." The subjective section of the note was left entirely blank, and the objective section noted simply "Doing good, lower abdomen painful, heavy periods due to fibroids, going to have another U.S. [ultrasound] next month." No physical examination was noted. Respondent's assessment was "Headaches Migraine; Peptic Ulcer Disease; Heavy periods first 2 days." Respondent made no mention of H.I.'s back pain or scoliosis. Her plan consisted simply of a list of medications, including Vicodin, lorazepam, and promethazine.

20. On or about September 13, 2010, H.I. presented again to Respondent. The chief complaint was noted as "refill on meds." The subjective section of the note was left entirely blank, and the objective section noted improvement in the patient's menstruation and fibroid problems. No physical examination was noted. Respondent's assessment was "Headaches Migraine; Neck Injury and back M.V.A.; G.E.R.D. [gastroesophageal reflux disease]." No basis was given for the diagnosis of G.E.R.D. Respondent's plan was again a list of medications, including Vicodin, lorazepam, and promethazine. Respondent ordered a follow up abdominal ultrasound and colonoscopy.

21. On or about October 25, 2010, H.I. presented again to Respondent. The chief complaint was "patient here for refill on meds." The subjective section of the note was left entirely blank, and the objective section noted simply "Nauseated, feverish, no diarrhea." No examination was noted. Respondent's assessment was "Flu symptoms; chronic gastritis; Headaches Migraine." Respondent's plan was again a list of medications, including Vicodin, lorazepam, and promethazine, as well as new prescriptions for Soma and Fioricet.

22. On or about January 24, 2011, H.I. presented again to Respondent. The chief complaint was "patient here for med refill." In the subjective section, Respondent noted "Has difficulty in swallowing and stomach knots whether eats or not." In the objective section,

Respondent noted "Periods heavy, had fibroid [illegible] U.S. done 6 months ago, want to compare the fibroids as of today; enlarged uterus." Respondent's assessment was "H.T.N.; chronic gastritis; Migraine H/A [headache]." No mention was made of H.I.'s prior back or neck pain or scoliosis. Respondent's plan was noted as "repeated medicines as written on 10/25/10. Refills given." Respondent ordered a repeat pelvic ultrasound.

23. On or about January 31, 2011, H.I. returned for follow up regarding her gastritis. Respondent prescribed medication for her gastrointestinal complaints, but also prescribed Norco 10/325 #90 for the first time. No reason was noted for the Norco prescription.

24. On or about February 21, 2011, H.I. presented again to Respondent. The chief complaint was "refill on meds." The subjective and objective sections of the note were left entirely blank. No physical examination was noted. Respondent's assessment was "D.D.D. [degenerative disc disease] Spine; Flatulence abdomen r/o I.B.S. [irritable bowel syndrome]." Respondent's plan was a list of medications, including Vicodin, Soma, Fioricet, and promethazine. A prescription for Norco was crossed out.

25. On or about March 7, 2011, H.I. presented again to Respondent. The chief complaint was "refill on meds." The subjective section noted "severe pain with periods. The pain is not relieved even when the period is over." The objective section of the note was entirely blank, and no physical examination was noted. Respondent's assessment was "D.D.D. spine; f/u U.S. Abdomen; Flatulence in stomach; Dysmenorrhea possible Endometriosis." Respondent's plan was again a list of medications, including promethazine and lorazepam. Respondent ordered a computed tomography (C.T.) scan of the abdomen and pelvis.

26. On or about March 17, 2011, H.I. presented again to Respondent. The chief complaint was "refill on meds," despite the fact that only ten days had elapsed since her last visit. The subjective section was left entirely blank, and the objective section noted only "pain in lower abdomen and offensive discharge." No examination was noted. Respondent's assessment was "Pain in lower abdomen and flatulence and offensive discharge." Respondent's plan was again a list of medications, this time including Norco 10/325 #90.

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27. On or about March 24, 2011, H.I. presented again to Respondent. The chief complaint was "headaches and med refills." The subjective and objective sections of the note were entirely blank, although Respondent noted that H.I.'s bowel problems were improving with medication. Respondent's assessment was "Headache for past 3 days; f/u P.I.D. [pelvic inflammatory disease]; Flatulence." Respondent's plan was a list of medications, including Fioricet and promethazine. Respondent again ordered a CT scan of the patient's abdomen and pelvis.

28. On or about April 4, 2011, H.I. presented again to Respondent. The chief complaint was "here for refill on med." The subjective and objective sections of the note were entirely blank, except for a notation of abdominal pain. Respondent noted "Patient is going for C.T. scan as soon as possible" and "gave treatment for P.I.D. already, still the discharge." Respondent's assessment was "P.I.D.; offensive discharge." No mention was made of the status of any of H.I.'s earlier problems, such as back pain or scoliosis. Respondent's plan was a list of medications including Soma and Vicodin.

29. On or about April 7, 2011, H.I. returned for follow up. Respondent noted "P.I.D. symptoms getting better with medications." The subjective section of the note was entirely blank, no examination was noted, and Respondent did not note any plan.

30. On or about April 14, 2011, H.I. presented again to Respondent. The chief complaint was "HTN check and refill meds; mammo to be ordered." The subjective and objective sections of the note were left entirely blank. Respondent noted "(1)Endoscopy by [Dr. K.] on 19th April (2) C.T. of pelvic abdomen on 4/27/11 for abdo and pelvic pain." Respondent's assessment was "F/u P.I.D. pain in pelvic area, reduced with RX last time." Her plan was again a list of prescriptions, including Norco, Soma, and Fioricet.

31. On or about April 21, 2011, H.I. presented again to Respondent. The chief complaint was "patient here for med refill." The subjective and objective sections of the note were left entirely blank. Respondent noted "feels better with meds. Discharge reduced. Nausea still present." Her assessment was "P.I.D. r/o endometriosis." Her plan was simply a prescription for promethazine 25 mg #90.

32. On or about May 5, 2011, H.I. presented again to Respondent. The chief complaint was "here for med refill." The subjective and objective sections of the note were left entirely blank. No examination was noted. Respondent's assessment was "P.I.D. or Endometriosis H.T.N. [hypertension.]" Her plan was a list of medications including Norco and Soma. Respondent noted a planned abdominal and pelvic C.T. "to diagnose endometriosis, fibroids, P.I.D."

33. On or about May 12, 2011, H.I. presented again to Respondent. The chief complaint was "here for med refill." The subjective and objective sections of the note were left entirely blank. No examination was noted. Respondent noted "Disability given 5/12/11 to 8/12/11." Respondent's assessment was discharge and "pain in lower abdomen I.B.S. endometriosis bloating." No mention was made of the status of any of H.I.'s earlier problems, such as back pain or scoliosis. Her plan was a list of medications including Norco and Fioricet. She again noted the planned C.T. scan.

34. On or about May 19, 2011, H.I. presented again to Respondent. The chief complaint was "refill on meds." The subjective and objective sections of the note were left entirely blank. No examination was noted. Respondent noted "pain in abdomen and pelvic cramps [illegible] pain comes and goes." Respondent's assessment was "Abdo. Cramps; Rectal pain; I.B.S.; Menorrhagia, Endometriosis, Anxiety." No further information was given regarding the new diagnosis of anxiety. Respondent's plan was simply another prescription of promethazine. Respondent noted "URGENT CT Scan Abdo."

35. On or about May 24, 2011, an unsigned note was generated, showing that H.I. was continuing on Norco and Fioricet.

36. On or about June 8, 2011, H.I. presented again to Respondent. The chief complaint was "here for med refill." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Pain in abdo [illegible.]" Respondent's assessment was "(1) Pain in lower abdomen and back, possible endometriosis; (2) Flatulence in abdomen r/o I.B.S. possible endometriosis." Respondent's plan was again a list of medications, including Vicodin, Fioricet, and Soma.

37. On or about June 16, 2011, H.I. presented again to Respondent. The chief complaint was "here for CT Reports." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Abdomen gets bloated now and again. Constantly in pain. C.T. scan showed cervical/endometrial cyst in vagina and multiple fibroids in uterus." Respondent's assessment was "(1) cervical/endometrial cyst; (2) G.E.R.D. and bloating." The plan section of the note was left entirely blank. Respondent noted "referred to Gyn [Dr. M.] for fibroid uterus and [illegible.]".

38. On or about June 29, 2011, H.I. presented to a physician assistant who continued her on Vicodin, Soma, and Fioricet.

39. On or about July 9, 2011, H.I. presented again to Respondent. The chief complaint was "here for lab results and med refill." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination. Respondent's assessment was "ultrasound abdomen and pelvis; large Fundal Fibroid; Referred to OB. Gyn." Respondent's plan was simply a prescription for Norco 10/325 #90.

40. On or about July 15, 2011, H.I. presented to a physician assistant who continued her on Vicodin.

41. On or about July 29, 2011, H.I. presented to a physician assistant who continued H.I. on Fioricet.

42. On or about July 30, 2011, H.I. presented again to Respondent. The chief complaint was "patient has pelvic pain lot of pressher [sic] in abdominal aria [sic]." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "still has severe pain in lower abdomen and bloating, menstrual cramps heavy periods." Respondent's assessment was "Severe pain; inflamed abdomen due to enlarged [illegible]; possibly endometriosis." Respondent's plan was simply "continue meds; refer to [Dr. M.] URGENTLY." Respondent noted a call to Dr. M. for gynecological referral.

43. On or about August 11, 2011, H.I. presented to a physician assistant who continued her on Vicodin and Soma.

44. On or about August 15, 2011, H.I. presented to a physician assistant who continued her on Fioricet.

45. On or about August 20, 2011, H.I. presented again to Respondent, who recorded the progress note on a different form than usual. The chief complaint was "refill on meds." Respondent noted "Discharge and pain in pelvis, endometriosis, cyst on CX (free liquid), going to be seen soon by [Dr. M.]." Respondent's impression was "fibroid uterus, chronic pelvic pain, Accident [illegible.]" Respondent's treatment plan was simply a prescription for Norco. Respondent made no notation regarding the outcome of the gynecological referral.

46. On or about September 9, 2011, H.I. presented to a physician assistant, who discontinued the Norco prescription, and continued the Vicodin, Soma, and promethazine prescriptions.

47. On or about October 4, 2011, H.I. presented to a physician assistant, who continued her on Vicodin, Soma, promethazine, and Fioricet.

48. On or about November 1, 2011, H.I. presented to a physician assistant, who "refilled meds as Rx'd previously."

49. On or about November 17, 2011, H.I. presented to a physician assistant, who "refilled meds," and increased the Vicodin prescription to 7.5/750 #150.

50. On or about December 6, 2011, H.I. presented to a physician assistant, whose plan included "(1) prior authorization for Vicodin done" and "(2) maintain all meds."

51. On or about December 10, 2011, H.I. presented again to Respondent. The chief complaint was "patient has migraine headache; lower abdominal pain." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Patient went to [Dr. V.] (OB-Gyn) for abdominal pain and showing C.T. scan, U.S. as fibroids [illegible] possibly endometriosis. Patient is seeking disability for discomfort in abdomen 12/9/11 to March 31, 2012." Respondent's assessment was "D.D.D./Arthritis; Nausea, abdo discomfort from endometriosis C.T. scan fibroid [illegible] U.S.; Migraine H/A." Respondent failed to note any basis for the arthritis diagnosis. Respondent's plan was simply prescriptions for "Vicodin 7.5/750 or Norco" and Fioricet.

52. On or about January 16, 2012, H.I. presented again to Respondent. The chief complaint was "refill on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "[Dr. V.] OB. Gyn did laparoscopy in Dec 2011 and biopsy and D&C; need to have the report." Respondent's assessment was "Fibroid uterus; Endometriosis; Pelvic Pain; H.A. Migraine." Respondent's plan was simply a list of medications including Norco, Soma, lorazepam, and Fioricet.

53. On or about February 4, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for refills on meds and f/u on car accident." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Going to see [Dr. V.] next week; O.K. all meds for another 12 days." Respondent's assessment was "Fibroid uterus; Endometriosis; Pelvic Pain; H.T.N." Respondent's plan was simply to add a medication for hypertension.

54. On or about February 29, 2012, H.I. presented again to Respondent. The chief complaint was "refills on med's [sic]; pain on neck." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Going for exam and evaluation by [Dr. V.] in 2 weeks." Respondent's assessment was "Fibroid uterus; possibly endometriosis; H.T.N Migraine H/A; neck injury; pelvic pain; endometriosis." Respondent's plan consisted of prescriptions for Vicodin, Fioricet, lorazepam, and Soma.

55. On or about March 22, 2012, H.I. presented again to Respondent. The chief complaint was "B/p [sic]." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Patient in Reedley Hospital re: chest pain [illegible] pain suprapubic." Respondent's assessment was "Benign chest pain; Anxiety." Respondent's plan was simply another prescription for lorazepam. Respondent noted a referral to "Selma cardiologist for Echo stress test for chest pain."

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56. On or about March 29, 2012, H.I. presented again to Respondent. The chief complaint was "Patient here for refill on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination. Respondent's assessment was "Fibroid uterus and endometriosis; Anxiety; Headache; D.D.D. spine/Arthritis. Going for operation in April, settling down with chest pain investigations pre-op." Respondent's plan consisted of a list of medications, including Vicodin, Fioricet, and Soma.

57. On or about April 16, 2012, H.I. presented again to Respondent. The chief complaint was "HTN check; Fibroid uterus." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "[Dr. S.] cardiologist evaluated today with stress E.K.G./treadmill and [illegible] duplex U.S. for mid chest pain, S.O.B., H.T.N." Respondent's assessment was "H.T.N.; Menorrhagia due to Fibroid uterus and endometriosis; D.D.D. spine/arthritis multiple joint; chest pain to r/o C.A.D. and [illegible] stenosis, S.O.B." Respondent's plan was simply another prescription for Norco.

58. On or about April 27, 2012, H.I. presented again to Respondent. The chief complaint was "here for med refills." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "(1) Headaches, [illegible] sinuses stuffed up itchy eyes, watery; (2) Had an accident rear ended in Jan 12; neck stiffness and knots; (3) vomiting and diarrhea. Going to see cardiologist for stress and Doppler studies chest pain." Respondent's assessment was "Gastritis [illegible] D.D.D. spine H.T.N." Respondent's plan was simply a list of medications, including Vicodin, Soma, and lorazepam. Respondent ordered x-rays of the neck and thoracic spine "for whiplash injury to neck after M.V.A."

59. On or about May 14, 2012, H.I. presented again to Respondent. The chief complaint was "refill on migraine headaches." The subjective section of the note was left entirely blank, and the objective section noted a normal physical examination of the ears, nose, throat, and neck, but no other examination. Respondent noted "sinuses stuffed up." Respondent's assessment was "G.E.R.D.; Migraine H/A; Nausea and Gastritis; Allergies." Respondent's plan was simply a list

of prescriptions including one for promethazine. Respondent again noted an order for x-rays of the neck and thoracic spine.

60. On or about May 22, 2012, H.I. presented again to Respondent. The chief complaint was "c/o lower abdominal pain." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "(1) Patient is going for neck pain due to recent whiplash injury. (2) Operation by [Dr. V.] OB-Gyn next week." Respondent's assessment was "Headaches; backaches; endometriosis." Respondent's plan was simply prescriptions for Fioricet and lorazepam. Respondent noted "Disability from 5/17/12 to Aug 31st 12; Disability for backache, heavy periods, fibroid uterus, enlarged uterus, pelvic pain, endometriosis."

61. On or about May 25, 2012, H.I. presented again to Respondent. The chief complaint was "refill on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Headaches and pain in lower abdomen." Respondent's assessment was "(1) [illegible] discs of back; (2) Headaches migraine; (3) Pain in abdomen, [illegible], endometriosis." Respondent's plan was simply prescriptions for several medications including Vicodin and Soma.

62. On or about June 11, 2012, H.I. presented again to Respondent. The chief complaint was "follow up on neck pain." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination with no other information. Respondent's assessment was "(1) Neck hurts; acute pain; D.D.D. spine [illegible] C5-6; Scoliosis [illegible] C5 only; (2) Endometriosis and Fibroids; (3) Review of meds." Respondent's plan was "I.B.U. [illegible] T.I.D. #100; Disability forms signed; Review of meds; continue."

63. On or about June 19, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for refills on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination with no other information. Respondent's assessment was only "D.D.D. spine. Scoliosis." Respondent's plan was simply "Refills as written on 5/25/12 and also written on 5/22/12."

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64. On or about July 2, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for refills on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although this time Respondent noted "Patient trying to go back to work. For employment until she will be asked to go for operation on Endometriosis in pelvic area, pain and enlarged uterus." Respondent's assessment was "Pain from pelvic; Endometriosis and enlarged uterus." In the plan section of the note, Respondent wrote "Disability/resuming job as of June 15th in retrospect patient given the letter to be [sic]." No other plan was noted.

65. On or about July 20, 2012, H.I. presented to a physician assistant, who refilled her prescriptions for Vicodin, Soma, and Fioricet, and made a referral to a gynecologist.

66. On or about August 17, 2012, H.I. presented again to Respondent. The chief complaint was "refills on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Menorrhagic and fibroids, anemic, anxiety." No basis was noted for any of these diagnoses. Respondent's assessment was "Scoliosis; D.D.D. spine; Endometriosis; Anxiety; Heavy periods, painful; Fibroid uterus; Headaches; Anemic; Menorrhagia." Respondent's plan was again a list of medications, including Vicodin, Soma, lorazepam, and Fioricet.

67. On or about September 7, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for acid reflex [sic]; check up and refill on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "Doing good; Zantac is doing good for reflux." Respondent's assessment was "G.E.R.D.; Anxiety; Heavy periods painful; fibroids; endometriosis; enlarged uterus." Respondent's plan was to prescribe medication for acid reflux, and to refer the patient to a gynecologist for "laparoscopic exploration."

68. On or about September 14, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for refills." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination with no other information. Respondent's assessment was "G.E.R.D.; Anxiety; Endometriosis/fibroids painful."

Respondent's plan was simply to again prescribe Vicodin, Soma, lorazepam, and Fioricet, as well as to refer H.I. to a gynecologist "urgently for pain [illegible] endometriosis for diagnostic laparoscopy."

69. On or about October 3, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for refills on GERD and anxiety." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "cough and congestion in chest [illegible] phlegm +." Respondent's assessment was "G.E.R.D.; Anxiety; Endometriosis/Fibroids; Pain in pelvic area." Respondent's plan was to prescribe promethazine with codeine[7] 8 fl. oz., Norco 10/325, and acid reflux medication.

70. On or about October 5, 2012, H.I. presented again to Respondent. The chief complaint was "patient complaint of headache." The subjective section of the note was left entirely blank, and the objective section noted "[illegible]; runny nose; chest clear; [illegible]; periods heavy; nauseated." Respondent's assessment was "Headaches, flu like symptoms." Respondent's plan was to prescribe an antibiotic and Zoldem, a benzodiazepine used for the treatment of insomnia.

71. On or about October 12, 2012, H.I. presented again to Respondent. The chief complaint was "patient here for refills." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "[illegible]; chest clear; feels like a mass in esophagus while swallowing; burning sensation in stomach." Respondent's assessment was "Headaches; Anxiety; Endometriosis/Fibroids; Pain in stomach due to [sic]; Pain on swallowing r/o lump in esophagus." Respondent's plan was to prescribe Zoldem, lorazepam, Vicodin, Fioricet, Soma, and acid reflux medication.

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[7] Phenergan (promethazine) with codeine is a liquid combination of the first-generation antihistamine promethazine, with the weak, short-acting opiate codeine. It is indicated for the acute treatment of cough. It is not recommended for long-term use. It causes respiratory and central nervous system suppression. Its use with other agents that cause respiratory suppression is contraindicated. It has a high potential for abuse, and is the main ingredient in the popular drug cocktail "Purple Drank."

72. On or about November 5, 2012, H.I. presented again to Respondent. The chief complaint was "patient here refill on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "cough, congested chest, throat [illegible]." Respondent's assessment was "H/A [headache]; Bronchitis; Pharyngitis [sore throat]." Respondent's plan was to prescribe antibiotics, Phenergan with codeine, and Norco 10/325.

73. On or about November 12, 2012, H.I. presented again to Respondent. The chief complaint was "refill on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "going to see gyn this week for laparoscopy for pain in abdo." Respondent's assessment was "Headaches; Anxiety; Endometriosis/fibroid." Respondent's plan was to prescribe Zoldem, lorazepam, Vicodin, Soma, and Fioricet.

74. On or about December 11, 2012, H.I. presented again to Respondent. The chief complaint was "refill on meds; complaint of back pain." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination. Respondent's assessment was "[illegible]; Fibroid uterus and Bilateral ovarian cyst, endometrial tissue prominent. R/o endometriosis in pelvic area." Respondent's plan was a list of medications, including Vicodin, Soma, Fioricet, lorazepam, and Phenergan. Respondent noted "severe pain and back hurts. C.T. Scan of pelvic organs followed by U.S., previous C.T. shows fibroids and ovarian cyst, endometrial tissue [illegible.]"

75. On or about January 3, 2013, H.I. presented again to Respondent. The chief complaint was "patient here for refills on meds." The subjective section of the note was left entirely blank, and the objective section noted an entirely normal physical examination, although Respondent noted "cough and vomiting; back hurts." Respondent's assessment was "D.D.D. spine; U.A.I." Respondent's plan was to prescribe Norco, Zoldem, and Phenergan with codeine. Respondent made no mention of the previously ordered C.T. scan or ultrasound.

76. On or about January 11, 2013, H.I. presented again to Respondent. The chief complaint was "refill m; complaint of headache and back pain." Respondent's assessment was

"scoliosis; Allergies; Refills for D.D.D. spine; endometriosis, fibroid uterus." The subjective, objective, and plan portions of the note were left entirely blank.

Circumstances Related to Patient F.R.

77. Between April 1, 2010, and January 16, 2013, Patient F.R., a man in his late thirties, visited the Mountain View Medical Clinic a total of 27 times. During this period, Respondent authored 24 handwritten progress notes for in-person visits with F.R., on standardized SOAP forms.

78. On or about April 1, 2010, F.R. presented to Respondent. The chief complaint was "back pain refill meds." Respondent recorded a history of lumbar back pain related to a parachute jump when F.R. was in the Army, as well as degeneration of one or both knees, and stiffness in one or both ankles. Respondent's assessment was "Sinusitis R.A.D. [reactive airway disease]; Bulging Discs; Old Fractures L3-4-5; Sciatic pain bilaterally; Migraine H/A; G.E.R.D. [illegible] stomach." Respondent's plan consisted of a list of medications including Lortab 7.5/450, Soma, Neurontin,[8] and Phenergan.

79. On or about May 17, 2010, F.R. presented again to Respondent. The chief complaint was "Back pain and med refills." The subjective and objective portions of the note were left entirely blank, except for the notation "back hurts." Respondent's assessment was "Bulging Discs; D.D.D. Spine; old fractures." Respondent's plan was to prescribe Lortab 7.5/500. Respondent noted "Has all other meds."

80. On or about July 8, 2010, F.R. presented again to Respondent. The chief complaint was "Back pain, refill meds." The subjective and objective portions of the note were left entirely blank, except for the notation "Hips, knees and ankles got hurt in Army while coming down in a parachute." Respondent's assessment was "Bulging Discs; D.D.D. Spine; old fractures; G.E.R.D.; Muscle cramps; Allergies." In the section for plan, Lortab was scratched out, and Respondent wrote "Norco 10/325 or 5/325 or 4.5/325," then wrote "Norco 10/325

[8] Gabapentin (Neurontin) is a medication used as an anticonvulsant and analgesic. It was originally developed to treat epilepsy, and is currently also used to relieve neuropathic pain.

P.O.T.I.D.P.R.N. [one orally three times per day as needed] #90" and circled this last notation. No other plan was noted. No explanation was given for changing the patient's prescription from Lortab to Norco, and Respondent made no record of how the patient was responding to treatment.

81. On or about July 22, 2010, F.R. presented again to Respondent. The chief complaint was "complaint of left ear pain." The subjective and objective portions of the note were left entirely blank, except for the notation "lower legs hurt, cannot bend," and "disability papers filled." Respondent's assessment was "B.O.M.; Pharyngitis; Allergies; D.D.D., bulging 3-4-5." Respondent's plan was to prescribe antibiotics, ear medication, and Phenergan.

82. On or about August 16, 2010, F.R. presented again to Respondent. The chief complaint was "here for refill meds, back pain." The subjective and objective portions of the note were left entirely blank, except for the notation "doing well, some back ache." Respondent noted "Filled Vicodin from another doctor 7.5/750 [illegible] C.V.S. Visalia [illegible] 1-2 weeks ago. 8/10/10. Patient says this is not strong enough for pain so went to Norco from our clinic on 8/16/10." Respondent's assessment was "D.D.D. Spine; old fractures; G.E.R.D.; Muscle Cramps and burning sensation [illegible]; Restless leg syndrome; Allergies." Respondent's plan was a list of medications including Norco, Soma, Neurontin and Phenergan.

83. On or about September 16, 2010, F.R. presented again to Respondent. The chief complaint was "here for refill on back pain meds." The subjective and objective portions of the note were left entirely blank, except for the notation "doing well." Respondent's assessment was "D.D.D. Spine; old fractures spine; G.E.R.D.; Muscle Cramps and burning." Respondent did not note any plan.

84. On or about October 21, 2010, F.R. presented again to Respondent. The chief complaint was "patient here for refill on meds." The subjective and objective portions of the note were left entirely blank, except for check marks indicating an entirely normal physical examination. Respondent's assessment was "D.D.D. Spine; old injuries, fractures spine; G.E.R.D." The only notation under plan was to refill the patient's Norco prescription.

85. On or about December 13, 2010, F.R. presented again to Respondent. The chief complaint was "refill on meds." The subjective and objective portions of the note were left

entirely blank, except for the notation "feeling sleepy all the time." Respondent's assessment was "H.T.N. T. B. Test; D.D.D. Spine; old injury fractured spine; G.E.R.D." Respondent's plan was a list of medications including Norco, Neurontin, and Soma.

86. On or about January 31, 2011, F.R. presented again to Respondent. The chief complaint was "refill on meds." The subjective portion of the note was left entirely blank. The objective portion noted a mostly normal physical examination, with the sole exception of the notation "Heart R.R.R. [regular rate and rhythm] [illegible.]" Respondent's assessment was "Allergies; H.T.N.; D.D.D. Spine; old injury fractured spine; G.E.R.D." Respondent's plan consisted of prescriptions for Norco and Soma.

87. On or about March 21, 2011, F.R. presented again to Respondent. The chief complaint was "H.T.N./Back pain; allergies and med refills." The subjective and objective portions of the note were left entirely blank, except for the notation "doing well." Respondent's assessment was "D.D.D. Spine; H.T.N.; G.E.R.D.; Allergies; H/A and nausea." Respondent's plan was a list of medications including Neurontin, Soma, and Norco.

88. On or about April 25, 2011, F.R. presented again to Respondent. The chief complaint was "here for refill on meds." The subjective and objective portions of the note were left entirely blank, except for check marks indicating an entirely normal physical examination. Respondent's assessment was "D.D.D. Spine; H.T.N.; Allergies; G.E.R.D.; H/A." Respondent's plan was a list of medications including Norco and Soma.

89. On or about May 23, 2011, F.R. presented again to Respondent. The chief complaint was "here for med refill." The subjective and objective portions of the note were left entirely blank. Respondent's assessment was "H.T.N; D.D.D. Spine; G.E.R.D.; Allergies." Respondent's plan was to prescribe Norco and Soma.

90. On or about June 23, 2011, F.R. presented to a physician assistant who continued the patient on Norco and Soma.

91. On or about July 28, 2011, F.R. presented again to Respondent. The chief complaint was "here for med refill." The subjective and objective portions of the note were left entirely blank, except for the notation "doing good; B.P." Respondent's assessment was "H.T.N.;

Allergies; D.D.D. Spine; G.E.R.D." Respondent's plan was a list of medications, including Norco and Soma.

92. On or about October 17, 2011, F.R. presented to a physician assistant who continued him on Norco and Soma.

93. On or about November 30, 2011, F.R. presented to a physician assistant whose plan included "refill meds, but not Soma."

94. On or about January 14, 2012, F.R. presented again to Respondent. The chief complaint was "refill on meds." The subjective and objective portions of the note were left entirely blank, except for the notation "Patient is to have refill on his H.T.N. medication." Respondent's assessment was "H.T.N.," and her plan was a prescription for heart medication. There was no notation regarding any other complaint or condition.

95. On or about February 16, 2012, F.R. presented again to Respondent. The chief complaint was "patient here for HTN and refill on meds." The subjective portion of the note was left entirely blank, except for the notation "Has costochondritis; muscle strain of chest wall singing and preaching." In the objective section, Respondent noted "costochondritis; tender muscles of chest; doing well," and an otherwise normal physical examination. Respondent's assessment was "H.T.N.; chronic G.E.R.D.; D.D.D. Spine; Obesity." Respondent's plan was a list of medications, including Norco, Soma, and "Phenergan 25 mg or Zoldem 4mg." Respondent noted that the patient was to undergo an echocardiogram and a CT scan of the chest.

96. On or about March 6, 2012, F.R. presented again to Respondent. The chief complaint was "Here for results." The subjective and objective portions of the note were left entirely blank, except for a note regarding "essentially normal" results of a CT scan of the chest. Respondent noted "Patient is going to Echo soon." Respondent's assessment was "Lab check; U.R.I.; H.T.N." Respondent's plan was a list of medications including Phenergan with codeine.

97. On or about March 12, 2012, F.R. presented again to Respondent. The chief complaint was "patient here for med refills." The subjective and objective portions of the note were left entirely blank, except for the notation "doing well." Respondent's assessment was "H.T.N.; D.D.D. Spine; Obesity." Respondent's plan was to prescribe Norco and Soma.

98. On or about April 30, 2012, F.R. presented again to Respondent. The chief complaint was "patient here for med refills; Patient Need TB Inj." The subjective and objective portions of the note were left entirely blank, except for check marks indicating an entirely normal physical examination, and the notation "pain in back persists." Respondent's assessment was "H.T.N.; Anxiety; D.D.D. Spine; G.E.R.D.; Allergies." Respondent's plan was a list of medications including Norco, Soma, and Xanax.[9]

99. On or about July 3, 2012, F.R. presented again to Respondent. The chief complaint was "patient here for refills on meds." The subjective and objective portions of the note were left entirely blank, except for check marks indicating an entirely normal physical examination. Respondent's assessment was "refill H.T.N.; D.D.D.; G.E.R.D.; Allergies." Respondent's plan was a list of medications including Norco, Soma, Xanax, and Phenergan with codeine.

100. On or about August 28, 2012, F.R. presented again to Respondent. The chief complaint was "H.T.N.; D.D.D. check refill meds." The subjective and objective portions of the note were left entirely blank, except for check marks indicating an entirely normal physical examination, the notation "chest" with no elaboration, and the notation "pharynx red, ear canals pinkish." Respondent's assessment was "G.E.R.D.; H.T.N.; D.D.D. Spine." Respondent's plan was a list of medications including Norco, Soma, and Phenergan with codeine.

101. On or about September 7, 2012, F.R. presented to Respondent to obtain results of a blood panel. Respondent diagnosed F.R. with anemia and prescribed folic acid. No mention was made of any other complaint.

102. On or about October 2, 2012, F.R. presented again to Respondent. The chief complaint was "Here for refills on meds and lab results." The subjective and objective portions of the note were left entirely blank, except for the notation "[illegible] good performance; Hep-C

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[9] Xanax (alprazolam) is a short-acting benzodiazepine, indicated for the acute treatment of anxiety states, particularly panic attacks. Benzodiazepines are highly habit forming, and are commonly abused because at high dose, or when "snorted", they cause euphoria. When combined with opiate agents, benzodiazepines can result in profound hypotension, respiratory suppression, and profound central nervous system suppression resulting in coma or death.

Negative." Respondent's assessment was "lab results satisfactory; H.T.N.; D.D.D. Spine." Respondent's plan was a list of medications including Norco and Soma. Respondent noted a referral to a hepatitis specialist.

103. On or about December 4, 2012, F.R. presented again to Respondent. The chief complaint was "Patient follow up on H.T.N.; patient needs refills." The subjective and objective portions of the note were left entirely blank, except for a notation regarding the phone number of a pharmacy, and the notation "pain in back." Respondent's assessment was "H.T.N.; D.D.D. Spine." Respondent's plan was a list of medications including Norco and Soma. Respondent noted "Patient wants to transfer himself from Methadone clinic in Visalia to organize regular clinic attendance /blood work. Going to [illegible.]" No other notations regarding F.R.'s treatment at a Methadone clinic, or his possible drug abuse, appear anywhere in F.R.'s medical record.

104. On or about January 16, 2013, F.R. presented again to Respondent. The chief complaint was "D.D.D. check refill meds PSA Needed." The subjective and objective portions of the note were left entirely blank, except for a notation regarding F.R.'s hemoglobin and his treatment with folic acid. Respondent's assessment was "D.D.D. Spine; H.T.N.; Anemia; Costochondritis." Respondent's plan was a list of medications including Soma, Norco. Respondent noted that F.R. was to obtain an echocardiogram, x-rays, and other studies to investigate dizziness and chest pain.

Circumstances Related to Patient E.R.

105. Between August 10, 2011, and March 4, 2013, Patient E.R., a man in his thirties, visited the Mountain View Medical Clinic a total of 17 times. During this period, Respondent authored 14 handwritten progress notes for in-person visits with E.R., on standardized SOAP forms.

106. On or about August 10, 2011, E.R. presented at the Mountain View Medical Clinic and was seen by another practitioner. E.R. complained of left knee pain related to an injury many years prior. He was prescribed the non-steroidal anti-inflammatory drug Naproxen 500mg.

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107. On or about August 20, 2011, E.R. presented to Respondent. The chief complaint was "patient complaint of pain on left knee + here for MRI [magnetic resonance imaging] report." The subjective and objective portions of the note were left entirely blank, except for the note "fell hurting left knee 13 years ago; had no f/u and no other doctor so far; left knee hurts all the time." Respondent's assessment was "left knee pain; torn left knee meniscus; f/u on MRI." Respondent's plan was "On Naprosyn; Vicodin 5/500 P.O.T.I.D.P.R.N. after work #50; left knee brace to support supplied from Walgreens." Respondent noted a referral to an orthopedic surgeon for care of the left knee.

108. On or about September 17, 2011, E.R. presented again to Respondent. The chief complaint was "here for med refill." The subjective portion of the note was left entirely blank. Respondent noted a fungal rash on the patient's abdomen, and noted that the orthopedic referral resulted in a recommendation of knee surgery. Respondent's assessment was "torn left lateral meniscus; knee joint; dermal fungus; [illegible]." Respondent's plan was a list of medications including Norco 10/325 #60. Respondent noted that E.R. was to have another appointment with the orthopedic surgeon.

109. On or about October 17, 2011, E.R. presented to another practitioner, who refilled his medication prescriptions and referred him to physical therapy.

110. On or about January 20, 2012, E.R. presented again to Respondent. The chief complaint was "complaint of possible Allergies and Abd pain." The subjective portion of the note was left entirely blank. Respondent noted "lifting heavy weight; suddenly ribcage; one of the bones [illegible] made noise yesterday." Respondent's physical examination noted sinusitis and allergies. Respondent's assessment was "sinusitis; rib dislocation vs. muscle strain; chest muscles." Respondent's plan was to prescribe Soma, Norco, and an antibiotic.

111. On or about January 21, 2012, E.R. presented again to Respondent for follow up on x-ray results. Respondent noted no dislocation and normal results. Respondent noted that E.R. was attending physical therapy.

112. On or about February 29, 2012, E.R. presented again to Respondent. The chief complaint was "complaint of allergies and refill meds." The subjective and objective portions of

the note were left entirely blank. Respondent's assessment was "Costochondritis; muscle strain due to [illegible] and shifting gears in the truck driving; periodic asthma; Allergies." Respondent's plan was a list of medications including Norco and Soma.

113. On or about April 19, 2012, E.R. presented again to Respondent. The chief complaint was "complaint of allergies and refill on meds." The subjective portion of the note was left entirely blank. In the objective section, Respondent noted "throat red, congested; chest clear at this time; heart; T.M.S. red, nasal drip, itchy eyes, periodic." Respondent's assessment was "Allergies; periodic asthma; pharyngitis; arthritis/muscle strain." Respondent's plan was a list of medications including Phenergan and Vicodin.

114. On or about April 30, 2012, E.R. presented again to Respondent. The chief complaint was "complaint of chest pain." In the subjective section, Respondent noted "S.O.B. wheezing past 2 weeks; OE lungs wheezing mainly in right lung." The objective portion of the note was left entirely blank. Respondent's assessment was "Asthma Acute Exacerbation; Pharyngitis." Respondent's plan was a list of medications including Phenergan, Norco, and Soma. Respondent ordered a chest x-ray and echocardiogram.

115. On or about May 2, 2012, E.R. presented to Respondent for follow up on his complaint of chest pain and x-ray results. Respondent noted "x-ray chest normal," and prescribed asthma medication.

116. On or about June 11, 2012, E.R. presented again to Respondent. The chief complaint was "patient complaint of Allergies; back pain." The subjective portion of the note was left entirely blank. In the objective section, Respondent noted "runny nose, itchy eyes; OE sinusitis and headache, redness of conjunctivae," but failed to note any physical examination. Respondent's assessment was "Allergies; rhino sinusitis; H/A; back muscle strain." Respondent's plan was a list of medication including Norco 5/325.

117. On or about September 11, 2012, E.R. presented again to Respondent. The chief complaint was "follow up on back pain." The subjective and objective portions of the note were left entirely blank. Respondent's assessment was "Allergies, sinusitis; H/A; muscle strain." Respondent's plan was "same meds as written on 6/11/12."

118. On or about October 11, 2012, E.R. presented again to Respondent. The chief complaint was "follow up on back pain." The subjective and objective portions of the note were left entirely blank, except for the notations "nasal congestion" and "pain in back." Respondent's assessment was "Sinusitis; Allergic Dermatitis; Back spinal area muscle strain from prolonged sitting." Respondent's plan was a list of medications including Soma and Norco.

119. On or about November 12, 2012, E.R. presented again to Respondent. The chief complaint was "refill on meds." The subjective and objective portions of the note were left entirely blank. Respondent's assessment was "Allergic Dermatitis; Muscle strain of back and legs from prolonged sitting." Respondent's plan was a list of medications including Norco and Soma.

120. On or about December 10, 2012, E.R. presented again to Respondent. The chief complaint was "follow up on allergies; patient needs refills." The subjective and objective portions of the note were left entirely blank, except for the note "wheezing in chest sometimes." Respondent's assessment was "Allergies; Muscle strain of back and legs from prolonged sitting." Respondent's plan was a list of medications including Soma and Norco.

121. On or about January 4, 2013, E.R. presented again to Respondent. The chief complaint was "complaint of back pain; refill on meds." The subjective and objective portions of the note were left entirely blank. Respondent's assessment was "Allergies; muscle strain of back and legs." Respondent's plan was a list of medications including Soma and Norco.

122. On or about March 4, 2013, another practitioner placed a note in E.R.'s medical record stating "patient refused to be examined by [Dr. H], and insisted for Norco. (Patient was refunded his fee.) We may not see this patient in future." Another note on the same date states "Patient refuse to take any other pain medication other than Norco 10/325 and Soma as I try to give him some other pain medication."

The Standard of Care

123. The standard of care is to keep timely, accurate, and legible medical records. The medical record should include a detailed history of the present illness or status of chronic conditions. It should reflect up-to-date medication lists, and should document the physical examination that was done at that visit, which should be appropriate for the complaint and

medical conditions being followed. The diagnosis and treatment plan should be adjusted to reflect the care that was provided that day.

124. The standard of care in prescribing controlled substances for the management of chronic pain requires timely, accurate, and legible medical records which record pain levels, levels of function, quality of life, possible adverse effects of multiple psychogenic medications, and response to treatment for pain and anxiety.

125. The standard of care in prescribing controlled substances for the management of chronic pain requires a medical history and physical examination, which includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

126. The standard of care in prescribing controlled substances requires that the medical record contain a treatment plan that states objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychological function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of the patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

127. The standard of care requires periodic review of the course of pain treatment, any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Departures from the Standard of Care

128. Respondent failed to maintain adequate and accurate records relating to the provision of services to patients H.I., F.R., and E.R. The majority of the notes authored by Respondent do not contain sufficient documentation to clearly explain the patient's medical history, and justify

the treatment plan. The "chief complaint" is most often "refill on meds." Most of the notes do not include any comments on the "problems from last visit." The subjective section is where a history of the patient's current conditions, and a review of systems should be documented. In almost all of Respondent's notes, the subjective section is left blank, or has very limited information. In the objective section, there is generally either no exam documented, or check boxes indicating normal exam. In the assessment section, Respondent noted a diagnosis with no elaboration. In the plan section, Respondent generally noted only the medications prescribed. Her failure to maintain adequate and accurate records represents an extreme departure from the standard of care as to each patient.

129. Respondent failed to note any response to treatment of chronic pain, including pain levels, levels of function, quality of life, and possible side effects of multiple concurrent psychogenic medications, in her records of treatment of patients H.I., F.R., and E.R. Her failure to do so represents an extreme departure from the standard of care as to each patient.

130. Respondent failed to document a medical history to support her prescription of controlled substances to patients H.I., F.R., and E.R. In her treatment of E.R., Respondent prescribed Norco and Soma for conditions that do not warrant this level of treatment. Her failure to document a medical history that supports her prescription of controlled substances represents an extreme departure from the standard of care as to each patient.

131. Respondent failed to document a treatment plan for H.I., F.R., or E.R. that stated objectives by which the outcomes could be evaluated. Her documented plan was typically no more than a list of medications, without elaboration. Her failure to document a treatment plan with objectives represents an extreme departure from the standard of care as to each patient.

132. Respondent failed to provide any recommendations to H.I. or F.R. regarding alternatives to pharmacological treatment, such as formal physical therapy, or psychological referral. Although Respondent referred E.R. to physical therapy for his knee pain, she failed to do so for his complaint of "muscle strain." Her failure to recommend alternatives to pharmacological treatment represents an extreme departure from the standard of care as to each patient.

133. Respondent failed to document any periodic review of the pharmacological treatment she provided to H.I., F.R., and E.R. with subjective or objective response to treatment, and consideration of other therapeutic modalities. With respect to H.I., her only notation regarding any review at all, on or about June 11, 2012, consisted only of the notation "Review of meds; continue." Respondent did not document E.R.'s response to the medication she prescribed, or offer any explanation as to why he was not improving. Her failure to document periodic review represents an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

134. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that she engaged in repeated negligent acts. The circumstances are set forth in paragraphs 9 through 122, and are incorporated here as if fully set forth.

The Standard of Care

135. The standard of care requires a physician to discuss with the patient, caregiver, or guardian, the risks and benefits of, and alternatives to, the use of controlled substances for the treatment of chronic, non-cancer pain. The standard of care requires timely, accurate, and legible documentation of an informed consent process.

136. The standard of care requires referral of a patient, as necessary, for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist. In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications, including those whose living arrangements pose a risk for medication misuse or diversion.

Departures from the Standard of Care

137. Respondent failed to document any discussion with H.I., F.R., or E.R. of the risks and benefits of the use of controlled substances, or discussion of alternative treatment options. She prescribed combinations of psychogenic drugs with significant potential for physical dependence, over long periods, without documenting any discussion with her patients of the significant side

effects these drugs, alone and in combination, may cause. Her failure to document an informed consent process represents a separate departure from the standard of care as to each patient.

138. Respondent sought consultation from a gynecologist regarding H.I.'s pelvic pain, and sought a neurologic consultation regarding H.I.'s headache complaint. However, Respondent failed to document the results of these consultations or modify H.I.'s treatment plan in any way as a result of these consultations. Respondent's treatment modalities were limited to pharmacological interventions, and did not incorporate formal physical therapy, and/or psychological and pain management referral. These failures represent departures from the standard of care.

139. Respondent failed to document F.R.'s possible history of illicit drug use, and thus failed to consider referral to an addiction or pain specialist, as may have been indicated. This failure represents a departure from the standard of care.

140. Although Respondent referred F.R. to physical therapy and an orthopedic surgeon for his knee pain, she failed to make any referral for his complaint of "muscle strain," despite this condition persisting for many months. This failure represents a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Recordkeeping)

141. Respondent is subject to disciplinary action under section 2266 in that she failed to maintain adequate records. The circumstances are set forth in paragraphs 9 through 133, and 135 through 140, which are incorporated here as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A52697, issued to Kishwar R. Gill, M.D.;

2. Revoking, suspending or denying approval of Kishwar R. Gill, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Kishwar R. Gill, M.D. to pay the Medical Board of California, if placed on probation, the costs of probation monitoring; and

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

DATED: March 27, 2015

Elizabeth Amaral
for KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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