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

In the Matter of the First Amended Accusation Against:	)	
GREGORY JOHN VAN DYKE, M.D.	)	**Case No. 800-2014-008191**
Physician's and Surgeon's Certificate No. A 51101	)	
Respondent	)	

DECISION AND ORDER

The attached Stipulated Surrender of License and 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 March 22, 2018

IT IS SO ORDERED March 15, 2018.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
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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 First Amended Accusation Against: GREGORY JOHN VAN DYKE, M.D. 26732 Crown Valley Pkwy., #421 Mission Viejo, CA 92691 Physician's and Surgeon's Certificate No. A 51101 Respondent.	Case No. 800-2014-008191 **STIPULATED SURRENDER OF LICENSE AND 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 Trina L. Saunders, Deputy Attorney General.

2. Gregory John Van Dyke, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On August 11, 1992, the Board issued Physician's and Surgeon's Certificate No. A 51101 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all

times relevant to the charges brought in First Amended Accusation No. 800-2014-008191 and will expire on August 31, 2018, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2014-008191 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on January 5, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of First Amended Accusation No. 800-2014-008191 is attached as Exhibit A and is incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in First Amended Accusation No. 800-2014-008191. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2014-008191, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation and that those charges

constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender 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.

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

13. 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 Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 51101, issued to Respondent Gregory John Van Dyke, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2014-008191 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/4/2018

GREGORY JOHN VAN DYKE, M.D.
Respondent

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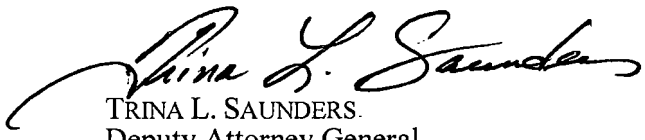
ENDORSEMENT

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

Dated: March 8, 2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



TRINA L. SAUNDERS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2014-008191

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 5 2018
BY K. Voong ANALYST

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

In the Matter of the First Amended Accusation Against: GREGORY JOHN VAN DYKE, M.D. 34145 Pacific Coast Highway #512 Dana Point, CA 92629-2808 Physician's and Surgeon's Certificate No. A 51101, Respondent.	Case No. 800-2014-008191 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 11, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number A 51101 to Gregory John Van Dyke, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2018, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code (Code).

4. 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."

5. Section 2234 of the Code states:

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

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. 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)

7. Respondent is subject to disciplinary action pursuant to Code section 2234 (b), gross negligence, in that he failed to properly evaluate and manage the extremely high blood pressure of Patient A[1]. The circumstances are as follows:

8. On April 17, 2013, Patient A was sent from his surgeon's office to Respondent for evaluation of extremely elevated blood pressure. Patient A's blood pressure was 235/106. A repeat reading was taken and Patient A's pressure was 247/103. The review of systems/ subjective/history section of the patient record is blank. A third blood pressure reading was taken. Patient A's blood pressure was 229/92. Respondent did not ask Patient A whether he was experiencing chest pain, other pain, shortness of breath, altered thinking, headache, difficulty speaking, or whether his ability to feel and move his arms and legs normally. Respondent conducted very little physical examination. The physical examination only included that the patient was "awake/alert," and illegible findings related to lung and heart findings were documented. Assessment #1 notes, "HTN." There is no evaluation done to determine whether the patient was experiencing an emergency. A three-component combination blood pressure medication was listed under the plan. No instructions were given regarding when the patient should return, or what symptoms the patient or family should be aware of.

9. If blood pressure reaches systolic levels greater than 220, or diastolic levels greater than 110-120, an assessment of the potential for immediate harm must be taken. A physician must immediately determine if the patient's condition constitutes a hypertensive urgency, which is defined by the absence of apparent end organ damage, and can usually be managed by lowering the blood pressure over a period of 1-2 days, or whether it constitutes a hypertensive emergency, which in most cases, requires that the blood pressure be lowered within minutes to hours. Hypertensive emergencies require immediate treatment, usually in an ICU setting. Hypertensive urgencies should be treated by initiating medication in carefully, especially in elderly patients.

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[1] In the Accusation in this matter which was filed on September 15, 2017, Patient A was referenced by the initials J.V.

The patient should be kept under observation until either the blood pressure decreases, or after careful evaluation, there is no evidence of the need to lower the blood pressure very quickly. A return visit in one to two days, at the most, should occur to reevaluate the patient.

10. Respondent did not examine and evaluate Patient A to determine whether he was suffering from a hypertensive emergency versus a hypertensive urgency. Thereafter, he sent Patient A home without a clear plan of treatment or a follow-up appointment within the required one to two days. Respondent's failure to evaluate, assess and manage Patient A's extremely elevated blood pressure is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to disciplinary action pursuant to section 2234 (b) for gross negligence in that he failed to properly evaluate and manage Patient B's anxiety disorder, and improperly prescribed Adderall to this patient. The circumstances are as follows:

12. Patient B first presented to Respondent on or about August 5, 2014. A complete history and physical examination and drug abuse history was taken. No Adderall or Xanax was prescribed. No Suboxone therapy was prescribed.

13. Patient B was seen two weeks later on August 19, 2014. The patient requested Adderall for her ADHD. No formal psychiatric or mental exam was performed. Respondent did not review the patient's psychiatric records. Respondent requested that the patient provide a copy of her psychiatric records. A month's supply of Adderall and Xanax were prescribed for ADHD and generalized anxiety disorder. No urine test was performed.

14. On September 3, 2014, Patient B presented to Respondent. She reported that her medications had been stolen. Adderall and Xanax were prescribed again.

15. On October 7, 2014, Patient B presented to Respondent. The patient requested a refill of Adderall and Xanax. Medication was prescribed without a detailed assessment of her conditions.

16. On October 15, 2014, Patient B again presented to the clinic. She reported that her medications had been stolen by her father and she requested a refill. Her medication was refilled.

Vyvanse was prescribed temporarily in place of Adderall, to minimize abuse. It was noted that Adderall would not be prescribed until psychiatric notes were received.

17. On October 27, 2014, Patient B presented to Respondent. She was returned to her monthly refills of Xanax and Adderall. The patient complained of chronic right knee pain for four years. She was prescribed Norco, Xanax, and Adderall. No psychiatric records were available.

18. Patient B returned on November 18, 2014. She received refills of Xanax and Adderall.

19. Patient B presented to Respondent again on November 21, 2014. She complained of an acute ankle injury from a mechanical fall, and persistent right knee pain with swelling. No examination of her ankles or knees was conducted. Her pain medication was changed to Tramadol.

20. On December 26, 2014, Patient B was seen for follow-up on her medication and ongoing ADD issues/anxiety. Respondent prescribed refills of Xanax, Adderall and Norco for the patient's ongoing anxiety, ADHD, and pain, respectively. The patient's psychiatry records were still unavailable. The patient chart indicates that a psychiatry consultation was recommended. No urine drug test was performed.

21. On January 22, 2015, Patient B was seen in the emergency room following a sexual assault. She presented to Respondent the following day for follow-up. She complained of increased anxiety and insomnia. She was prescribed Xanax, Adderall, and Norco.

22. On February 23, 2015, Patient B was given Norco, Tramadol and Oxycodone for pain management. The patient chart indicates that Respondent still needed the patient's psychiatric records.

23. On March 2, 2015, the patient signed an authorization for release of medical records.

24. On March 3, 2015, Respondent received Patient B's psychiatric records. The records confirmed DSM Axis Diagnoses of chemical dependency, alcohol abuse, anxiolytic medication abuse, and moderate generalized depression. Recommendations were to continue outpatient drug

treatment programs and psychotherapy to maintain sobriety. The psychotropic medications recommended were Zoloft, Gabapentin, and Trazodone.

25. On March 11, 2015, despite having received the patient's psychiatric records, Respondent continued to refill prescriptions for Xanax and Adderall. A urine test was performed. The patient was referred for psychiatric follow-up.

26. Two weeks later, on March 25, 2015, another urine test was completed. The test was positive for cocaine, amphetamine, marijuana, opiates, and benzodiazepines. Patient B admitted to heroin use. She was started on buprenorphine and naloxone therapy to treat her opioid dependency.

27. Patient B did not see Respondent for more than six months.

28. In October and November of 2015, the patient again presented to Respondent. She received refills of Adderall and Xanax.

29. Respondent was grossly negligent and departed from the standard of care in the care and treatment of Patient B as follows:

A. He failed to appropriately manage the patient's anxiety disorder. He did not treat her with non-benzodiazepine medications, he failed to review her prior psychiatric records, failed to notice the patient's aberrant behaviors, and failed to taper the patient off of Xanax upon learning that the patient's psychiatric care did not support the prescribing of this medication.

B. He inappropriately prescribed Adderall. He prescribed the medication without attempting to confirm a diagnosis to justify the prescription, he failed to perform an extensive psychiatric screening evaluation for ADHD in this patient, who was a recovering drug addict, he did not perform urine drug testing at each visit wherein he prescribed Adderall, and after finally receiving the patient's psychiatric records he continued to prescribe the medication, despite it not being recommended in the prior psychiatric consultation.

Patient C

30. Respondent is subject to disciplinary action pursuant to section 2234 (b) of the Code for gross negligence in that he failed to appropriately manage and monitor Patient C's buprenorphine therapy. The circumstances are as follows:

31. Patient C first presented to Respondent in July 2012.

32. On July 2, 2012 he was first prescribed buprenorphine.

33. After his initial induction period in July 2012, Patient C received four additional buprenorphine refills over the following 12 months. The refills were for 8 mg, totaling 240 tablets. This appears to have been the patient's stable maintenance dosage.

34. In October 2013, Patient C's usage escalated. He began receiving regularly monthly prescriptions for buprenorphine 60 tablets, 8 mg.

35. Beginning in 2014, Patient C received variable monthly quantities of buprenorphine, ranging from a low of 30 tablets per month, to a high of 120 tablets per month. He was prescribed a total of 850 tablets of 8 mg, each, for buprenorphine over the twelve months in 2014.

36. In January through September 2015, Patient C received 675 tablets of buprenorphine, which was an average of 75 tablets per month.

37. The patient had two clinic visits in 2012, five clinic visits in 2013, five clinic visits in 2014, and four clinic visits in 2015. He was prescribed buprenorphine and/or alprazolam each visit. The reason for these two medications was opioid dependence and chronic anxiety, respectively. During these 36 months of visits, urine toxicology testing was done twice. No goals of care were discussed. No psychiatry counseling was offered. No laboratory blood testing was done.

38. Respondent's failure to suspect aberrant behaviors in light of the increase in medication required during buprenorphine therapy, his failure to perform regular urine drug screening, failure to monitor liver function blood testing during therapy, failure to offer psychological counseling, and failure to discuss goals of care and tapering of the use of the medication constitutes an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

39. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate patient records related to patients A, D, B, and C. The records are devoid of

pertinent information to allow a physician to make medical decisions and devoid of clear and consistent up to date medication lists of active medications. The circumstances are as follows:

Patient A

40. Patient A presented to Respondent on at least twelve occasions between 2008 and 2014, including the following dates: January 25, 2008, February 27, 2008, June 9, 2008, December 5, 2008, January 16, 2009, July 27, 2009, August 7, 2012, January 24, 2014, February 14, 2014, August 7, 2014, October 10, 2014, and November 24, 2014. On each of these visits he failed to appropriately document the patient's medical status and/or treatment in the patient record. Examples of Respondent's inadequate documentation include, but are not limited to the following:

A. On January 25, 2008, the chief complaint is illegible. There is no mention of the patient's diabetes or neuropathy.

B. On February 27, 2008, no foot exam was documented. The neurological exam states, "No changes." No glucose levels are recorded and the majority of the plan is illegible.

C. On June 9, 2008, an incomplete examination is documented based on the reported chief complaints. Labs are ordered and the plan states, "recheck PRN." No specific follow-up visit or telephone assessment is scheduled.

D. On December 5, 2008, Patient A's blood pressure is 186/71. There is no documented plan for the treatment of elevated blood pressure, and no documented mental status/cognitive testing. Aricept was started. The plan states, "recheck PRN."

E. On January 16, 2009, the patient presented with a chief complaint of discomfort and liquid vomit. No reported home blood sugars are recorded. The chart states, "Plan: report further episodes to me. Consider stop the diabetic medication Metformin. Recheck PRN." Trental was started for treatment of peripheral vascular disease. There were no documented symptoms of peripheral vascular disease, nor physical exam findings related to same.

F. The July 27, 2009, progress note was mostly illegible. Several sections were blank.

There was no recorded exam of peripheral pulses, extremity temperature, or symptoms of peripheral vascular disease, or response to Trental. There was no medication list.

G. On January 24, 2014, the patient was seen with a complaint of low back pain after a fall. The intensity of pain was not recorded. Dementia is recorded. A topical analgesic Lidoderm is prescribed with no documented plan and fentanyl 25-ucg q 3 days was prescribed with no number of patches specified.

H. November 24, 2014, the chief complaint was "headache after injury," and "dizziness." Fentanyl 50 mcg is listed under current medications.

Patient D[2]

41. Patient D presented to Respondent on at least 15 occasions between 2008 and 2014, including the following dates: September 16, 2008, March 2, 2009, August 13, 2009, November 5, 2009, March 11, 2010, March 16, 2010, June 13, 2011, August 13, 2012, October 2, 2012, January 14, 2013, November 5, 2013, January 2, 2014, February 4, 2014, April 4, 2014, and June 6, 2014. On each of these visits he failed to appropriately document the patient's medical status and/or treatment in the patient record and failed to keep an accurate and complete medication list. The failures include, but are not limited to the following:

A. On September 16, 2008, the patient's chief complaint was low back pain and shoulder pain. No intensity or exam was recorded. There was no medication list. The plan included Vicodin #90. The strength was not specified.

B. On March 2, 2009, the patient complained of a pulled muscle in his back. There was no description of any pain. The plan included Vicodin #60 and "Recheck PRN."

C. On November 5, 2009, the patient complained of stomach pain for ten days and back pain for one year. No physical exam was recorded. The assessment/plan was illegible.

D. On March 11, 2010, the patient presented with chest pain with intermittent radiation

[2] In the Accusation in this matter which was filed on September 15, 2017, Patient D was referenced by the initials G.R.

to the neck. The assessment was, "atypical chest pain." The plan note included Vicodin ES #40 with no documented reason for use of an opioid containing medication.

E. On March 16, 2010, the patient was seen by Respondent post ER evaluation. No note was made regarding chest pain or patient's response to Vicodin.

F. On August 13, 2012 the notes are only partially legible and are incomplete.

G. On November 5, 2013 and January 1, 2014, the patient presented for a Vicodin refill for ongoing back pain. There was no medication list, nor documentation of non-opioid treatment.

H. On February 4, 2014, the medication list does not include Lantus which the patient had been taking, but only another insulin preparation, Humalog 72/25 Mix, no dose specified.

I. On April 4, 2014, Lantus was increased to 26 units. There was no mention of the Humalog Mix.

J. On June 6, 2014, the documented current medications include two different strength tablets of Vicodin and Norco, and Lantus as well as the Humalog Mix, with no dose specified for either preparation.

K. On September 10, 2014, November 3, 2014, August 24, 2015, September 16, 2015, it is impossible to determine from the record what medications and dosages the patient was taking.

42. Respondent departed from the standard of care in that he failed to maintain adequate records related to the care and treatment to patients A and D, in that the patient records on each patient visit between 2008 and 2015, including but not limited to those identified above, are either illegible and/or incomplete and do not enable a subsequent provider the ability to determine the patient's medical status or treatment provided.

Patient B

43. Respondent failed to maintain adequate records for Patient B. The patient presented to Respondent on at least fifteen occasions between 2014 and 2015. The medical records during

that time failed to reflect any improvement or lack of improvement in pain management and functionality. The records did not include a pain care agreement or informed consent forms.

Patient C

44. Respondent failed to maintain adequate records related to the care and treatment of Patient C, in that the patient medical records lack details supporting the diagnosis of anxiety disorder and thus fail to justify the need for alprazolam therapy. They also do not contain a buprenorphine treatment consent agreement.

DISCIPLINARY CONSIDERATIONS

45. To determine the degree of discipline, if any, to be imposed on Respondent Gregory John Van Dyke, M.D., Complainant alleges that on or about March 23, 2012, in a prior disciplinary action entitled *In the Matter of the Accusation Against Gregory John Van Dyke, M.D.* before the Medical Board of California, in Case Number 04-2009-201759, Respondent's license was placed on probation for 35 months with various terms and conditions, including the completion of PACE and a records keeping course for failing to timely recognize and diagnose type II adult onset diabetes and provide appropriate care for same. That decision is now final and is incorporated by reference as if fully set forth herein.

46. On June 19, 2009, in a disciplinary action entitled, "*In the Matter of Accusation Against Gregory John Van Dyke, M.D.*," Case No. 09-2007-185231, the Medical Board of California, issued an order in which Respondent's, Physician's and Surgeon's Certificate No. A51101, was Publicly Reprimanded, and ordered to successfully complete a medical record keeping course and a prescribing practices course. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 51101, issued to Gregory John Van Dyke, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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

DATED: January 5, 2018

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

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