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

In the Matter of the Accusation Against:	)	
Maria Isabel Aruiza Bacay, M.D.	)	**Case No. 800-2014-005051**
Physician's and Surgeon's Certificate No. A 51759	)	
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 October 5, 2018.

IT IS SO ORDERED: September 7, 2018.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, Chair
Panel A

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
JOHN S. GATSCHET
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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: MARIA ISABEL ARUIZA BACAY, M.D. 1140 Norman Dr., Ste 103 Manteca, CA 95336 Physician's and Surgeon's Certificate No. A 51759 Respondent.	Case No. 800-2014-005051 OAH No. 2017080214 **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 John S. Gatschet, Deputy Attorney General.

2. Respondent Maria Isabel Aruiza Bacay, M.D. ("Respondent") is represented in this proceeding by attorney Peter J. Kelly, whose address is:

Peter J. Kelly
Riggio, Mordaunt & Kelly
2509 West March Lane, Ste. 200
Stockton, CA 95207

3. On or about April 5, 1993, the Board issued Physician's and Surgeon's Certificate No. A 51759 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. 800-2014-005051, and will expire on November 30, 2018, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-005051 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 April 28, 2017. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-005051 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-005051. 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.

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CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2014-005051.

10. Respondent agrees that her Physician's and Surgeon's Certificate No. A 51759 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

11. 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.

12. 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.

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 Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 51759 issued to Respondent Maria Isabel Aruiza Bacay, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) 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 Schedule(s) III, 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.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a

true copy of the permit to the Board or its designee.

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 of the following: 1) the name and address of the 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. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course

not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the 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.

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the 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.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 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. MONITORING - PRACTICE. 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, 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 standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. 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 approved in advance by the Board or its designee 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.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the 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.

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.

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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's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 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 his or 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, Peter J. Kelly. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 51759. 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: 1-4-18

MARIA ISABEL ARUIZA BACAY, M.D.
Respondent

I have read and fully discussed with Respondent Maria Isabel Aruiza Bacay, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve of its form and content.

DATED: 1/5/18

PETER J. KELLY
Attorney for Respondent

ENDORSEMENT

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

Dated: 1/8/18

Respectfully submitted,

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

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-005051

XAVIER BECERRA
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 28 20 17
BY D. Richards ANALYST

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

In the Matter of the Accusation Against: **Maria Isabel Aruiza Bacay, M.D.** **1140 Norman Dr., STE 103** **Manteca, CA 95336** **Physician's and Surgeon's Certificate No. A 51759,** Respondent.	Case No. 800-2014-005051 **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 ("Board").

2. On or about April 5, 1993, the Medical Board issued Physician's and Surgeon's Certificate No. A 51759 to Maria Isabel Aruiza Bacay, M.D. ("Respondent"). The Physician's and Surgeon's Certificate No. was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2018, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

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.

"...

"(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.

"..."

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."

PERTINENT DRUG INFORMATION

7. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent that morphine and hundreds of more times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

8. Oxycodone – Generic name for Oxycontin, Roxicodone, and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short acting opioid analgesic used to treat moderate to severe pain. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

9. Alprazolam – Generic name for the drugs Xanax and Niravam. Alprazolam is a short acting benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

10. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section

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[1] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

11. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Butorphanol Tartrate – Generic name for Stadol. Butorphanol tartrate is a morphinan-type synthetic agonist opioid analgesic used to manage moderate to severe pain. Butorphanol tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(g). It is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Butalbital with caffeine and with aspirin – Generic name for Fiorinal. Butalbital is a barbiturate with an immediate duration of action. Often combined with other medications, it is commonly used for the treatment of pain and headache. Fiorinal is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13. Fiorinal is a dangerous drug pursuant to Business and Professions Code section 4022.

14. Promethazine with codeine syrup – Generic for the drug Phenergan with Codeine and others. Promethazine with codeine syrup is an antihistamine and antitussive agent used to temporarily relieve cough and upper respiratory symptoms associated with allergy or the common cold. Promethazine with codeine syrup is a Schedule V controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.15(c). Promethazine with codeine syrup is a Dangerous Drug as defined by California Business and Professions Code section 4022 and a Schedule V controlled substance pursuant to California Health and Safety Code section 11058(c).

15. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a

transdermal patch, Butrans is used for chronic pain. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

16. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

17. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride ("hcl") is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

18. Morphine – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Dextropropoxyphene HCL – Generic name for the drug Darvocet. Dextropropoxyphene HCL is a narcotic drug. It is used medically to treat mild to moderate pain. Dextropropoxyphene HCL is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14, subdivision (b). On November 19, 2010, the United States Food and Drug Administration banned the sale of Dextropropoxyphene HCL in the United States due to scientific evidence that it could cause fatal cardiac abnormalities.

20. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

21. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. On January 11, 2012, Carisoprodol was classified a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

23. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to

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[2] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately sever pain. Effective August 18, 2014, Tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

26. Oxymorphone – Generic name for the drugs Opana and Numorphan. Oxymorphone is a powerful semi-synthetic opioid analgesic used to treat moderate to severe pain. Opana ER is used as a long-acting, around the clock treatment that should not be used on an as-needed basis for pain. Oxyomorphone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligence acts during the treatment of Patients J.D., K.M., T.B., S.B., J.B., and A.R. The circumstances are as follows:

Patient J.D.

28. Respondent began providing care to Patient J.D. in 1996[3]. During that period of time, Respondent treated Patient J.D. for a number of ailments, including chronic pain. On January 22, 2011, Respondent saw Patient J.D. in the clinic. Respondent noted that Patient J.D. was receiving a 2 mg. tablet of Dilaudid every 6 hours, 2 tablets of 1 mg. clonazepam daily, 1

[3] Conduct occurring prior to May 1, 2010, is for informational purposes only, and is not alleged as a basis for disciplinary action in this matter. Deviations from the standard of care that occurred before May 1, 2010, that led to on-going violations occurring after May 1, 2010, are alleged as a basis for disciplinary action in this matter.

tablet of .5 mg. Xanax three times daily, and Darvocet as needed. Respondent documented that the patient was in no apparent distress, and documented that the patient's musculoskeletal examination was unremarkable. Respondent continued all medications and renewed a prescription for one tablet of 5 mg. oxycodone every six hours. Respondent advised Patient J.D. not to drive. Respondent failed to document: a pain assessment; a functional patient status; an explanation of why oxycodone was being added to Patient J.D.'s medications; an explanation why Patient J.D. required two benzodiazepines; and past treatments for prior pain syndrome. Finally, Respondent failed to document a comprehensive treatment plan, including pain and function goals. Respondent electronically signed the note.

29. On February 24, 2011, Respondent saw Patient J.D. in the clinic for a complaint of a rash. Respondent noted, "diffuse mylagias persists but better," under review of musculoskeletal systems. Pain medication was not adjusted. There is no documentation of a pain assessment, functional status, and/or treatment plan. On March 24, 2011, Respondent saw Patient J.D. in the clinic for a six month history of painful joint symptoms. The pain was described as severe, that it ached, and that prolonged sitting aggravates the pain. The Respondent noted that nothing alleviated the pain, despite the patient being prescribed controlled substances. The Respondent also noted that the patient was not taking NSAIDS.[4] There was no description of the pain level and if the current controlled substances were beneficial in treating the pain. Respondent's medication list included Xanax and Stadol in the patient's medical records kept by Respondent. There is no mention of oxycodone despite pharmacy records showing Respondent prescribing 120 pills of 5 mg. oxycodone on January 27, 2011, and 200 pills of 5 mg. oxycodone on both February 25, 2011, and March 25, 2011. Respondent wrote that Patient J.D. had chronic pain syndrome that was controlled and arthritis not otherwise specified that was getting worse but failed to document a comprehensive treatment plan.

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[4] Non-Steroidal Anti-Inflammatory Drugs such as Aleve or Ibuprofen.

30. On April 21, 2011, Respondent documented that Patient J.D. was presenting with pain in her joints. Once again the pain was described as inflammatory arthritis not otherwise specified. Oxycodone is not included on Respondent's current list of medications for Patient J.D. There is no documentation related to the level of pain, whether the controlled substances were helping with the pain, or whether the pain was currently controlled. Respondent noted in her plan that she would check labs for drug surveillance. On May 2, 2011, Respondent prescribed 200 pills of 5 mg. oxycodone to Patient J.D. On May 16, 2011, Respondent saw Patient J.D. in the clinic for a preoperative physical. Patient J.D. was to have left knee arthroscopic surgery. Under musculoskeletal subjective findings, Respondent documented right wrist, left hip. There is no description of whether Patient J.D. was currently having pain. Under musculoskeletal objective findings, Respondent described normal symmetry and range of motion. Once again, Respondent failed to include oxycodone in Patient J.D.'s current medications. Respondent stated there was no tenderness to palpation. Respondent stated that Patient J.D.'s rheumatoid arthritis was controlled on DMARD[5] infusions. Respondent failed to document why this patient remained on narcotic pain medications. Respondent also failed to document whether the controlled substances, in particular opioid prescriptions would impact the upcoming surgery. Despite writing in her plan on April 21, 2011, that she would check labs for drug surveillance, there is no mention in Respondent's May 16, 2011, note that she had verified that Patient J.D. was compliant with her medications.

31. On May 26, 2011, Patient J.D. received 40 10-325 mg. tablets of hydrocodone with acetaminophen from the physician who performed her knee surgery. On May 31, 2011, Respondent prescribed 30 pills of 5 mg. diazepam, and 90 pills of .5 mg. alprazolam to Patient J.D. On June 2, 2011, Patient J.D. received an additional 40 10-325 mg. tablets of hydrocodone with acetaminophen from the physician who performed her knee surgery. On June 4, 2011, Patient J.D. received 200 5 mg. tablets of oxycodone from Respondent. On June 13, 2011, Respondent saw Patient J.D. in the office. Both oxycodone and hydrocodone remain absent from

[5] DMARD stands for Disease-modifying anti-rheumatic drug.

Patient J.D.'s list of current medications. Respondent stated that Patient J.D. continues to have, "arthralgias involving her hips, knees, and hands persists" under subjective review of musculoskeletal symptoms but fails to document whether or not the controlled substances are helping with Patient J.D.'s pain. Under objective review of musculoskeletal symptoms, Respondent noted normal range of motion and no tenderness to palpation. Respondent documented that the patient now has uncontrolled rheumatoid arthritis. Respondent failed to document: a pain assessment; a treatment plan involving controlled substances; and whether or not non-opiate therapy was beneficial to Patient J.D. Respondent failed to document the appropriateness of continued opioid use, nor list that this patient remained on powerful opioid medications.

32. Respondent saw Patient J.D. in the clinic on July 18, 2011, and, August 15, 2011. Respondent failed to document that the patient was on oxycodone despite continuing to prescribe oxycodone on July 19, 2011, and August 17, 2011, following each appointment. Respondent documented that Patient J.D. was seen for a complaint of arthralgias on August 15, 2011. Respondent documented that nothing alleviated Patient J.D.'s joint pain but Respondent continued to document that the patient had never tried NSAIDs and Respondent failed to document whether continued opiate prescriptions were necessary. In the assessment, Respondent documented that Patient J.D.'s inflammatory arthritis was stable and that Patient J.D.'s chronic pain syndrome was controlled. However, there was no pain assessment, functional examination, or comprehensive treatment plan documented in Patient J.D.'s medical chart that indicates that the controlled substances Respondent was prescribing, in particular oxycodone, were necessary.

33. On September 12, 2011, Respondent documented seeing Patient J.D. in the clinic for arthralgias. Respondent documented that the patient had constipation which may be due to pain regimen. Respondent documented that the patient was taking oxycodone. Respondent documented that the patient continues to have joint pain, that she hasn't taken NSAIDs, and that multiple joints were affected. Respondent failed to document: Patient J.D.'s pain level; a treatment plan; and a functional pain assessment. Respondent documented a normal range of motion in the musculoskeletal evaluation, and no tenderness to palpation. Between January and

September 2011, there is no evidence that Respondent performed a periodic review of Patient J.D.'s controlled substance prescriptions.

34. Respondent saw Patient J.D. in the clinic on October 10, 2011, November 7, 2011, December 5, 2011, January 5, 2012, February 6, 2012, March 14, 2012, April 3, 2012, April 16, 2012, and April 30, 2012. During that time Respondent prescribed oxycodone, Butrans, butorphanol tartrate, alprazolam, and promethazine with codeine. Respondent saw the patient for arthritis, headaches, and diabetes management. Respondent failed to document a comprehensive treatment plan, including pain and function goals. As noted above on prior dates, Respondent repeatedly documented normal range of motion and no tenderness during examination, but diagnosed the patient as having joint pain caused by arthritis at each examination. Respondent failed to document pain assessments, or assess whether continued controlled substances were necessary. Despite changing Patient J.D.'s prescription of 200 pills of 5 mg. oxycodone to a prescription for a Butrans patch on December 19, 2011, there is no documentation in the notes from December 5, 2011, regarding this change in medication.

35. On May 1, 2012, Respondent prescribed 120 pills of 10 mg. oxycodone to Patient J.D. Patient J.D. continued to receive butorphanol tartrate. On May 29, 2012, Respondent saw Patient J.D. in the clinic. Respondent documented that Patient J.D. was present for a medication refill. Respondent noted that Patient J.D. was compliant with medications. Respondent noted that Patient J.D. has "diffuse and widespread achiness" but under musculoskeletal symptoms that Patient J.D. had normal range of motion and no tenderness to palpation. Respondent did not document why she was now placing Patient J.D. on a 120 pills of 10 mg. oxycodone prescription in the medical record. Respondent didn't document a pain assessment or a comprehensive treatment plan.

36. On June 26, 2012, Respondent saw Patient J.D. in the office for a complaint of a cough. Respondent noted that the patient reported, "getting flares in her wrists and hips and knees and costochondral joints." In the musculoskeletal examination, Respondent noted normal range of motion and no tenderness to palpation. Respondent documented that Patient J.D. was currently taking tramadol, alprazolam, diazepam, and oxycodone as controlled substances. Despite

increasing Patient J.D.'s oxycodone prescription, Respondent did not document obtaining informed consent. Respondent didn't document a complete pain assessment, functional status, and didn't develop a comprehensive treatment plan. There is no indication that Respondent reviewed whether opioids were appropriate for continued use.

37. Respondent saw Patient J.D. on July 26, 2012, and on August 27, 2012, in the clinic. Controlled substances remained consistent with 120 pills of 10 mg. oxycodone, 90 pills of .5 mg. alprazolam, 6 containers of 10 mg./ml. sprays of butorphanol tartrate being prescribed. Both times, Respondent documented normal range of motion and no tenderness to palpation in Patient J.D.'s musculoskeletal examination. On September 24, 2012, Respondent saw Patient J.D. for back pain. Respondent documented that the pain was 10 out of 10, constant, and radiating. Respondent noted that Patient J.D. should be referred back to her orthopedist and should see a pain specialist. Respondent then noted that the 10 mg. oxycodone prescription was being continued. On September 21, 2012, and October 22, 2012, Patient J.D. filled prescriptions for 90 pills of .5 mg. alprazolam prescribed by Respondent. Respondent saw Patient J.D. in the clinic on October 18, 2012, and October 22, 2012.

38. Patient J.D. began seeing additional practitioners for pain treatment between October 18, 2012, and December 31, 2012. For example, Dr. Z prescribed two prescriptions for 30 pills of 15 mg. morphine sulfate, and Dr. D prescribed oxycodone with acetaminophen, hydromorphone, and diazepam to Patient J.D. Respondent was not prescribing at that time. On or about October 10, 2012, Patient J.D.'s therapist, Ms. A.O. sent a letter to both Respondent and Patient J.D.'s orthopedist. The letter stated that Patient J.D. wished to stop taking alprazolam for anxiety as she had been using it for 25 years to cope with her son's motorcycle accident and that she on occasion had misused medications. The letter mentioned that Patient J.D. had presented to family in the past with slurred voice, glassy eyes, and personality changes. The letter also mentioned that Patient J.D.'s GI doctor had become concerned with her prior prescribed pain medications due to a high tolerance to anesthesia. The letter requested that only one physician prescribe medications to Patient J.D. The letter was sent to Respondent's medical office. On November 15, 2016,

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during the subject interview, Respondent admitting receiving a copy of the letter from the therapist.

39. Respondent next saw Patient J.D. on January 17, 2013, for a medication refill. Respondent again took over responsibility for Patient J.D.'s controlled substances. Respondent noted that the Patient's current pain level is 10 out of 10, yet documented that she was benefiting from narcotic medications. Respondent noted that there was no pain contract in place, and noted that Patient J.D. had severe fatigue from her pain medications. Respondent noted normal range of motion and no tenderness to palpation. On January 17, 2013, Respondent prescribed 60 tablets of 20 mg. Oxycontin, and 120 tablets of 15 mg. oxycodone, to Patient J.D. On January 29, 2013, Respondent restarted Patient J.D.'s 90 pill .5 mg. alprazolam prescription. While Respondent's medical charting was now more complete in regards to pain management, Respondent failed to document Patient J.D.'s pain therapy history between October 18, 2012, and December 31, 2012. Respondent failed to document a treatment plan, document reasons for restarting alprazolam, and document why she was prescribing opiate medications. Respondent documented that Patient J.D. had excellent compliance with pain medication but doesn't mention the letter from Patient J.D.'s therapist in her charting.

40. Respondent saw Patient J.D. in the clinic on February 28, 2013, March 28, 2013, April 25, 2013, May 23, 2013, and, June 20, 2013. Respondent saw Patient J.D. for Vitamin B-12 injections, arthritis, and urinary symptoms. During that time, Respondent prescribed a total of 60 tablets of 20 mg. Oxycontin, 180 tablets of .5 mg. alprazolam, 360 tablets of 15 mg. oxycodone. Patient J.D. was also receiving butorphanol tartrate. On both March 28, 2013, and April 25, 2013, Respondent documented that Patient J.D.'s pain remains 10 out of 10, and that she aches constantly. Respondent noted that Patient J.D. had still not taken NSAIDs. Respondent did not document whether she thought controlled substances were helping this patient. Respondent did not document a treatment plan, or document if she was considering tapering Patient J.D. off of controlled substances.

41. On July 1, 2013, Patient J.D. was discovered by her daughter. Patient J.D. was non-responsive. Patient J.D.'s daughter called 911 but unfortunately Patient J.D. could not be revived.

Patient J.D.'s cause of death was listed as acute poly-pharmacy and acute cocaine intoxication. On November 15, 2016, Respondent admitted that she failed to document a pain management plan and that she failed to obtain informed consent from Patient J.D. before prescribing controlled substances.

42. Respondent's license is subject to disciplinary action because she committed the following repeated negligent acts during the care of Patient J.D.:

a.) As more fully described above, by failing to complete a pain assessment; by failing to develop a comprehensive treatment plan; by failing to obtain informed consent before prescribing controlled substances; and/or by failing to perform a periodic review of long term opioid therapy represents a departure from the standard of care; and/or,

b.) By failing to document accurate examination findings in the areas of reported pain; failing to document Patient J.D.'s functional status; failing to document past diagnostic evaluations; and/or by failing to document Patient J.D.'s prior treatment for each pain syndrome represents a departure from the standard of care.

Patient T.B.

43. Respondent began providing care to Patient T.B. on January 3, 2013. Patient T.B., a 57 year old male, presented with chronic pain. Respondent documented that his pain level was currently 7 out of 10, that Patient T.B. wished to be weaned from narcotics, and that he was currently on stool softeners for constipation. Respondent documented a history of smoking, multiple sclerosis, severe COPD[6], and chronic airway obstruction. Respondent documented that Patient T.B. was currently being prescribed Ambien, methadone, Norco, Soma, and diazepam. Under objective review, Respondent documented a chronically ill, emaciated patient who ambulated with a cane. However, under musculoskeletal examination, Respondent documented normal symmetry, tone, strength, and range of motion. Respondent also documented no effusions, instability, or tenderness to palpation. Respondent documented that they reviewed and entered a narcotic contract, but the only pain contract provided with medical records to the Board

[6] COPD stands for chronic obstructive pulmonary disease

was completed August 20, 2015. Respondent documented that Patient T.B. had no side effects from his medication. On January 3, 2013, Respondent prescribed 120 10 mg. pills of methadone, 120 350 mg. pills of carisoprodol, 180 pills of 10-325 mg. hydrocodone with acetaminophen, 50 5 mg. pills of diazepam, and 30 10 mg. pills of zolpidem tartrate. These prescriptions were to last one month. The morphine equivalent dose ("MED")[7] of these medications was 380 morphine equivalents combined with the potentially respiratory depressing effects of diazepam, zolpidem tartrate, and carisoprodol. A chest x-ray conducted on January 29, 2013, revealed clear lungs, and a normal cardiac silhouette. No definite acute findings were seen in the bones and soft tissues. Degenerative changes were noted within the thoracic spine. Respondent had a CT scan completed in August 2013 but there was no other imaging to support controlled substance treatment in the medical records.

44. Respondent did not fully document functional status of Patient T.B., document accurate exam findings in the area of reported pain, and prior pain treatments. Respondent did not develop a comprehensive treatment plan, including pain and function goals. While Respondent documented a pain contract was reviewed, no evidence of an informed consent in the form of a January 3, 2013, pain contract is contained in the medical records. Respondent did not document any concerns regarding the high level of Patient T.B.'s pain medications, the potential synergistic effects of the medications to cause respiratory depression, and/or whether his current controlled substance prescriptions posed special dangers in a patient with COPD and chronic airway obstruction.

45. Respondent provided on-going treatment to Patient T.B. between January 3, 2013, and December 3, 2015. Respondent documented repeated clinical visits with Patient T.B. during that time. During that time, Patient T.B. failed to show up for follow-up appointments on May 23, 2013, on August 3, 2015, August 10, 2015, and October 28, 2015. The medical records document Patient T.B. requesting repeated early refills of his medications. For example, Patient T.B. requested early refills of his medication on June 16, 2015, and on September 14, 2015. By

[7] An MED is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency.

phone, on September 8, 2015, Patient T.B. requested permission to take 4 carisoprodol per day because 3 a day was not working. Respondent didn't document or address this phone request during Patient T.B.'s clinic visits on September 8, 2015, and October 10, 2015.

46. Patient T.B.'s medical records provide documentation that Respondent counseled the patient to be compliant with medications and to reduce usage. For example, on October 14, 2014, Respondent advised the patient it was not warranted and unsafe to be taking more narcotic medications. Respondent documented a history of falls. Respondent documented that it would not be in Patient T.B.'s best interest to increase benzodiazepine dosages. Respondent documented that Patient T.B. refused to go to a pain specialist. On December 30, 2014, Respondent documented that she discouraged Patient T.B. from taking lorazepam and diazepam after he requested taking diazepam in addition to lorazepam. However, Respondent continued prescribing to Patient T.B. despite multiple warning signs. Between October 21, 2014, and October 28, 2014, Patient T.B. filled prescriptions from Respondent for 45 tablets of .5 mg. lorazepam, 120 tablets of 350 mg. carisoprodol, 30 tablets of 10 mg. zolpidem tartrate, and 180 tablets of 10-325 mg. hydrocodone with acetaminophen. Respondent also prescribed lorazepam, zolpidem tartrate, carisoprodol, and hydrocodone with acetaminophen after the visit on December 30, 2014. On June 9, 2015, Respondent documented that Patient T.B. would be dismissed from the practice if he didn't comply with the pain contract going forward after Respondent provided an early refill of hydrocodone with acetaminophen. Despite missing multiple appointments in August 2015, and October 2015, and requesting early refills of medications in September 2015, Respondent continued to refill and prescribe controlled substances to Patient T.B. and did not dismiss him from her practice.

47. Despite Respondent repeatedly documenting that Patient T.B. appeared chronically ill, emaciated, and ambulating with a cane, Respondent repeatedly documented normal physical evaluations. For example on December 3, 2015, Respondent documented that Patient T.B. had a pain level of 10 out of 10, and was presenting with chronic back, neck, and knee pain. However, Respondent documented no deformities, clubbing, cyanosis, or edema in her evaluation of Patient T.B.'s extremities. Respondent documented normal symmetry, tone, strength and range of

motion, and no effusions, instability, or tenderness to palpation in her evaluation of T.B.'s musculoskeletal examination.

48. On July 24, 2014, Patient T.B. was admitted to the hospital for hypercarbia hypoxia and altered mental status. At the time, Respondent was prescribing diazepam, carisoprodol, hydrocodone with acetaminophen, and zolpidem tartrate. Patient T.B. was discharged from the hospital on July 27, 2014. He was advised to continue medication but discuss his medications with Respondent. On July 31, 2014, Respondent saw Patient T.B. in the clinic. Respondent changed Patient T.B.'s prescription for diazepam to lorazepam. All other prescriptions remained the same and there is no further discussion documented regarding respiratory depression could be caused by these medications.

49. On October 6, 2014, Patient T.B. was admitted to the hospital for COPD exacerbation. At the time, Respondent was prescribing 1 to 2 .5 mg. pills of lorazepam a day, 4 pills of 350 mg. carisoprodol a day, 6 pills of 10-325 mg. hydrocodone with acetaminophen, and 1 pill of 10 mg. zolpidem tartrate. On October 7, 2014, Patient T.B. was discharged. In the discharge summary was a notation that Patient T.B. was post fall, near syncope, and COPD exacerbation. Patient T.B. was advised to discuss his medications and side effects of medications with his primary care physician. On October 10, 2014, Patient T.B. saw Dr. B.B., Respondent's partner, in the clinic. There is no documentation that Dr. B.B. counseled him regarding his medications, side effects, or a discussion of his admission to the hospital on October 6, 2014. Dr. B.B. added 60 tablets of 15 mg. morphine sulfate. Respondent saw Patient T.B. on October 14, 2014. She documented advising him regarding a history of falls and of the dangers of medications. However, Respondent continued Patient T.B.'s prescriptions, prescribing lorazepam, zolpidem tartrate, hydrocodone with acetaminophen, and carisoprodol in previous doses. In addition to the hospitalizations listed above, Patient T.B. fell in January 2015, and was hospitalized for respiratory failure in August of 2015. On July 28, 2015, Patient T.B. presented with neurological problems. Respondent continued prescribing multiple controlled substances to Patient T.B. after each of these events.

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50. On March 28, 2015, Patient T.B. was discharged from San Joaquin General Hospital following an episode of acute encephalopathy, syncope, CO2 narcosis, opiate overdose and COPD. Patient T.B. was instructed to stop Norco, Soma, Ativan and Ambien by hospital staff. Patient T.B. was provided with a discharge explanation on the causes of overdose. On April 1, 2015, Respondent saw Patient T.B. in the clinic. Respondent documented telling Patient T.B. that he needed to slowly get off Norco and all narcotic analgesia due to his severe COPD and the resulting episodes of encephalopathy. Respondent didn't document a treatment plan on how she was going to lower and/or cease Patient T.B.'s Norco consumption. Respondent didn't note opiate overdose as part of the hospitalization. On April 22, 2015, Patient T.B. filled a prescription of 180 pills of 10-325 mg. hydrocodone with acetaminophen. Respondent lowered Patient T.B.'s monthly prescription from 180 tablets of 10-325 mg. hydrocodone with acetaminophen on May 21, 2015, to 120 tablets of 10-325 mg. hydrocodone with acetaminophen on June 19, 2015. On August 20, 2015, Respondent again advised Patient T.B. to use non narcotic pain relief and taper controlled substances, however she continued the monthly 120 tablet prescription of 10-325 mg. hydrocodone with acetaminophen through December 2015. There is no evidence that Respondent performed a periodic review of Patient T.B.'s pain management treatments despite providing care for almost three years.

51. On November 15, 2016, during Respondent's subject interview with the Board, Respondent acknowledged that it was possible her prescriptions were contributing to Patient T.B.'s history of falling and respiratory distress. Respondent stated that despite Patient T.B. not being compliant with medications that she didn't terminate him from her practice for almost three years because of fear of Patient T.B. experiencing withdrawal. Respondent admitted that Patient T.B. refused to go to a pain specialist and she didn't terminate him from the practice. There is no record of a urine screen being performed on Patient T.B. There is no record that Respondent attempted to learn or discover that Patient T.B. was receiving controlled substances from other providers. Respondent admitted that she didn't document her discussions with Patient T.B. regarding medications being a cause for his falls. Respondent admitted that mixing Valium, Soma, Norco, and Ambien is a concern due to a fear of respiratory depression, nevertheless she

continued to prescribe combinations of prescriptions. In regards to the pain contract signed August 20, 2015, Respondent admitted that Patient T.B. violated the terms of the contract on a repeated basis but she continued to prescribe controlled substances to Patient T.B. Respondent admitted there was no informed consent obtained before August 2015 with Patient T.B. Respondent admitted that the pain contract signed on August 20, 2015, was incomplete as it didn't include the name of the pharmacy where prescriptions would be obtained, and that the contract was not modified as pain medication quantities and dosages were changed.

52. Respondent's license is subject to disciplinary action because she committed the following repeated negligent acts during the care of Patient T.B.:

a.) As more fully described above, by failing to develop a comprehensive treatment plan; by failing to obtain informed consent before prescribing controlled substances; by continually prescribing controlled substances, in particular opioids to a patient with compromised lung function; and/or by failing to perform a periodic review of long term opioid therapy while prescribing opioids for chronic pain represents a departure from the standard of care; and/or,

b.) By failing to document accurate examination findings in the areas of reported pain, failing to document Patient T.B.'s functional status; by failing to document past diagnostic evaluations; by failing to document a harm assessment of Patient T.B.'s controlled substances; and/or by failing to document Patient T.B.'s prior treatment for each pain syndrome represents a departure from the standard of care.

Patient J.B.

53. Dr. B.B., Respondent's partner, first saw Patient J.B. on February 18, 2014, in order to establish care at Respondent's medical clinic. Patient J.B., a 54 year old woman, was the wife of Patient T.B. whose medical treatment is more fully set forth above. Dr. B.B. documented a full history and physical, and noted that Patient J.B. was currently being prescribed Ambien, Norco, Ultram, Ativan, and Soma. Dr. B.B. noted that she suffered from knee pain which was listed as nine out of ten in terms of severity. Dr. B.B. observed moderate knee effusion and swelling. Dr. B.B. documented tenderness to palpation at the patella, and the patellar facets. In the plan, Dr. B.B. documented that Patient J.B. admitted the possibility of being dependent on Norco, Soma,

and Ativan. Dr. B.B. refilled her medications but documented that he wished to slowly reduce her intake of Norco, Soma, and Ativan. Dr. B.B. recommended that she be started on a Butrans patch prescription, a long acting topical opioid, and that a pain specialist should be consulted if they were unsuccessful in lowering the dosage of medications. Dr. B.B. prescribed 120 tablets of 10-325 mg. hydrocodone with acetaminophen, 60 tablets of 1 mg. lorazepam, and 120 tablets of 350 mg. carisoprodol.

54. Respondent first saw Patient J.B. on April 10, 2014. Patient J.B. requested a note off from work. Respondent documented that Patient J.B. was taking Norco for osteoarthritis, Ativan for anxiety, and Soma for jaw pain. Respondent noted that Patient J.B. was taking Ambien. Respondent documented that Patient J.B.'s back examination was normal and documented that Patient J.B.'s musculoskeletal system was normal with no tenderness to palpation. Respondent documented that Patient J.B.'s Ativan dosage would be cut in half, with a "hope that someday, she will not take anymore narcotic analgesia." Following this visit, Respondent prescribed 60 pills of .5 mg. lorazepam on May 15, 2014. On December 3, 2014, Respondent prescribed 30 pills of 1 mg. lorazepam. However, on January 2, 2015, Respondent returned Patient J.B.'s lorazepam prescription to 60 pills a month and continued the prescription in a 1 mg. dosage.

55. Between April 10, 2014, and December 1, 2015, Respondent saw Patient J.B. in the clinic on 8 separate visits. Nurse practitioners employed by Respondent saw Patient J.B. on two other occasions. During that time, Respondent repeatedly documented that Patient J.B. had normal back and extremity examinations with normal range of motion. Respondent failed to document a comprehensive treatment plan with the intent to end Patient J.B.'s use of controlled substances. In fact, between May 1, 2015, and October 30, 2015, Respondent provided monthly prescriptions of 120 pills of 10-325 mg. hydrocodone with acetaminophen, 60 pills of 1 mg. lorazepam, 30 pills of 10 mg. zolpidem tartrate, and 120 pills of 350 mg. carisoprodol. There is no evidence that Respondent tapered Patient J.B. off any of these controlled substances during that time. On October 22, 2015, October 26, 2015, and November 30, 2015, Patient J.B. missed appointments with Respondent. Respondent failed to document the reason for the missed

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appointments in the clinical visits and continued to prescribe medications despite missed appointments.

56. Respondent failed to properly perform periodic review of Patient J.B.'s pain treatment. There is no record that she reevaluated pain and function goals and the appropriateness of continued opiate and sedative controlled substances despite a concern for drug dependency set forth when Dr. B.B. established care for this patient. There is no evidence that Respondent provided informed consent, including an explanation of the dangers of the combined medications that she was prescribing, to Patient J.B. during the two year period that she provided care to Patient J.B. The records lack evidence that Respondent attempted to initiate tapering plans, maximize nonpharmacologic modalities and facilitate coordination of specialty care including physical therapy, rehabilitation and/or substance use disorder programs.

57. On November 15, 2016, during Respondent's subject interview with the Board, she admitted that she was aware of Dr. B.B.'s plan to reduce Patient J.B.'s use of controlled substances and plan to prescribe Butrans. Respondent admitted that she believed Patient J.B. when Patient J.B. verbally stated that she had cervical spine degenerative disease but Respondent had no other evidence to support this condition contained in Patient J.B.'s medical records. Respondent admitted that she did not have an informed consent discussion with Patient J.B. regarding the risks and benefits of the controlled drugs she was prescribing before August 20, 2015. The only pain contract contained in the medical records is dated August 20, 2015. Other than reducing Patient J.B.'s Ativan prescription for a short period of time, Respondent admitted that she didn't reduce the amount of chronic sedatives and opiates during her treatment of Patient J.B. Respondent admitted that Patient J.B.'s medical records were inaccurate and that medical examinations documented in the records did not take place and were in fact self-populated templates. Respondent admitted that she was aware of the Medical Board's 1994 and 2007 Guidelines when she provided treatment to Patient J.B.

58. Respondent's license is subject to disciplinary action because she committed the following repeated negligent acts during the care of Patient J.B.:

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a.) As more fully described above, by failing to obtain informed consent before prescribing controlled substances; by failing to perform a periodic review of long term opioid therapy while prescribing opioids for chronic pain; by failing to perform a more complete interval pain assessment including reevaluation of pain/function goals and appropriateness of continued opioid/sedative use given concerns for drug dependency; and by failing to initiate opioid tapering plans represents a departure from the standard of care; and/or,

b.) By failing to document accurate examination findings in the areas of reported pain, failing to document Patient J.B.'s functional status; by failing to correct self-populated templates in the electronic medical records that falsely indicated examinations had taken place; by failing to document past diagnostic evaluations; by failing to document a harm assessment of Patient J.B.'s controlled substances; and/or by failing to document Patient J.B.'s prior treatment for each pain syndrome represents a departure from the standard of care.

Patient S.B.

59. Respondent has been providing care to Patient S.B. for more than ten years. The Board received medical records between January 2009 and January 2016. On January 20, 2009, Respondent documented that she saw Patient S.B. for follow-up regarding anxiety and panic attacks. Respondent documented that Patient S.B. suffered from rheumatoid arthritis and diabetes. The note documented that she was stable on methotrexate and fentanyl. Respondent prescribed alprazolam for anxiety. On February 17, 2009, Respondent documented that Patient S.B. was receiving a 125 mcg./hr. fentanyl patch to be applied every 72 hours.

60. On December 13, 2010, Respondent documented that Patient S.B. was now receiving a 100 mcg./hr. fentanyl patch to be applied every 48 hours. The fentanyl patch is designed and manufactured to be applied every 72 hours. The 125 mcg./hr. fentanyl patch was discontinued. Respondent did not document why she was approving a 100 mcg./hr. patch to be used for only 48 hours and why she was now prescribing 15 patches a month, rather than 10 patches a month. At her subject interview on November 15, 2016, Respondent was unable to explain what happened to the fentanyl patches after they were removed from Patient S.B. with still 24 hours of active medication, stating that Patient S.B. just took them off. According to the medical records,

Respondent prescribed a daily tablet of 10 mg. Opana ER. During the subject interview, Respondent stated that this was an error in the medical records and that she was not prescribing two long-acting narcotics.

61. Respondent documented that she was prescribing high potency opioid medications to Patient S.B. for rheumatoid arthritis and fibromyalgia. In reviewing records from January 20, 2009, to January 2016, there is scant evidence to support a finding of rheumatoid arthritis and fibromyalgia. For example, Respondent stated at her subject interview that she recalls finding multiple tender points during palpation of extremities but there is no documentation. Also, there is poor documentation to validate a diagnosis of rheumatoid arthritis, including a lack of independent testing and corroborating examinations in the medical records. For example, the records contain repeated entries that indicated examinations of her musculoskeletal system and findings that her extremities were normal. By way of example the notes on March 10, 2011, September 26, 2011, and July 31, 2012, all state that the examination of extremities were normal, no loss of range of motion, and no pain upon palpation.

62. Between January 2009 and December 2011, Respondent continued Patient S.B. on fentanyl, Opana ER, and alprazolam. On December 6, 2011, during a visit for chronic pain follow-up, Respondent documented that Patient S.B.'s pain level was 3 out of 10, patient was interested in weaning off narcotics, and there was a normal physical examination documented. Of note there was no documentation of arthralgias, myalgias, or joint swellings documented in the review of symptoms under musculoskeletal. Under the objective examination of musculoskeletal, Respondent documented normal symmetry, tone, strength, and range of motion. Respondent also documented no effusions, instability, or tenderness to palpation. Respondent continued fentanyl and alprazolam without making any changes to reduce or lower the amount of medications taken despite the documentation contained in the medical record.

63. A review of the medical records for Patient S.B. between January 2009 and January 2016, reveals that Respondent failed to document an initial pain assessment, a comprehensive treatment plan, and a periodic review of treatment for chronic pain. At the subject interview on November 15, 2016, Respondent stated that she had formulated a simple long-term pain

management plan for Patient S.B. where Respondent would maintain all medications because Patient S.B. was functional. However, there is no documentation of that treatment plan in the records. Respondent's stated treatment plan does not take into account visits like December 6, 2011, where it appeared Patient S.B. would benefit from a reduced prescription of controlled medications. Respondent stated there was a signed pain contract with Patient S.B. that evidenced documentation of informed consent but the Board was not provided with a pain contract when it received the complete certified medical records.

64. Between December 2011 and November 2015, Respondent on a monthly basis provided 15 100 mcg./hr. Fentanyl patch, 60 tablets of 1 mg. clonazepam, and 120 tablets of .5 mg. alprazolam. On March 3, 2014, Respondent added a monthly prescription of 120 2 mg. pills of Dilaudid. During her subject interview, Respondent stated that she typically didn't want to prescribe opiate medications in an amount over 40 morphine equivalents. At the time she began prescribing Dilaudid to Patient S.B., Patient S.B. was receiving a morphine equivalent dose of 272. Respondent's chart note of March 3, 2014, stated that Patient S.B. would begin using the Dilaudid instead of the Fentanyl and that Respondent would discontinue patches. Respondent continued prescribing both 15 100 mcg./hr. Fentanyl patches with 90 to 120 tablets of 2 mg. Dilaudid until June 9, 2015, in contradiction to her chart note dated March 3, 2014.

65. On November 2, 2015, Patient S.B. was seen in the clinic by a nurse practitioner employed by Respondent. At this time, Patient S.B. was on 4 tablets daily of .5 mg. alprazolam and 1 Fentanyl patch of 100 mcg/hr. to be applied every 48 hours. The nurse practitioner documented the following note under plan,

> "Patient is here for her narcotic refills, discussed the amount she takes and the needs to cut down and see her rheumatologist for other options to her pain. She was unable to find words and her speech was slow. Patient states she is not driving and she is warned against it."

On December 8, 2015, Respondent saw Patient S.B. for follow-up and continued her medications for Fentanyl patch and alprazolam. Respondent documented that Patient S.B.'s pain was now 10 out of 10. There is no documentation that Respondent discussed the nurse practitioner visit dated November 2, 2015, with Patient S.B. and there is no evidence that Respondent considered a new

treatment plan with Patient S.B. At her subject interview, Respondent stated that she discussed the nurse practitioner's concerns with Patient S.B. but she failed to document her discussion with S.B. in the medical records. During the entire time that Respondent treated Patient S.B., she failed to consider, recommend, or use non-narcotic agents, nonpharmacologic modalities, and specialty management before continuing high dose opiate therapies.

66. At her subject interview on November 15, 2016, Respondent admitted that for a large period of Patient S.B.'s treatment, she was providing high dose opioid therapy to Patient S.B. despite Patient S.B. not actually having destructive joint disease. Instead, Respondent stated the fentanyl was more for pain rather than the clinical manifestations of rheumatoid arthritis. Respondent admitted that prior to 2012, there was no documented informed consent for controlled substances, just a verbal consent between her and Patient S.B. Respondent stated in her interview that she added Dilaudid in early 2014 to treat the physical symptoms of polyarthritis but the records do not support her contention. In June 2014, Patient S.B. was suffering from allodynia, but Respondent admitted that she didn't consider that Patient S.B. might be suffering from opiate-induced hyperalgesia. Respondent admitted that she never had this patient provide a urine test for controlled substances despite providing high dose opiate treatment for more than ten years. Respondent acknowledged that she was prescribing both alprazolam and clonazepam to Patient S.B. for anxiety. Respondent stated her goal was to get Patient S.B. off of short-acting alprazolam. Respondent admitted that she continued to prescribe both benzodiazepine medications for three and a half years and admitted that she is still hoping to get Patient S.B. off of alprazolam.

67. Respondent's license is subject to disciplinary action because she committed the following repeated negligent acts during the care of Patient S.B.:

a.) As more fully described above, by failing to perform a periodic review of long term opioid therapy while prescribing opioids for chronic pain; by failing to perform a more complete interval pain assessment including reevaluation of pain/function goals and appropriateness of continued opioid/sedative use given concerns for drug dependency; by failing

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to use urine drug testing, and/or by failing to attempt opioid tapering plans represents a departure from the standard of care; and/or,

b.) By failing to document accurate examination findings in the areas of reported pain; by failing to properly document support in the medical record for a diagnosis of rheumatoid arthritis and/or fibromyalgia; by failing to document Patient S.B.'s functional status; by failing to document informed consent; by failing to document a comprehensive treatment plan; by failing to document past diagnostic evaluations; by failing to document a harm assessment of Patient S.B.'s controlled substances; and/or by failing to document Patient S.B.'s prior treatment for each pain syndrome represents a departure from the standard of care.

Patient K.M.

68. Respondent began seeing Patient K.M. before 2002. On February 4, 2009, Respondent documented that Patient K.M. was requesting an initial evaluation for headaches. Respondent documented that Patient K.M. was experiencing dizziness and fatigue. Also, Patient K.M. described facial numbness. Respondent documented that the headaches were getting worse, and that Patient K.M. has had balance problems. Respondent ordered a brain MRI. At the time, Patient K.M. was receiving oxycodone with acetaminophen for pain. Respondent also began prescribing Fiorinal to combat chronic headaches. On additional visits on November 30, 2009, and January 12, 2010, Respondent saw Patient K.M. in the clinic for cough and reflux. Respondent was still prescribing oxycodone with acetaminophen, and Fiorinal. At the clinic visit on January 12, 2010, Respondent added Soma. The documented examinations were normal and failed to describe why the Patient required Soma and oxycodone with acetaminophen.

69. The Board reviewed Patient K.M.'s medical records from February 24, 2011, November 30, 2011, February 9, 2012, August 1, 2012, September 5, 2012, October 2, 2012, October 18, 2012, November 1, 2012, June 3, 2013, June 27, 2013, April 17, 2014, July 18, 2014, and November 13, 2014. Between November 5, 2012, and October 9, 2015, Respondent prescribed a total of 420 pills of 5-325 mg. oxycodone with acetaminophen, 120 pills of 10-325 mg. oxycodone with acetaminophen, 2100 pills of 350 mg. carisoprodol, and 4080 pills of 325-50-40 mg. butalbital-aspirin-caffeine. On an almost monthly basis, Respondent prescribed 180

pills of Soma and 360 pills of Fiorinal. A review of the records between February 24, 2011, and November 13, 2014, found no documentation that Patient K.M. was suffering from headaches at that time. The records specifically stated, "no headaches." A review of the records between February 24, 2011, and November 13, 2014, found no documentation to support the prescribing of carisoprodol. The records specifically noted that the musculoskeletal system was normal upon examination.

70. Patient K.M.'s medical records contained a medication contract dated November 14, 2014. There was no other record of informed consent and/or a medication contract documented in Patient K.M.'s records. There was no record that Respondent requested a consultation with a neurological specialist. There was no record that Respondent performed urine testing on Patient K.M. There is no documented comprehensive treatment plan or periodic review documented in Patient K.M.'s medical records. There is no evidence that Respondent considered alternative therapies for migraines and/or potentially drug induced headache syndromes.

71. On November 15, 2016, at her subject interview with the Board, Respondent could not recall if she went through Patient K.M.'s prior medical records regarding headaches before prescribing Fiorinal and diagnosing chronic migraine headaches. Respondent admitted she tried no other treatments aside from Soma, opiates and Fiorinal to treat Patient K.M.'s headaches. Respondent admitted that the records between February 2011 and November 2014 repeatedly stated that Patient K.M. had no headaches. Respondent admitted that if Patient K.M. had come to the office between February 2011 and November 2014 regarding a complaint of frequent, severe, and/or bad headaches that she would have documented that complaint. Respondent admitted that there was no pain contract or controlled substance agreement signed before November 13, 2014. Respondent could not recall if she ever ordered urine tests to determine if Patient K.M. was compliant with his prescriptions. At the subject interview, Respondent admitted that Patient K.M. was not under a neurologist's care and that she personally did not seek any advice from a neurologist on how to treat Patient K.M.'s headaches. Respondent stated she is familiar with the term "analgesic rebound headache," and admitted that Patient K.M. may have had that condition

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at some point but she admitted she never consulted with a neurologist to treat Patient K.M.'s condition.

72. Respondent's license is subject to disciplinary action because she committed the following repeated negligent acts during the care of Patient K.M.:

a.) As more fully described above, by prescribing narcotics to Patient K.M. for chronic headaches over a prolonged period of time despite a lack of symptoms; by failing to provide an adequate initial assessment, comprehensive treatment plan, and/or perform a periodic review of treatment goals; by failing to use non-narcotic agents, nonpharmacologic therapies, and/or attempt to taper controlled substances; by failing to obtain informed consent, urine drug testing, and perform a harm assessment; and;

b.) By failing to document symptoms in the medical record to support the ongoing prescribing of controlled substances; by failing to document informed consent, by failing to document an initial assessment, comprehensive treatment plan, and/or perform a periodic review of treatment goals; by failing to document that she considered neurologic consultation, other therapies for migraines, and the potential for drug induced headache symptoms.

Patient A.R.

73. Respondent initiated treatment with Patient A.R. in 2006. Patient A.R. had a history of hypertension, major depression, chondromalacia of patella, migraines, and obesity. In 2009, Patient A.R. underwent gastric bypass surgery. On January 12, 2012, Respondent saw Patient A.R. in the clinic. Respondent noted that Patient A.R. was not compliant with medications, taking more than prescribed and running out early. Respondent noted he had "mild shakes" as a symptom of withdrawal. At the time, Respondent stopped prescribing 7.5/500 mg. hydrocodone with acetaminophen, and began prescribing 15 mg. oxycodone HCL four times a day. On February 7, 2012, Respondent documented Patient A.R. was not compliant with pain management treatment. On February 13, 2012, Patient A.R. appeared for a medication refill and Respondent documented that Patient A.R. must have a pain management consultation before the next appointment. On February 24, 2012, Respondent saw Patient A.R. in the clinic for a scratch caused by a chicken. Respondent refilled his oxycodone prescription, noting that Patient A.R.

was in withdrawal after missing a couple of doses of medication. On March 14, 2012, Respondent saw Patient A.R. in the clinic. She noted that he was overusing medication and needed a refill of his pain medications. On March 27, 2012, Respondent saw Patient A.R. in the clinic. Respondent noted that Patient A.R. was now taking his oxycodone prescription every 4 hours, rather than every six hours as prescribed. Respondent refilled his oxycodone prescription each time despite these warning signs.

74. Respondent saw Patient A.R. on July 26, 2012, after he was discharged from the hospital for intestinal torsion with multiple complications including aspiration pneumonia, respiratory failure, ventilator dependency requiring tracheostomy, percutaneous feeding tube, right upper extremity deep vein thrombosis, and lung fibrosis. Patient A.R. was prescribed methadone upon discharge from the hospital. Oxycodone was discontinued. Respondent noted that Patient A.R. was now on 2 tablets of 10 mg. methadone a day. In addition she prescribed 1 mg. Ativan to be taken three times daily. Despite Respondent continuing Patient A.R.'s prescription for methadone, there is no evidence that she documented a treatment plan with goals for pain and function. Respondent failed to document a complete initial assessment including physical and psychological functional status, history of prior treatment, and/or prior diagnostic work up necessitating the need for Methadone. Despite Respondent repeatedly documenting that Patient A.R. had previously been non-compliant with oxycodone, Respondent failed to have him sign a medication agreement or agree to urine drug testing before she continued his methadone treatment.

75. On January 17, 2013, Respondent saw Patient A.R. in the clinic for depression. At the time, Respondent was prescribing 90 tablets of 10 mg. methadone HCL and 90 tablets of 1 mg. alprazolam on a monthly basis. Respondent documented that she explained that benzodiazepines are meant to be used for temporary relief of symptoms and that benzodiazepines would only be given for 3-4 weeks until Patient A.R.'s prescription for anti-depressant became therapeutic. Between January 17, 2013, and January 27, 2014, Respondent, Dr. B.B. or Respondent's nurse practitioner prescribed or refilled a total of 1170 10 mg. methadone pills, 1080 1 mg. alprazolam pills, and 810 milliliters of promethazine cough syrup with codeine.

There is no documentation regarding whether or not Patient A.R. was complying with Respondent's treatment plan, if she had even created one, and there is no evidence that she performed a periodic review.

76. Respondent continued prescribing methadone and alprazolam into early 2014 to Patient A.R. In April and May 2014, Patient A.R. was seen by a pain specialist, Dr. Z. On May 20, 2014, Dr. Z. recommended that narcotic medications be limited as methadone had side effects on Patient A.R.'s GI system. Dr. Z. recommended that the Patient receive 10 mg. oxycodone pills, three times a day. Methadone would be discontinued. Respondent admitted during her subject interview on November 15, 2016, that only one physician should have been prescribing controlled medications to Patient A.R. after he was referred to Dr. Z. Dr. Z. prescribed 90 tablets of 10 mg. oxycodone on April 21, 2014, and May 20, 2014. Despite Dr. Z. taking over care for Patient A.R., Respondent prescribed 90 tablets of 10 mg. methadone on April 10, 2014, and May 10, 2014. Respondent admitted she was not supposed to prescribe methadone at that time. At her interview, Respondent stated that Patient A.R. fired Dr. Z. because Dr. Z. would not give him more medication. Respondent continued to prescribe methadone after Patient A.R. fired Dr. Z.

77. On May 29, 2014, Respondent documented that she had a long talk with Patient A.R. about a pattern of drug dependence. Respondent documented that she told Patient A.R. if he increased his intake of medication that he should discuss it with Respondent first and if poor patient behavior continued he would be discharged from the practice. On May 29, 2014, and June 19, 2014, Respondent provided prescriptions for 120 10 mg. methadone pills. There is no documentation in the record why Patient A.R. was now receiving 4 10 mg. methadone pills a day. On July 18, 2014, Respondent saw Patient A.R. in the clinic. Patient A.R. complained of chronic pain and a current pain level of 10 out of 10. Respondent documented that she increased the methadone prescription to 6 tablets a day and provided a prescription for 180 10 mg. methadone tablets. At this dosage, Patient A.R. was now at 600 morphine equivalent doses. There is no explanation or documentation in support of this increase. After July 18, 2014, Patient A.R.'s opiate therapy was taken over by a pain expert named Dr. A.

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78. During her subject interview with the Board, Respondent stated she had verbal agreements with Patient A.R. regarding controlled substance therapy but acknowledged that there was no written documentation provided to the Board. Respondent admitted that there was no evidence of urine screening being performed with this patient.

79. Respondent's license is subject to disciplinary action because she committed the following repeated negligent acts during the care of Patient A.R.:

a.) As more fully described above, by failing to perform a periodic review of long term opioid therapy while prescribing opioids for chronic pain; by failing to provide an adequate initial assessment, including physical and psychological functional status; by failing to provide a comprehensive treatment plan; by failing to review history and prior diagnostic work up necessitating the need for long term methadone therapy; by failing to refer Patient A.R. to detoxification or substance abuse services despite claiming that she was concerned with drug withdrawal as a reason to not discontinue narcotics and/or,

b.) By failing to document accurate examination findings in the areas of reported pain; by failing to document informed consent; by failing to document a comprehensive treatment plan; by failing to document past diagnostic evaluations; by failing to document a harm assessment of Patient A.R.'s controlled substances; and/or by failing to document Patient A.R.'s prior treatment for each pain syndrome represents a departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

80. Respondent's license is subject to disciplinary action under section 2266 of the Code in that the records of her care and treatment of six patients were either inaccurate or inadequate or both. The circumstances are as follows:

81. The allegations of paragraphs 27 through 79 above are incorporated herein by reference.

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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 No. Number A 51759, issued to Maria Isabel Aruiza Bacay, M.D.;

2. Revoking, suspending or denying approval of Maria Isabel Aruiza Bacay, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Maria Isabel Aruiza Bacay, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: April 28, 2017

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

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