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

In the Matter of the Accusation Against:	)	
GRANVILLE H. MARSHALL, M.D.	)	Case No. 800-2014-008397
Physician's and Surgeon's Certificate No. A70232	)	OAH No. 2017100748
Respondent	)	

DECISION

The attached Amended Proposed Decision 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 November 8, 2018.

IT IS SO ORDERED: October 9, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson

Kristina Lawson, JD, Chair
Panel B

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

In the Matter of the Accusation Against: GRANVILLE H. MARSHALL, M.D. Physician's and Surgeon's Certificate No. A 70232 Respondent.	Case No. 800-2014-008397 OAH No. 2017100748

AMENDED PROPOSED DECISION[1]

A hearing in this matter convened before Marilyn A. Woollard, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), in Sacramento, California, on April 9 through 13, and April 16, 2018.

John Gatschet, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, in her official capacity as Executive Director of the Medical Board of California (Board).

Respondent, Granville H. Marshall, M.D., appeared and represented himself.

Oral and documentary evidence was received. At the conclusion of the evidentiary hearing, the record remained opened for written closing arguments which were timely filed and marked for identification as follows: Exhibits 25 and 26, respectively, complainant's closing and reply briefs; and Exhibit T, respondent's closing brief. Respondent also submitted: (a) a reply to complainant's reply brief, marked for identification as Exhibit U, which was considered; and (b) the four-page Declaration of Jennifer Baker with attachments, filed after the hearing on April 25, 2018, marked for identification as Exhibit V, discussed

[1] The Proposed Decision is amended to correct typographical errors as follows: (a) on page 9, paragraph 29, the last sentence is replaced to read: "DF's Authorization for Release and Declaration are admitted and considered to the extent permitted in Government Code section 11513, subdivision (d);" (b) on page 29, on the second to last line of footnote 15 (formerly footnote 14), *Gherardini* was deleted and replaced with *Pating*; on page 30, at paragraph 93, 11th line, the phrase "four-page" preceding the phrase "Authorization for Release" was deleted.

below. On July 15, 2018, pursuant to the April 26, 2018 Case Status Order, the record closed and the matter was submitted for decision.

FACTUAL FINDINGS

1. On November 5, 1999, the Board issued Physician's Certificate Number A 70232 to respondent. The certificate is current and has an expiration date of April 30, 2019. There is no history of prior disciplinary action having been taken against the certificate by the Board.

Overview of Complaint and Background

2. During times relevant to this proceeding, respondent was in solo practice in internal medicine, doing business as Marshall Healthcare Systems at 170 Russell St., Suite L, in Susanville, California 96130. Respondent treated Patient SF from April 30, 2012, through May 30, 2014, for conditions that included lung disease and brain lesions.[2] Respondent's medical records for SF contain a completed "Marshall Healthcare Systems Registration Form," which provides basic information about SF, including his name, address, insurance information and marital status. This form indicated that SF was married and that, in case of emergency, his wife, DF, was the person to contact. DF, who was also known as DMF, was also treated by respondent.[3]

Throughout this treatment, respondent prescribed certain long-acting and short-acting controlled substances/dangerous drugs to SF. These included: (1) the Schedule II drugs hydromorphone hydrochloride; morphine (MS Contin); oxycodone and oxycodone ER (OxyContin); and oxycodone with acetaminophen (Percocet); and (2) the Schedule III drugs hydrocodone with acetaminophen (Norco)[4] and Buprenorphine (Butrans transdermal patch). On May 30, 2014, respondent discharged SF from care due to drug-seeking behavior. In his discharge note, respondent documented that SF had requested medication refills and had attempted to blackmail him.

3. On August 1, 2014, SF signed and dated a Medical Board of California Consumer Complaint Form which detailed his complaints against respondent. SF also partially completed the Authorization for Release of Medical Information (Authorization for

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[2] On his complaint form, SF indicated that his treatment with respondent began in April 2010; however, both the medical records and the Accusation identify his initial treatment date as April 30, 2012.

[3] The names of respondent's former patients are confidential and subject to the August 21, 2018 Protective Order.

[4] During the relevant time period, hydrocodone with acetaminophen was a Schedule III controlled substance; it was reclassified as Schedule II after October 6, 2014.

Release), which was the last page of a four-page pamphlet that began with the Consumer Complaint Instructions and Complaint Form. Instructions for completing this form provided that: "If there is more than one physician involved in the patient's care, you may copy the blank form and complete one for each physician and/or facility. When a medical record release form is completed and signed, it allows the Medical Board to order records from **ONLY** the doctors or facilities you have listed on the medical record release form(s)." In completing the Authorization for Release, SF provided his name, date of birth and Social Security number, and he signed and dated the form. SF did not write in respondent's name and address as the physician or facility he authorized to release his medical records. These documents were received by the Board on September 11, 2014.

4. The complaint was assigned to Board Investigator Anna Vanderveen, who conducted two consecutive investigations. The first investigation was criminal in nature and involved SF's allegation that respondent had asked him to harm two local physicians. This complaint was later determined to be unsubstantiated.[5]

5. SF died on May 3, 2015. The May 12, 2015 certified Certificate of Death from the Nevada Department of Health and Human Services listed his immediate cause of death as acute cardiopulmonary arrest due to chronic obstructive pulmonary disease (COPD). The certificate listed the reporting party as DF and provided the maiden name of SF's surviving spouse as DM, with the same first name for DF and DMF.

6. In July 2016, shortly after she learned that SF had died, Investigator Vanderveen began the second, quality of care investigation. This investigation involved SF's report that respondent had given him a Proposition 215 recommendation for medical marijuana and then, "started buying pot from me for personal use and for to [*sic*] give some to special patients. . . ." During her investigation into respondent's medical treatment of SF, Investigator Vanderveen requested and received SF's medical records from respondent after providing him a copy of the signed Authorization for Release onto which she had inserted respondent's name and address.

7. On June 20, 2017, respondent and his attorney Stephen King attended an interview with Investigator Vanderveen at Mr. King's office in Susanville. Deputy Attorney General (DAG) Gatschet and medical consultant Kevin Mitchell, M.D., joined the interview by telephone. Respondent refused to participate in the interview and left. On July 12, 2017, Investigator Vanderveen provided SF's medical records to David Olson, M.D., for expert review, with a redacted copy of her draft Investigation Report. She made several unsuccessful attempts to arrange an interview with respondent.

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[5] Due to the prejudicial nature of this unsubstantiated allegation, efforts were made during the hearing to limit evidence and testimony about it. For example, the unredacted Investigation Report (Exhibit 7) was excluded. Nonetheless, the substance of this allegation was known to the undersigned and was discussed by the parties and witnesses at various times during the hearing. In reaching this decision, no reliance has been placed on this allegation or on any other unsubstantiated allegation about respondent recorded in Exhibit 7.

8. Accusation: On September 5, 2017, complainant filed the Accusation against respondent's license for alleged unprofessional conduct regarding his care and treatment of SF. Specifically, complainant alleged respondent had engaged in gross negligence and repeated negligent acts in his inappropriate treatment of SF for chronic pain and by his inadequate and inaccurate recordkeeping. (Bus. & Prof. Code §§ 2234 subds. (b), (c); 2266.) Complainant also alleged respondent had engaged in unprofessional conduct by repeatedly failing to attend and participate in an interview with the Board. (Bus. & Prof. Code § 2234 subd. (h).)

9. On September 28, 2017, respondent signed and filed his Notice of Defense requesting a hearing. Complainant accepted the Notice of Defense and set the matter for hearing. Respondent represented himself throughout this proceeding.[6] He argued that Mr. King had failed to properly represent him, including by failing to timely notify him about scheduled Board interviews, about the Accusation and need to file a Notice of Defense.

10. Exclusion of Respondent's Medical Expert Witness: On March 8, 2018, respondent timely submitted his expert witness disclosure, indicating that he had retained himself for an hourly fee of five cents and a daily fee of $.50 for providing testimony and consulting. Respondent disclosed he would testify that he did not over prescribe controlled medications and did not deviate from the standard of care in treating SF, and that SF's original medical record had been "altered, and pertinent medical documentation was removed . . ."

On March 16, 2018, complainant filed her "Motion In Limine to Exclude Respondent's Expert Witness Testimony," based on his alleged failure to comply with the disclosure requirements of Business and Professions Code section 2334. By order dated April 5, 2018, after considering respondent's opposition, complainant's motion to exclude respondent from testifying as an expert witness was granted. Respondent's testimony at hearing was limited to his own knowledge of SF's treatment and his understanding of what he believed to be the standard of care for prescribing and record keeping at the time he treated SF. Based on this ruling, complainant offered the only expert medical opinion testimony.

11. Respondent's Pending Motion to Prohibit the Use of SF's Medical Records: On February 20, 2018, respondent filed a document entitled "Accusation Unsubstantiated and Without Merit" in which he argued, *inter alia*, that the Authorization for Release had not been completed by SF; that Investigator Vanderveen had obtained SF's medical records illegally and later altered the original records; and that the Board could not access or use SF's medical records because they were "fruit from the poisonous tree." At the March 2, 2018 Prehearing Conference, respondent again expressed his concerns about the validity of SF's Authorization for Release.

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[6] While representing himself, respondent would occasionally employ the services of an attorney to help him brief legal issues in motions and closing briefs.

On March 7, 2018, DAG Gatschet sent a letter to DF notifying her that, pursuant to *Shelmeyer v. Department of General Services* (*Shelmeyer*) (1993) 17 Cal.App.4th 1072, the Board was in possession of SF's medical records and would introduce them in the pending administrative hearing against respondent unless she objected. DF was asked to sign a new Authorization for Release of SF's medical records if she agreed that the Board could use these records, and to include a letter indicating that SF's original authorization for release was authentic and consistent with his intent. Further efforts to communicate with DF, were made by Board Investigator Michel Veverka.

On March 23, 2018, OAH received respondent's "Motion to Bar Use of Medical Record Authorized," challenging the authenticity of the Authorization for Release of SF's medical records. Relying on *Shelmeyer*, respondent argued that, in the absence of a notice and a release, SF's medical records may not be used. He requested that SF's medical records be excluded and that any expert testimony based on these records be barred. Respondent further asserted that any attempt by complainant to cover her lack of authority by submitting a recent release form purportedly signed by DF, whose status as SF's wife he disputed, was not sufficient to cure the problem.

Ruling on this motion was deferred pending receipt of testimony about the manner in which SF's records were obtained from respondent, and to allow the parties to address whether, as a threshold matter, respondent had standing to raise SF's right to privacy of his medical records as a defense to the Accusation. Ultimately, the parties agreed to submit this matter for decision, subject to a motion to strike Dr. Olson's testimony and the first three causes for discipline if respondent's motion prevailed.

12. Respondent's Pending Motion to Dismiss Fourth Cause for Discipline: On March 23, 2018, OAH received respondent's "Motion to Quash the Fourth Cause for Discipline," for failing to participate in a Board interview. By order dated April 5, 2018, after considering complainant's opposition, respondent's motion to dismiss this allegation of unprofessional conduct was denied as premature. This motion was submitted for decision at the conclusion of the evidentiary hearing.

13. Hearing: The following witnesses testified for complainant: Investigator Anna Vanderveen, Supervising Investigator Michel Veverka, and expert David Andrew Olson, M.D. Respondent called Harry Mohan Singh Dhesi, D.D.S., as a witness and testified on his own behalf. The testimony of these witnesses is paraphrased as relevant below.

I. QUALITY OF CARE INVESTIGATION

14. Testimony of Investigator Vanderveen: Investigator Vanderveen has been a sworn peace officer since approximately 1988. She was a California Highway Patrol officer for three years (1988-1991) before becoming an investigator with Department of Consumer Affairs. Since 1991, she has investigated over 500 complaints against medical licensees for the Board. At least 100 of these cases have involved allegations about the prescription of controlled substances. While the majority of her investigations have involved quality of care

issues, Investigator Vanderveen is also authorized to conduct criminal investigations pertaining to Board licensees. She typically carries a firearm with her in the field.

15. On October 10, 2014, Investigator Vanderveen was assigned to investigate SF's complaint against respondent. When she received it, SF's consumer complaint was no longer in its original pamphlet form. Instead, it had been cut into two separate, two-sided 8.5 x 11 pieces of paper to which two additional pages were attached. SF's smaller handwritten notations explaining his complaint had been taped to these pages.

16. Investigator Vanderveen acknowledged that SF had left blank the portion of the Authorization for Release form for the name of the physician or facility to whom or to which the release was directed. This omission did not concern her particularly because it was not unusual. In her experience, because the form has only one Authorization for Release and there may be a need to obtain medical records from multiple physicians or facilities, it is often partially completed and signed by the patient, with this portion left blank to be filled in as needed. When this need arose, a copy of the signed Authorization for Release form would be made and the name of the physician or facility would be entered by the investigator on the copy. A copy of that completed form would then be provided to the physician or facility to obtain the records.

17. Investigator Vanderveen followed this standard practice in this case. On October 14, 2014, she spoke with SF by telephone and confirmed with SF that he authorized the release of his medical records from respondent. SF had no objection to the release of his medical records to the Board; however, due to the nature of his complaint against respondent, he expressed some concern about his personal safety and wanted to distance himself from respondent. Based on this conversation, Investigator Vanderveen concluded that SF was fully aware that she would request his medical records from respondent sometime in the future. Several weeks after this conversation, she copied SF's original Authorization for Release and wrote in respondent's name and address in blue ink as the physician from whom SF authorized release.

Investigator Vanderveen spoke with SF again on January 27, 2015. In both of these conversations, Investigator Vanderveen called SF at the telephone number he had provided in the complaint. She knew she was speaking to SF based upon his detailed knowledge of the information provided in the complaint. SF never revoked his prior authorization for release. On February 26, 2015, she received a voice mail from SF informing her that he had moved to Carson City, Nevada and giving her his new address and phone number. She tried returning SF's call on numerous occasions without success and had no other communications with him. Investigator Vanderveen did not request SF's records from respondent at that time, due to her focus on the initial criminal investigation, as well as SF's safety concerns.

18. On July 22, 2016, Investigator Vanderveen learned that SF had died on May 3, 2015. That same day, she prepared a letter to respondent requesting SF's certified medical records with an advisement that failure to do so by August 8, 2016 may result in a citation, fine or civil penalties. With this letter, respondent was provided a copy of Business and

Professions Code section 2225.5, a blank Certification of Records form to be completed and returned with the records, and a copy of SF's original signed Authorization for Release form onto which she had inserted respondent's name and address. She prepared a declaration of service by certified mail to respondent at his address of record, receipt for which respondent signed on July 25, 2015.[7]

19. On July 25, 2016, respondent called Investigator Vanderveen about the records request. Respondent was "very cordial" over the phone and did not raise any concerns about providing SF's medical records. He told her that SF's medical records were contained in two volumes and that he would be happy to send her his original records if she could provide him with a scanned copy of the records. On July 27, 2016, she received a box from respondent with two manila folders containing SF's records (charts) along with several CDs of imaging studies. Respondent's signed Certification of Records, declaring under penalty of perjury that SF's complete records consisted of 295 pages, was also included. These records were not Bates stamped (serially paginated) or indexed.

20. Investigator Vanderveen reviewed each page in these original records in the order in which they were placed in the charts. As she turned each page, she used a Bates stamp to number the pages in sequence. During this process, she encountered copies of prescriptions on NCR (carbonless) paper that respondent had tucked into the spine of the charts. Each time she encountered such a paper, Investigator Vanderveen taped the smaller NCR paper onto an 8.5 x 11 piece of paper, Bates-stamped the page, and placed the prescription back into the chart in its original position. While the NCR prescriptions in respondent's original charts were typically placed in a position roughly corresponding to his date of service, if a prescription had been tucked in by a different date range, she left the new page in that same (non-chronological) position.

21. As a result of this process, the total number of pages in SF's medical records increased from 295 to 339 pages. Investigator Vanderveen copied the Bates stamped documents and made a CD of the records, which she sent to respondent by certified mail on August 16, 2016. When she returned them to respondent, these medical records were in substantially the same condition as the originals provided to her, except for the addition of page numbers and the extra pages on which the NCR prescriptions had been taped. She hand delivered the original records to attorney King on July 17, 2017. Respondent never raised any objections to the condition of the original records and CD copies she had returned to him until July 2017.

22. There was no doubt in Investigator Vanderveen's mind that SF had authorized the release of his medical records from respondent to the Board. In addition to SF's verbal

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[7] This declaration of service confirmed that these documents, marked collectively as Court Exhibit 10, were sent to respondent by certified mail on July 22, 2016. On July 27, 2016, Investigator Vanderveen received the return receipt for this package, which had been signed by respondent on July 25, 2016. These were internal documents which not sent to respondent or provided to the DAG until the hearing.

permission, the Authorization for Release SF signed was originally attached to the consumer complaint pamphlet form on which he had expressly identified respondent by name and had listed the address of respondent's medical office, together with his detailed complaints about respondent. Inspector Vanderveen did not threaten respondent or seize SF's medical records. Respondent voluntarily sent these records to her and she had a good faith belief at the time that the records could be turned over to her as an investigator for the Board.

23. Investigator Vanderveen acknowledged that SF indicated he had no complaints about respondent's "professionalism" and that he had not checked the "substandard care" box on the consumer complaint form. SF did complain that respondent had given him a marijuana recommendation and then bought marijuana from him. This complaint related to respondent's medical care. She clarified that, once a quality of care investigation has begun, the Board is not precluded from investigating other issues that arise even if they were not the basis of the initial complaint.

24. Investigator Vanderveen never told respondent there was a criminal investigation ongoing about him. She explained that when she finally talked to respondent, she had already determined that the criminal investigation was unfounded so there was no need to discuss it. She acknowledged that, when respondent called her on July 25, 2016, he brought up SF's allegation of a "hit for hire" by him.

25. Investigator Vanderveen has been an investigator for approximately 27 years. She testified that she "takes her badge seriously." She did not change, remove or destroy any of SF's original medical records provided to her by respondent except as explained above, and she did not forge any of the documents presented at hearing. Doing so would be a felony and would likely result in termination.

26. Testimony of Michel Veverka: Supervising Investigator Veverka is a sworn peace officer who has worked for 13 years as an investigator in the Sacramento Health Quality Investigation Unit's field office. On March 12, 2018, she contacted DF at the confidential telephone number contained in the Investigation Report to follow up on DAG Gatschet's *Shelmeyer* letter. Investigator Veverka confirmed that the woman she was speaking to was DF based on the detailed personal information DF revealed to her, about both herself and SF, which was consistent with information in the Investigation Report. DF asked not to testify in the hearing, but indicated she would return the Authorization for Release as soon as possible.

27. On March 15, 2018, Investigator Veverka received an Authorization for Release of SF's medical records by respondent to the Board. This document (Exhibit 12/12A) had a signature by "DMF. Wife" and was signed March 13, 2018. Several documents were attached to this document. There was a form Declaration under penalty of perjury, which was signed "DMF." but was undated and had no execution date. Handwritten information provided on the form stated that: "The release signed by my husband [SF] was authentic and true. It was my husband's & my intent that the Medical Board have access to [SF's] medical records, and that his medical records can be used in an administrative

proceeding against [respondent's] medical license." A separate handwritten note indicated the author was sorry she could not have the declaration notarized due to her remoteness from town and financial circumstances. This handwritten note was signed "DF" and dated March 13, 2018. These documents were received by the Division of Investigation on March 14, 2018, together with the return receipt (green card) signed by "DMF" on March 12, 2018.

28. Investigator Veverka never saw a marriage license for SF and DF. She assumed DF was SF's wife based upon: DF's self-identification as SF's wife and her statement that they had been married for 25 years; information in the Investigative Report; SF's death certificate; and DF's status as SF's relative in the law-enforcement database Accurint. The parties stipulated that DF's Authorization for Release was prepared after respondent had released SF's medical records to the Board. Investigator Veverka denied that she or anyone else in her unit had written and/or signed DF's Declaration. She testified: "we do not do that. We honor our badge."

29. For the reasons discussed in Findings 83 through 93, respondent's motion to exclude SF's medical records and to strike any expert witness testimony based on those records is denied. Complainant's Exhibit 10 and Court Exhibit 10 are admitted. Because the Declaration in Exhibit 12/12A was not provided to respondent as required by Government Code section 11514, it cannot be considered as direct evidence. The DF's Authorization for Release and Declaration are admitted and considered to the extent permitted in Government Code section 11513, subdivision (d).

Respondent's Medical Records for Patient SF

30. Respondent's treatment visits for SF are recorded on a "Marshall Healthcare Systems Office S.O.A.P. Note" template form. The form provides spaces for the patient's name, date, chief complaint, history of present illness, allergies, current medications, past medical history, social and family history, review of systems, vital signs, HEENT, chest, C.V.S., ABD, G.U., M.S., EXT, and NEURO. It provides spaces for LABS/STUDIES and "Accesment" [*sic*]. The second page is dedicated to "PLAN." At the end of each two-page template form, before the line for respondent's signature, the following words are printed: "ALL S.E.D. WITH PATIENT." Respondent testified that this acronym meant "all side effects discussed." Respondent's practice was to place the NCR copy of prescriptions he had written for the patient into the medical record next to the progress note for the visit at which the prescription was written.

31. Respondent's medical records for SF contain his two signed "Physician's Statements," recommending SF's use of medical marijuana for one year, dated October 4, 2012, and October 14, 2013. Documents respondent received from physicians or hospitals regarding SF's treatment, and letters and evaluations he had provided to agencies on SF's behalf, were also included. As discussed below, Dr. Olson reviewed all of respondent's medical records for SF. Specific treatment visits are discussed in relation to his testimony below.

Expert Report and Opinion Testimony

32. On July 12, 2013, Investigator Vanderveen provided Dr. Olson with background materials for his review of respondent's care and treatment of SF.[8] These included: the Controlled Substance Utilization Review and Evaluation System (CURES) report and Owens Healthcare prescription profiles for SF; SF's certified medical records from respondent with CDs of his CT and MRI scans; SF's death certificate; and the Board's "Policy and Guidelines For Prescribing Controlled Substances For Pain" (Guidelines). Investigator Vanderveen also provided Dr. Olson a redacted copy of her draft Investigation Report.

33. Dr. Olson received his medical degree in 1976 from Jefferson Medical College in Philadelphia, Pennsylvania. He then completed an internship and residency in internal medicine at Geisinger Medical Center in Danville, Pennsylvania (1976 -1979). As part of his internal medicine residency, Dr. Olson received training in caring for patients who were experiencing acute or chronic pain, including by prescribing controlled substances to them. This was in both inpatient and outpatient settings. From 1979 through 1981, Dr. Olson participated in a fellowship in infectious disease at the University of California, Davis Medical Center, Section of Infectious and Immunologic Diseases. In 1979, Dr. Olson was certified by the American Board of Internal Medicine (ABIM); based on this admission date, he is not required to recertify. In 1981, Dr. Olson became licensed to practice medicine in California. In November 1988, Dr. Olson received an ABIM Subspecialty Certification in Infectious Disease, and later added an ABIM certification in Geriatrics. He has been a member of the American Society of Internal Medicine since 1988.

Since July 1981, Dr. Olson has been in private practice in Oakdale, California, where he specializes in internal medicine and infectious disease treatment. His patients include those suffering from chronic pain, and he manages their pain treatment in accordance with the Guidelines which explain what the standard of care requires. He holds privileges and is an active/consulting staff member at the Oak Valley District Hospital (Oak Valley), as well as the following Modesto hospitals: Doctors' Medical Center, Memorial Medical Center and Central Valley Specialty Hospital (also known as Modesto Rehab Hospital/Central California Rehab Hospital/Kindred Hospital). Over the years, Dr. Olson has served in various professional capacities at these hospitals, including as Oak Valley's Chief of Staff and member of the Medical Executive Committee, as Chair of the Department of Medicine, and as Chair and Medical Director of the Infection Control Committee. Dr. Olson has participated in the Board's Expert Reviewer Program since 2005, and has performed 10 to 20 such reviews.

34. Dr. Olson's Expert Report: In his August 11, 2017 expert report, Dr. Olson provided an overview of respondent's medical records for SF during his 45 outpatient treatment visits between April 30, 2012 and May 30, 2014. During this treatment period, SF

[8] In this letter, Dr. Olson was also asked to review and evaluate respondent's care and treatment of DF.

received 17 prescriptions for Norco 10/325; eight prescriptions for Hydromorphone; four prescriptions for Morphine SR; two prescriptions for OxyContin; two prescriptions for Oxycodone; two prescriptions for Percocet; and six prescriptions for Butrans patches. Patient SF had severe respiratory insufficiency, hypertension and prostate hypertrophy. He was on multiple medications for these problems.

Dr. Olson noted that the progress notes of only 17 of the 45 visits mention pain or pain control. He found it very difficult to identify the source of SF's pain that was being treated by respondent. Occasionally, it seemed that SF had headaches, but most of his visits were for management of his breathing problems. In addition, Dr. Olson could not find any evaluations of the magnitude of SF's pain, or of the effectiveness of the various regimens that were being used. Many of his office visits with respondent were for: "f/u," which he assumed meant "follow up." On July 23, 2013, respondent conducted a Comprehensive Internal Medicine Evaluation, in which he noted that SF had shortness of breath and fatigue, but made no mention of problems with pain. On May 30, 2014, following two years of treatment, respondent diagnosed SF with Drug-Seeking Behaviors and discharged SF from his practice.

The medical records reflect that SF had at least two hospitalizations and several emergency room (ER) visits during his treatment by respondent. SF was seen in the ER on November 11, 2012, with shortness of breath that was not accompanied by any complaints of pain. On October 9, 2013, SF had a neurological evaluation with Dr. Tate who mentioned headaches, but did not address their magnitude or management and did not otherwise mention pain. On February 5, 2014, SF was admitted to Banner Lassen Medical Center (Banner) with COPD exacerbation, but there was no mention of pain or headaches.

In considering whether respondent complied with the standard of care for prescribing controlled substances to SF, Dr. Olson relied on the Board's 2007 Guidelines which were in effect during respondent's treatment of SF. While physicians can deviate from the standard of care set forth in these Guidelines, they must explain and document why that deviation was necessary.

35. Initial Medical History and Physical Examination: The standard of care requires a medical history and physical examination which includes an assessment of the patient's pain, including physical and psychological status and function; substance abuse history; history of prior pain treatments and assessment of any other underlying or co-existing conditions. Dr. Olson also noted that the history and physical should include documentation of recognized medical indications for the use of controlled substances such as opiates for pain control.

36. In his initial visit with SF on April 30, 2012, respondent documented that SF had a past medical history of asthma, COPD, HTN, pulmonary nodules and brain tumors. Dr. Olson found that respondent documented a history and physical examination, but failed to mention SF's pain. Respondent documented that SF was on Norco and morphine, but did not document the character, frequency and site of SF's pain, and he did not document the

success of previous interventions or his rationale for continuing SF on narcotics. For these reasons, Dr. Olson concluded that respondent had engaged in an extreme departure from the standard of care in his initial history and physical examination of SF.

37. Treatment Plan and Objectives: In discussing respondent's subsequent treatments of SF, Dr. Olson noted that the standard of care requires that the medical records contain a treatment plan with stated objectives that may include relief of pain, improved physical or psychological function, or ability to perform certain tasks or activities of daily living (ADLs). The record should also include any plans for further diagnostic evaluations and treatments such as a rehabilitation program. Based on his review of these records, Dr. Olson concluded that respondent repeatedly failed to record a treatment plan for SF or to describe the objectives of SF's treatment over the following 25 months. In his opinion, by failing to develop and record a treatment plan, respondent engaged in repeated simple departures from the standard of care.

38. Periodic Review: The standard of care requires that medical records reflect that the physician is periodically reviewing the patient's course of pain treatment and making appropriate modifications in treatment based upon the patient's progress or lack of progress. In Dr. Olson's review of the 339 pages of medical records, there was no documentation to demonstrate that respondent ever performed a periodic review of SF's pain treatment, despite his prescription of multiple combinations of narcotics over the treatment period. In his opinion, this constituted repeated simple departures from the standard of care, based upon respondent's failure to perform periodic reviews of SF's pain, treatment and status.

39. Medical Records: The standard of care requires that a physician maintain accurate and complete medical records which demonstrate a history and examination along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation. It also requires documentation that the physician discussed the risks and benefits of the use of controlled substances along with other treatment modalities with the patient.[9]

Dr. Olson observed that respondent's medical records for SF's treatment visits were typically one or two lines in length and were "fundamentally illegible." There was "no measure of subjection [*sic*] complaints" and many of the visits have a minimal record of a physical exam. In Dr. Olson's opinion, there were repeated simple departures from the standard of care in respondent's maintenance of SF's medical records "which are nearly illegible and quite cursory and failed to document standard guidelines in the use of controlled substances for patients with chronic pain conditions."

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[9] Dr. Olson determined there was no departure from the standard of care for failing to obtain SF's written informed consent before prescribing controlled substances because it is recommended, but not required, by the Guidelines, and the standard of care in the community varies on whether written or verbal consent is required. Dr. Olson found no deviation from the standard of care that requires a physician consider obtaining additional evaluations and consultations, noting that respondent sought consultation from Dr. Tate.

40. In summary, Dr. Olson opined that "taken altogether, the management of patient [SF] with opiate medications represents an extreme departure from the standard of care as outlined above." Based upon his expert report, Dr. Olson concluded that respondent had engaged in two extreme departures from the standard of care (initial visit and totality of treatment) and multiple simple departures from the standard of care.

41. Dr. Olson's Testimony: In treating a patient with narcotic medications for chronic pain, Dr. Olson emphasized the need to document and to describe and characterize the quality, duration and source of that pain. There were no pain contracts or pain assessment forms in the medical records he reviewed. Respondent's progress notes only occasionally referenced SF's pain without elaboration. In his initial progress note, there was no direct mention of the source or type of SF's pain; however, respondent indicated SF had a decreased range of motion in "M.S." [musculo- skeletal], which might have been associated with back pain. Subsequent progress notes either did not mention SF's pain or indicated SF was in no apparent distress ("INAD"). In the July 20, 2012 progress note, SF's pain was first indirectly mentioned when respondent documented that he prescribed controlled substance medications in the assessment/plan. On August 27, 2012, respondent's plan indicated that SF had multiple brain lesions and documented "pain control" for the first time. This was also documented as SF's chief complaint on September 7, 2012. While mentioning pain control, however, these progress notes did not provide any further detail or assessment as required by the standard of care. In August 2013, respondent indicated SF's chief complaint was "F/O pain control" and he documented the history of present illness as increased headaches. Respondent's plan was to add Percocet. Dr. Olson noted there is an assumption that Percocet is used to treat SF's headaches, but the progress note does not mention anything else about pain. If SF was experiencing an increase of pain, the progress note should have explained what that was and why and how it was being treated.

42. In Dr. Olson's opinion, it is not possible to extrapolate an explanation of the source of SF's pain and/or a reason for his treatment with pain medications from respondent's progress notes indicating SF had cerebral tumors. This is because some brain tumors cause pain and some do not. Similarly, the documentation of pulmonary nodules does not provide an explanation for SF's pain. While it is possible such nodules can cause pain, this is infrequent and the condition is more typically associated with shortness of breath. Dr. Olson noted that brain tumors were not found on CT scan and that SF's July 18, 2012 chest x-ray report indicated no evidence of acute pulmonary disease and did not mention pain.

43. On multiple visits, respondent prescribed narcotics to SF, but did not document doing so in the treatment plan in the chart. This was first seen on the initial visit, when respondent prescribed Norco 10/325. While SF was already on Norco at the time of this visit, that fact alone did not constitute an appropriate justification for continuing treatment with Norco. Respondent did not document anything about SF's pain (source, quality, duration), what the medication was previously used for or how effective it was. New prescriptions were written when the quantity of previous prescriptions indicated that SF should still have medications left, increasing the risk of drug diversion. For example,

respondent prescribed 180 Norco on the initial visit, and repeated that prescription five days later at the May 4, 2012 visit. This new prescription was not documented in the chart.

During treatment, respondent added other controlled substances to SF's regimen, including OxyContin, oxycodone and hydromorphone, without an explanation or treatment plan for the combination of drugs. On May 4, 2012, morphine sulfate ER was prescribed to SF without documented rationale. Other significant activity included a decrease in Norco in late 2012, when Butrans patches were prescribed. In early January 2013, Percocet was added while SF continued to take Norco. There was no explanation of which of these are more effective for breakthrough pain or whether they were used together. Norco was discontinued without explanation in late January 2013, and the Butrans patch was discontinued in late January by SF's insurance. Dr. Olson testified that, in a treatment plan to treat chronic pain with controlled substances, medications and changes in medication and their effects on the patient should be documented and explained in the progress note.

44. Dr. Olson was able to decipher some of the acronyms respondent used in his medical records. For example, he assumed that the notation "All S.E.D. with Patient" meant "all side effects discussed." In his opinion, this notation does not meet the standard of care for performing and documenting a history, physical examination and treatment plan for chronic pain. The phrase provides no analysis of the cause/s of pain, the levels of pain, the objectives of pain treatment, or the effect of past pain treatments on pain relief and ability to function (ADLs). It would not encompass a discussion of pain relief, which is a therapeutic effect rather than a side effect of the medication. It would not provide the patient's subjective complaints of an increase in pain, because this is a symptom or a chief complaint and not a side effect. The phrase "All S.E.D." would encompass recognized side effects of narcotics such as nausea, constipation, respiratory depression, or decrease in consciousness.

45. Dr. Olson was asked whether it is possible to use a copy of a written prescription placed in the chart to document treatment. He agreed that another doctor would be more easily able to follow the patient's treatment if the copy of the prescriptions were posted in the correct order in the chart. However, the prescriptions themselves do not provide an assessment of the patient's source of pain, level of pain or the effectiveness of treatment on ADLs, for example. They simply show what medications the patient is receiving. Assuming this was respondent's practice, it did not change Dr. Olson's opinions.

46. Dr. Olson noted an absence of periodic review of SF's pain management treatment. For example, in July 2012, approximately three months after SF's initial visit, respondent made no notations about how SF was progressing with his pain treatment. There was no way to tell if SF was functional or having improvement in his daily life, what his level of pain was following this course of treatment and how he was functioning on the combination of narcotics respondent had prescribed. This was particularly important because most of the notes indicate that Norco was a PRN ("as needed") medication and it would be important for respondent to have feedback about its frequency and effect. There was no documentation in the chart that respondent had discussed the importance of using medications as scheduled after SF had received an early medication refill.

On January 27, 2014, respondent documented "opiate seeking behavior" on SF's chart without clear explanation. Dr. Olson noted that, despite this documentation, respondent did not conduct a periodic review to reassess exactly what narcotics SF was using and to discuss a plan to control or decrease the amount of narcotics SF was taking. In February 2014, SF appeared with a chief complaint of breathing problems. Respondent's assessment was "cough-breathing treatment," his plan was "cough/pain control" and he prescribed hydromorphone (Dilaudid). In Dr. Olson's experience, Dilaudid is not frequently used for cough and respondent never documented that SF had episodes of syncope. He noted that both Norco and Dilaudid can cause respiratory suppression. On April 1, 2014, respondent prescribed the benzodiazepine Xanax to SF, in addition to his opioid medications for chronic headaches and chronic non-radiating pain. While this progress note provided a much better description of SF's pain than did prior notes, respondent's prescription for Xanax was not documented. When using a powerful narcotic to address breathing problems and cough, it is important to have a clear description of the patient's pain and past history.

47. Respondent's last treatment note for SF was dated May 30, 2014. It indicated his chief complaint was "drug seeking behavior." Under Plan, respondent wrote that SF had asked two people who worked at his office for drugs (one for Norco; the other for her husband's pain medications). Respondent also wrote that, on May 21, 2014, SF left a voicemail on his secure line in which SF attempted to blackmail respondent about whether he was providing SF drugs and if respondent had asked SF to kill Dr. H. Respondent placed a hand written notation on the side of his note for this visit which read: "nice try Honky." Under his signature, respondent included a notation that SF filled his Norco 10/325 prescription for 180 tablets on May 22, 2014, and again for 180 tablets on June 18, 2014, after his dismissal from care. Dr. Olson agreed it was appropriate to discharge SF at this time.

48. Dr. Olson recognized that tachyphylaxis can be one of the side effects of treating patients with opiate medications. Tachyphylaxis occurs when a patient has been treated with a particular drug for pain control over time with diminishing effects. Dr. Olson initially explained there are only two ways to treat tachyphylaxis: the physician can either escalate the patient's dose, or can take the patient off the medication for a "drug holiday." He noted that most patients would rather have their dosage increased to regain the same pain-killing effect than to take a drug holiday.

Dr. Olson acknowledged that an abrupt cessation of opiates typically used by a chronic pain patient could cause withdrawal symptoms. He agreed that a Butrans patch could possibly be used to address the effects of withdrawal or detox, and that another way to prevent tachyphylaxis is to use a different short-term or long-term medication to see if it works better. Such medication change would also be appropriate if an insurance company changed its formulary to discontinue an existing medication.[10] Dr. Olson noted that the

[10] On January 8, 2013 SF's insurance indicated it would no longer authorize the use of Butrans which was not in its formulary. SF was discontinued from Butrans after January 2014.

condition of tachyphylaxis would typically be reflected in the chart by the patient's subjective complaints of increased pain while on the same medications. Respondent never used the word "tachyphylaxis" in SF's progress notes and he never described subjective complaints by SF that would indicate he was experiencing this condition.

49. Dr. Olson agreed with respondent that almost any of his progress notes for SF "could have been better documented." While respondent's handwritten progress notes were "adequately legible," his level of documentation "left a lot to the imagination" and necessary information was missing. Consistent with the well-established rule that "if it is not on paper, it did not happen," the standard of care requires appropriate documentation. The purpose of this requirement is to ensure the treating physician can remember and reconstruct the thought process underlying treatment. It is not appropriate simply to rely on memory. Adequate documentation is also essential so that other physicians and/or medical facilities have sufficient information about the patient's history and treatment to provide appropriate medical services should the need arise. In addition, most insurance companies require medical records to justify treatment. Dr. Olson agreed with respondent that it is appropriate for the physician to focus on a patient in crisis; however, it is absolutely incumbent on the physician to document the care delivered after any emergency.

50. On cross-examination, Dr. Olson testified he had not seen SF's consumer complaint. He did read the redacted draft Investigative Report which contained a statement from another physician expressing concerns about respondent's lack of medical knowledge. Dr. Olson stated he would not allow hearsay in that report to affect his opinions. After reading the report, he had no opinion about respondent's character or personality. He formulated his opinions based on what was in the medical records and had no opinion about respondent's conduct outside of what is contained in those records.

51. Dr. Olson testified that, with the exception of addressing the elements necessary to treat SF for chronic pain, respondent's initial physical examination of SF was "reasonably complete." He also indicated that, except as to pain treatment, respondent performed a "very adequate" examination of SF on August 27, 2012, when he presented with shortness of breath and required nebulizer treatments.

52. The parties stipulated that, during his treatment by respondent, SF's total daily Morphine Equivalent Dosing (MED) was reduced from 120 MED to 76 MED per day.

53. Dr. Olson testified he was familiar with what is commonly referred to as the "holy trinity" of drugs: e.g., a combination of muscle relaxants, benzodiazepines and opioids that has a very high abuse potential. There was no indication in SF's medical records that respondent prescribed this high risk combination of drugs to SF at any time during his treatment.

54. Dr. Olson indicated that the opinions expressed in his testimony were consistent with those set forth in his expert report. Based on the questions posed to him by

respondent, Dr. Olson's opinions about respondent's deviations from the standard of care were unchanged.

II. ALLEGED FAILURE TO PARTICIPATE IN BOARD INTERVIEW

55. Testimony of Investigator Vanderveen: During a quality of care complaint investigation, it is standard practice to conduct a subject interview when the investigator believes there is sufficient information about the complaint and the medical consultant is available. The purpose of the interview is to allow the licensee to discuss his or her care and treatment of the patient and provide a rationale for the treatment that may not have been documented. Such interviews may alleviate the Board's concerns and result in the resolution of the complaint. Investigator Vanderveen has done hundreds of such investigations in her career. Typically, her role is to schedule the interview with the licensee and ask introductory questions. The medical consultant asks most of the questions on substantive medical matters and the DAG ensures that legal matters are addressed.

On May 15, 2017, Investigator Vanderveen stopped at respondent's Susanville office and personally gave him the CD she had made of DF's medical records. Respondent told her he had been doing some locum tenens work in Santa Barbara and had just returned to Susanville. They had a very cordial conversation and respondent did not express any concerns about SF's medical records which she had returned to him the previous summer. They talked briefly about scheduling an interview to discuss respondent's care and treatment of SF and DF. She later called and arranged for an interview to be conducted on June 20, 2017, in Sacramento.

56. On June 13, 2017, Investigator Vanderveen received a message from Mr. King as respondent's attorney. Due to his conflict, the location of the interview was changed to Mr. King's Susanville office. To accommodate this change, Investigator Vanderveen and Mr. King agreed that she would be present, but that both the medical consultant and the DAG would appear by telephone, and she generally advised Mr. King about the purpose of the interview. She did not recall whether she had told respondent who would be present at the interview; however, it is her general practice to tell licensees who will be at their interview. On June 15, 2017, Mr. King sent a letter to Investigator Vanderveen confirming he would represent respondent in the currently pending "hearing" on June 20, 2017.

57. On June 20, 2017, Investigator Vanderveen went to Mr. King's office for their 11:00 a.m. interview. She had her firearm with her; however, it was concealed in her purse. On arrival, she provided Mr. King with CD copies of DF's and SF's medical records, which his secretary downloaded into their system. Respondent arrived and met privately with Mr. King for 30 minutes while she waited in the reception area. Investigator Vanderveen had no idea that respondent was unwilling to engage in the interview. At 11:00, Investigator Vanderveen was invited into the room. At the time, respondent was laughing and seemingly happy. They exchanged cordial words and sympathy over the death of a pet dog. She then called medical consultant Dr. Mitchell and DAG Gatschet at the Sacramento field office.

Shortly after the interview began, respondent became increasingly agitated. His face had an angry expression and he was standing, sitting and moving his arms. Respondent finally put on his coat and left. Investigator Vanderveen did not hear Mr. King tell respondent he could leave and this alleged statement by Mr. King was not audible on the audiotape and did not appear in the transcript of this interview. From her observation, there was no reason respondent could not have participated in the interview. Because he left, there was no chance to discuss his care of the patients.

58. Investigator Vanderveen clarified that she opened the investigation against respondent as both a criminal investigation and an administrative investigation for quality of care issues. She initially deferred work on the administrative investigation and focused on the criminal investigation. At the time of the June 20, 2017 interview, the criminal investigation had been closed as unsubstantiated and it had "absolutely closed" as of SF's death because he was the only witness to the alleged offenses. The Board's investigation into respondent as a licensee at the June 20, 2017 interview was solely an administrative one to discuss his quality of care in treating both SF and DF.

59. On June 26, 2017, Investigator Vanderveen sent a letter to respondent indicating that, during the June 20, 2017, interview: "you stated that you did not trust me, nor did you trust the people that were on the phone. You also made claims that the investigation was a criminal investigation and you proceeded to take the Fifth Amendment Privilege against self-incrimination when asked where you went to medical school. You claimed we did not provide written notice of the charges that were being investigated, nor an explanation of why you were present for an interview. You then left the interview location."

Investigator Vanderveen advised respondent that, under Business and Professions Code section 2225 subdivision (a), he was not entitled to discovery prior to the filing of an accusation and that repeated failure to comply with the Board's request to attend an interview is grounds for disciplinary action. She indicated a desire to set up a second voluntary interview with him on July 14, 2017, and informed respondent that he could choose to either personally attend the interview in Sacramento, or have the interview in Susanville with the understanding that the medical consultant and the DAG would again appear by teleconference. Respondent was asked to inform her in writing within 10 days whether he intended to come for an interview and at which location, and he was advised that if he chose not to voluntarily participate in an interview on that date, the Board would determine whether it should use a subpoena to compel his attendance.

This letter was sent by certified mail to both Mr. King and to respondent at his Susanville office address. The certified mail letter sent to respondent's office address was returned unopened on July 3, 2017, with a hand written notation: "Refused." The certified letter to Mr. King was signed for on June 28, 2017, and was faxed to his office that date with a transmission verification report indicating delivery. Investigator Vanderveen indicated it was standard procedure to serve such letters on both the attorney and on the physician whose license "is on the line."

There was no response to this letter within the 10 days to confirm the interview from either respondent or Mr. King. On approximately July 10, 2017, Investigator Vanderveen learned that an arson fire had occurred in early July at the complex where Mr. King's office was located. She spoke with Mr. King's receptionist and learned that all their computers and files had been saved but that they had to move downstairs. She understood that the office was "up and running" at the end of the first week in July.

60. On July 13, 2017, the Department of Consumer Affairs issued an investigational subpoena to respondent which ordered him to appear and testify before Investigator Vanderveen at the Susanville Department of Motor Vehicles (DMV) on August 15, 2017, at 11:30 a.m. This subpoena was served by personal delivery to Mr. King's law office on July 17, 2017.

61. On July 18, 2017, Investigator Vanderveen called respondent's office as a courtesy to him, because the deadline to respond to her letter had passed. That same day, Mr. King sent her a letter acknowledging receipt of her June 26, 2017 letter to respondent, in which he indicated that "a response was delayed due to a fire at my office." Mr. King indicated that Investigator Vanderveen had engaged in "ex parte communications" with his client. He specifically advised that she did not have his permission to contact respondent and instructed her not to contact him again regarding this matter. Mr. King expressed "our belief" that the "true reasons for this investigation and your actions in pursuing this matter have been unethical and border on the fraud." In particular, Mr. King requested an explanation of the purpose of the investigation and wrote that, absent an ethical and transparent investigation, they would contest the matter to the fullest. There was no response on the request for an interview. Investigator Vanderveen received this letter on July 24, 2017, after the date for the second voluntary interview.

62. Following the service of the subpoena, Investigator Vanderveen heard nothing further from either respondent or Mr. King about the August 15, 2017 subpoena/interview date. Neither respondent nor Mr. King made any effort to raise any concerns about the date or to make arrangements for a different date. If she had been contacted after the issuance of the subpoena, Investigator Vanderveen would have worked to set a more beneficial date for the interview. She noted that is often done and, because she was aware of the fire, she could have changed the date.

63. On August 14, 2017, Mr. King sent a letter to DAG Gatschet advising him that respondent was unable to attend the August 15, 2017 interview because he was scheduled to take the ABIM Internal Medicine Certification Examination on August 16, 2017. He indicated that "submitting to a potentially stressful, contentious interview the day before this important test is likely to negatively affect [respondent's] performance." Mr. King indicated he had left a voicemail at Mr. Gatschet's office at 5 p.m. on Friday, August 11, 2017, and explained that he had suffered a "devastating office fire of near-total loss." Mr. King requested that the interview be rescheduled and indicated he would accept service for respondent. He also provided an ABIM Appointment Confirmation letter confirming respondent's examination date at 8:00 a.m. on August 16, 2017. Investigator Vanderveen

was apprised of this letter that day while driving to Susanville and canceled the interview. She signed her Investigative Report on August 15, 2017, and the Accusation was signed on September 5, 2017.

Respondent's Evidence[11]

64. Respondent's Testimony: Respondent received his Bachelor of Science from the University of San Francisco, where he majored in biology (1980). He attended and obtained his medical degree from Howard University College of Medicine in Washington, D.C. (1990-1996). Respondent then completed an internship in "preliminary medicine" and a residency in internal medicine at Howard University Hospital (1996-1999). In May 1997, he received the Intern of the Year award from Howard based on his work in the medical intensive care unit. He also received awards in bioethics.

Following his admission to practice in California, respondent worked at the Brotman Medical Center in Culver City. In November 2002, respondent opened Marshall Healthcare Systems Inc., a solo practice in internal medicine located in Susanville. He held privileges at Banner Lassen Medical Center (Banner) from November 2002 through November 2004. Respondent practiced as Marshall Healthcare Systems until October 10, 2016. Respondent is not board certified. From November 27, 2017 to April 15, 2018, respondent practiced at the Santa Maria Health Clinic, run by the Santa Barbara Department of Public Health. Since then, he has occasionally worked for Medical Doctors Associates as a locum tenens.

65. Respondent comes from a highly educated family that includes generations of physicians and professionals. He is a cousin of the late Hon. Thurgood Marshall. Respondent reports he has never had a lawsuit or complaint filed against him and he has never lost a patient in his career. In November 2004, he relinquished his privileges at Banner due to racial discrimination, which included being the focus of racial epithets from the two physicians referenced in SF's complaint. Since that time, respondent has pursued several discrimination lawsuits against Banner and these physicians and has written letters requesting their investigation.

66. Respondent testified that he has never over-prescribed opiates to patients and believes a prescription pad is very dangerous. The vast majority of pain patients respondent treated were already on pain medications when he accepted them into care. Respondent's narcotics prescribing philosophy grew out of his training and experience at Howard treating patients with sickle cell anemia, which he characterized as "the most painful chronic condition there is." In cases involving tachyphylaxis, respondent objects to the practice of increasing the narcotic dose, because this simply increases the patient's tolerance and drug-seeking behavior. Instead, he focuses on taking the patient off the medication to which they

[11] Based on the expert exclusion order (Finding 10), complainant made a standing objection to any expert opinions offered by respondent under Business and Professions Code section 2334 and *In the Matter of the Accusation Against Jill Meoni, M.D.*, Case No. 10-2007-185857.

have become tolerant and rotating in a different medication, often in an extended release formulation. He is also very careful about the amount of acetaminophen in prescribed medications and their potential negative effects on the liver.

67. Respondent explained that, as part of his practice in Susanville, he wrote cannabis recommendations for patients he had physically examined. He noted that Susanville has a large population of lower income residents. He charged $200 for an initial cannabis recommendation and $150 for renewal, and provided free healthcare to anyone who received a cannabis recommendation from him. He found this to be a great tool to get many patients with diabetes and other health problems to come in and it was also beneficial to his practice. He believes he was the first doctor in Lassen County to successfully treat hepatitis C. He also reported trying to provide Investigator Vanderveen with information about other physicians involved in on-line cannabis script mills.

68. When SF first came into respondent's care, he was on Norco. Respondent called the pharmacy to verify that SF had been receiving Norco and he had SF fill out a pain contract and a pain assessment, using a 1-to-10 scale. Respondent recognized that these documents are missing from SF's medical records, but clarified he is not blaming anyone for this. He treated SF for multiple brain lesions, pulmonary nodules and chronic pain. He prescribed a combination of Norco, oxycodone, Percocet, MS and Butrans patches, and he added Xanax in 2014. Over time, respondent worked SF up by referring him for chest x-rays, a CT brain scan and for neurosurgical evaluation. SF's July 18, 2012 chest x-ray showed no evidence of acute pulmonary disease, although there was a history of COPD. This was the reason he referred SF to Dr. Tate for a neurosurgical evaluation. Respondent agreed that the October 24, 2012 CT scan did not show any masses in SF's brain or neck and that only an indeterminate 3 mm lesion in the right lobe of the thyroid gland was seen. Although respondent considered this as evidence of potential malingering by SF, he did not document this suspicion in his progress notes or make any change in his treatment plan for pain management. He also acknowledged that he occasionally continued to document multiple brain lesions in SF's progress notes after the CT scan. This was later changed to possible brain lesions, chronic headaches, or C.N.S. lesions.

69. Respondent testified that he tried to rotate SF's pain medications and he wrote cannabis recommendations for SF in hopes of bringing his narcotics use down. As is his standard practice, respondent discussed the side effects of all the medications he prescribed to SF. This practice was reflected in his "All S.E.D." chart notation. Respondent acknowledged that his documentation in SF's medical records was poor and that it would be difficult for anyone else to follow his treatment based on these charts. He received low reimbursement from Medicare, had difficulty retaining staff and focused on patient care rather than documentation.

Respondent acknowledged that SF's pain level was not recorded in his progress notes. He recalled that SF often had acute pain (9/10) in his head from brain lesions; he also had chronic pain (5/6). Respondent could tell whether a particular medication was working for SF by looking at the prescription copy in the chart near the previous progress note. If the

prescription had been changed, it meant the previous medication was not working. Respondent explained his belief that the medical record was for his own use, and noted he has a very good memory. There were two incidents in which respondent called an ambulance for SF due to episodes of syncope. In these instances, he either wrote detailed notes and gave them to the paramedics or orally presented SF's situation to them. Respondent later prescribed Dilaudid to SF in an effort to reduce his cough and risk of syncope. After SF's insurer refused to pay for his Butrans patch, respondent switched him to MS Contin, a cheaper extended release opioid. He agreed that, on occasion, he gave SF a refill for Norco within a short time of the previous prescription without any explanation in the progress note. Respondent emphasized that SF suffered no harm in the two years he treated him and that SF was on a significantly lower dose of narcotics on discharge from his care: specifically, from 120 to 76 MED per day. He also noted that not all of SF's treatment visits involved pain control because he was also being closely monitored for other conditions.

70. In addition to his treatment, respondent also conducted a disability evaluation for SF, who had a workers' compensation claim against his former employer for toxic chemical exposure. After a year of treatment, respondent began to realize that SF was malingering and that his nature was more like a "con artist." While the MRI and CT scans did not show brain lesions or pulmonary lesions, SF did have COPD. Respondent later began to believe SF was drug-seeking and possibly diverting. This was one reason respondent visited SF at his home on a drop-in basis, as he did with other patients from time to time. Respondent estimated that over a two-year period he had probably visited SF at his house no more than 20 times. He initially noticed multiple people rummaging around SF's home, which raised drug-seeking concerns in his mind. He also noted that DF smoked in the home even though SF was on oxygen. After a friend came to respondent and told him SF wanted to sell him marijuana, methamphetamines and pills, respondent knew he had a problem. He began to wean down SF's prescriptions and he eventually discharged him after SF asked both his receptionist and his janitor for pain medications.

71. Respondent denied having been SF's friend as well as his doctor. When SF came to his care from the Indian Rancheria Clinic, respondent and his patients were fighting Banner about abusive treatment. He had nothing in common with SF except for obtaining information about how his patients were treated at the Banner. After SF told him that his mother (or aunt) in Oregon was a civil rights activist and could help, respondent dropped by SF's home occasionally to talk.

He described SF as having a "prison mentality." SF often stopped by his office to tell respondent "what was going on." Respondent eventually believed that SF was "sent by somebody" to speak to him and he grew concerned SF was trying "to set him up." In respondent's mind, SF's complaint about him to the Board was an act of retaliation for discharging him from care for drug-seeking behavior. Respondent eventually became worried about his personal safety after he learned that SF claimed he was working for the police.

72. Respondent recalled that he was first contacted by Investigator Vanderveen approximately July 2016. During a lengthy phone conversation, they discussed SF's allegations of a "hit for hire" and respondent told her he had nothing to hide. Investigator Vanderveen called him the following week and asked for SF's medical records. Respondent told her he was in the process of breaking down his office and would send her the original documents. Respondent complied with the request to provide DF's medical records. He had several other conversations with Investigator Vanderveen in September 2016, about other patients he thought were seeking narcotics and she helped him. By early 2017, respondent "honestly believed" that he was no longer under investigation by the Board.

73. Respondent received the package sent by Investigator Vanderveen requesting SF's medical records and acknowledged that the signature on the certified return receipt card was "more than likely his." The Authorization for Release signed by SF was not in the package. It only contained the Certification of Records, which he filled out, signed and returned with SF's original records. When he provided these medical records, respondent understood this request to be "within the jurisdiction of the Board." He did not think he needed an Authorization for Release from SF and sent the records to her by UPS in good faith compliance with the Board. He was never threatened or coerced by Investigator Vanderveen into providing SF's records, but he "cooperates with police and law enforcement." This was why he did not expressly object to releasing SF's medical records to Inspector Vanderveen. To the best of his knowledge, he never saw SF's Authorization for Release until he received discovery from DAG Gatschet in December 2017.

74. Respondent did some research and found he should have but did not receive SF's Authorization for Release. He then contacted attorney King, who he retained on June 15, 2017. During this proceeding, respondent retained a different attorney who assisted him in some aspects of this case, particularly regarding his efforts to argue that DF was not SF's wife and cannot retroactively authorize the release of his medical records. That attorney's office provided him with documents which respondent believes demonstrate that DF was not SF's wife.[12]

75. On June 13, 2017, Investigator Vanderveen called and asked him to participate in an interview. Respondent had no idea he was still under investigation by the Board. When he went to the interview on June 20, 2017, respondent was concerned as Investigator Vanderveen indicated it regarded patients DF and SF, who had previously accused him of an attempted "hit for hire" on two doctors. While she had told him a medical consultant would be on the telephone, she had never mentioned that the DAG would also be on the phone and Mr. King did not tell him this either. Respondent was startled and objected. He had been falsely accused before and believed that SF was working with the police. Respondent was

[12] Complainant's hearsay and foundation objections to respondent's Exhibits Q and R were sustained. Respondent was unable to establish the foundation for these documents, which were admitted only as administrative hearsay in support of his belief that DF is not SF's wife. Respondent's proposed Exhibit V, offered after the hearing, was excluded on the same basis.

concerned with determining the identity of the people on the telephone; it seemed very suspicious to him and he was concerned that SF, the FBI or DEA agents were in the room with the DAG. Even though Mr. Gatschet gave him his State Bar license number, respondent did not understand how anyone could be accurately identified by telephone. Respondent also explained that he saw the impression of a semi-automatic double action handgun in Investigator Vanderveen's purse. He knew she carried one because his "gun dog" had previously alerted to her purse when she visited his office. For these reason, respondent shut down the interview process with permission from his attorney.

76. After this interview, he and Mr. King received Investigator Vanderveen's June 26, 2017 letter to schedule a second interview. Respondent wanted to reschedule the interview in Sacramento and Mr. King would come and represent him. Mr. King was to write a letter to that effect; however, on July 2, 2017, a fire occurred in Mr. King's office. On July 13, 2017, respondent became aware of the fire. Mr. King showed him some "soaking wet and half burned papers" which were what was left of his file. The July 6, 2017 deadline for respondent to select his preferred location for the second interview passed. On July 13, 2017, the subpoena was faxed to Mr. King for the August 15, 2017 interview at the Susanville DMV. On July 18, 2017, Mr. King wrote to Investigator Vanderveen and advised her that all communication with respondent should go through him. Respondent explained that he was studying to take the ABIM examination, had just lost his dog, and felt he was being harassed. He was not aware that they had missed the deadline because he did not meet with Mr. King again until August 14, 2017. He had attempted to contact Mr. King before this without success. At that meeting, Mr. King told respondent he had heard nothing from the Board or Investigator Vanderveen regarding the subpoena for the interview set the next day. On August 16, 2017, respondent took the ABIM examination in Reno, Nevada. Three weeks later, he was given a letter Mr. King had written about his inability to come to the interview on August 15, 2017. Respondent did not pass his ABIM examination and believes it was due to the stress of the investigation in this case.

When the accusation was served on September 5, 2017, respondent never knew about it. He talked to Mr. King on September 27, 2017, and was told he had heard nothing from the Board. On September 27, 2017, respondent went into his Susanville office and saw letters from three attorneys offering to represent him in his case before the Board. He then checked his licensee profile and saw that an accusation was posted. He was panicked and in shock. He talked to DAG Gatschet who told him a default had not been filed and "graciously" allowed him to file his notice of defense.

Respondent provided a copy of the October 1, 2017 voicemail to him from Mr. King to show that Mr. King gave him the wrong deadline to respond to the Accusation. On October 12, 2017, Mr. King filed a "Notice of Withdrawal as Attorney of Record" with the Board, effective immediately. In respondent's view, Mr. King's actions were significant because he had retained him to represent him so he could study without being hassled and Mr. King's failure to properly represent him and arrange a convenient time for an interview caused the Board to prematurely file the accusation. On November 11, 2017, respondent filed an "Attorney Complaint" against Mr. King with the State Bar.

77. Respondent has not lived in Susanville since October 25, 2016. His office officially closed on November 27, 2016, when he left for Santa Maria. He has still not changed his official address with the Board. Respondent was too busy and had to leave Susanville in the middle of the night or he "might not have stayed alive." Respondent confirmed his signature on his progress notes for SF and his certification of the records. He did question whether certain prescriptions actually contained his signature, noting that his office had been burglarized in the past and that there "may be another prescription pad out there."

78. On cross-examination, respondent testified that he wanted to participate in a fair interview on June 20, 2017. He took the Fifth Amendment in response to the question where he went to medical school because he did not have the fund of knowledge of an attorney. He agreed there was no interview about his treatment of SF on that date, that the Board has a right to be concerned about patient care and that physicians should cooperate. At the time, he did not know the DAG, was unable to verify his identity and was extremely concerned. Respondent acknowledged that the DAG was not in a conspiracy against him because, if he were, he would have pursued a default judgment when there was a late notice of defense.

79. Respondent acknowledged that he wrote "Refused" on the certified mail envelope corresponding to Investigator Vanderveen's June 26, 2017 letter. He had already received the noncertified letter and felt the certified letter was "harassment." Respondent was aware of the second voluntary interview date of July 14, 2017, but his attorney "was supposed to handle it," so he could continue to study for the exam. When asked if he could have called Investigator Vanderveen before that date, respondent testified that he could not do so because Mr. King had instructed him not to contact her.

80. Respondent clarified that Mr. King had faxed the subpoena for the August 15, 2017 interview to him two-to-three days after it had been served and told respondent he would see if it could be deferred until after the exam. On August 15, 2017, respondent drove to Reno. He testified that he had tried to call Mr. King at least five to nine times between July 20 and August 14, 2017, but was repeatedly told by the receptionist that Mr. King was "on vacation." Respondent never tried to call Investigator Vanderveen, the DAG or the Board when he could not reach his attorney.

81. Respondent denies suffering any mental impairment. He is not currently under the care of a mental health professional. When asked about his ability to comply with any terms that might be imposed in a probationary order, respondent testified that he was, "well trained in medical hierarchy" and would obey any orders. He would comply with the practice monitor if ordered to do so. He would have financial constraints about attending a clinical assessment program like PACE because he has not been able to work as a locum tenens since September 2017. While he did not use electronic medical records (EMR) in his Susanville practice, respondent used them when working as a locum tenens and testified he received a Tour of Duty award for medical record keeping in Santa Maria. He reported

having taken over 150 continuing medical education (CME) units; however, none have been for medical record keeping.

82. Testimony of Dr. Dhesi: Harry Mohan Singh Dhesi, D.D.S., testified as a character witness for respondent. He has known respondent since they were undergraduates at the University of San Francisco in 1975, when they lived in the same dormitory and took similar pre-professional science classes. After completing their undergraduate degrees, respondent and Dr. Dhesi lost contact until respondent completed his residency and returned to California. Since that time, Dr. Dhesi has spoken to respondent about three times a year and he visited respondent in Susanville approximate three times.

Dr. Dhesi testified that respondent is a hard-working doctor who is "committed to being a professional." This character trait was reflected in the fact that respondent was voted resident of the year at medical school. In Dr. Dhesi's opinion, the most important thing in respondent's life is being a good doctor. Respondent works very hard, is committed to his patients and tries to provide the best quality medical care for them.

Dr. Dhesi clarified that he does not practice in Susanville. He based his testimony about respondent's care and treatment of his patients on casual conversations he has had in the streets in Susanville during times he visited respondent. He described Susanville as a very small town and indicated that everyone knew he was a stranger and lived at respondent's residence during his visits. During conversations, these individuals would tell him that respondent was a good doctor and that they were very satisfied with his care. He estimated that he had spoken to approximately 12 different patients of respondent during each visit. Dr. Dhesi never reviewed SF's medical records.

Discussion

I. QUALITY OF CARE ISSUES

A. Respondent's motion to exclude SF's medical records, strike Dr. Olson's testimony, and dismiss the first three causes for discipline:

83. Article I, section 1 of the California Constitution guarantees certain inalienable rights. It provides that: "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy."

84. SF undeniably had a constitutional right to privacy in his medical records. It is well-established that, because constitutional rights are generally personal, one cannot assert a constitutional claim on behalf of others. (*People v. Hazelton* (1996) 14 Cal.4th 101, 109; cited with approval by *Lewis v. Superior Court* (2017) 3 Cal.5th 561, 570, *cert. denied* sub nom. *Lewis v. Superior Court of California, Los Angeles County* (2018) 138 S.Ct. 657 (*Lewis*).) In seeking to exclude SF's medical records, respondent is attempting to use SF's privacy rights to shield himself from possible disciplinary action. Thus, before respondent's

argument for dismissal can be addressed on the merits, it must be determined whether he has legal standing to assert SF's right to privacy. As discussed below, it is determined that respondent does not have standing to assert SF's privacy rights to his medical records and, alternatively, if respondent has standing, he did not establish that SF's privacy rights were violated.

85. The California Supreme Court recently addressed the standing issue. In *Lewis, supra*, the Board filed an accusation against a physician for issues related to the treatment of a patient who had complained about his care, as well as five additional patients who were identified after its investigator obtained a CURES report for the physician. Three of the patients thus identified then consented to release their medical records to the Board. The investigator obtained the medical records of the remaining two patients via administrative subpoenas. Prior to the administrative hearing, Lewis filed a motion to dismiss allegations pertaining to the five additional patients, arguing that the Board had violated his patients' privacy rights by obtaining the CURES reports without a warrant. The ALJ denied the dismissal motion and found that the Board's interest in obtaining the CURES reports in a highly regulated area outweighed the invasion of privacy. (*Id.* at 568.) The matter proceeded to hearing, which resulted in the revocation of Lewis' license and a probationary practice order. Lewis filed a petition for a writ of mandate to set aside the disciplinary decision because the Board's decision violated his patients' right to privacy. After both the trial and appellate courts denied relief, the Supreme Court granted review.

86. Before turning to the merits of the privacy arguments, the Court addressed the Board's contention that Lewis lacked standing to assert his patients' privacy rights. The Court explained (*supra* at 570) that:

> Although constitutional rights are "generally personal," . . . the United States Supreme Court has departed from this rule when the third-party right asserted by the litigant is "inextricably bound up with the activity the litigant wishes to pursue" and when some "genuine obstacle" prevents the absent party from asserting his or her own interest. (*Singleton v. Wulff* (1976) 428 U.S. 106, 114, 116 . . .) The Courts of Appeal have often permitted physicians to assert their patients' right to privacy under the California Constitution. (See *Medical Bd. of California v. Chiarottino* (2014) 225 Cal.App.4th 623, 630-631, fn. 3 (*Chiarottino*); *Whitney v. Montegut* (2014) 222 Cal.App.4th 906, 918–921 . . . (*Whitney*); *Wood v. Superior Court* (1985) 166 Cal.App.3d 1138, 1143-1145 . . . (*Wood*); *Board of Medical Quality Assurance v. Gherardini* (1979) 93 Cal.App.3d 669, 675 . . . (*Gherardini*).) These cases stand for the principle that "[w]here the constitutionally protected privacy interests of absent patients are coincident with the interests of the doctor, the doctor must be permitted to speak for them." (*Wood*, at p.1145. . . .)

In arguing that Lewis did not have standing, the Board relied on *Pating v. Board of Medical Quality Assurance* (1982) 130 Cal.App.3d 608, 621 (*Pating*), in which the Court of Appeal held that the physician did not have standing to object to the introduction of third-party medical records, in part, because the majority of the patients whose records were subpoenaed appeared at the administrative hearing and voluntarily consented to the introduction of their medical records. In rejecting the Board's argument and concluding that Lewis had standing, the Court noted that the patients at issue were "unable to assert their own rights because they were never given notice that the records were accessed," and that "[w]ithout notice, there was no way for them to know of the potential constitutional violation. "A physician has standing to assert his patients' rights where they may not otherwise be established." (Citing, *People v. Barksdale* (1972) 8 Cal. 3d 320, 333.) Thus, Lewis' interests were not at odds with his patients' interests. (*Lewis*, *supra*, at 570-571.)[13]

87. Significantly, the Court in *Lewis* referenced *Pating*'s suggestion that, "having allegedly victimized his patients, [the physician] should not be permitted standing to thus assert their privacy rights for his own protection." (*Ibid.*) The Court stated: "even assuming this rule applies in some contexts, this line of reasoning is inapplicable where, as here, Lewis is not alleged to have victimized all of the patients whose rights he seeks to assert."[14]

88. In *Pating*, *supra*, the Board filed an accusation alleging Pating engaged in acts of dishonesty and falsification of both hospital and office medical records in his treatment of 10 patients. At the administrative hearing, Pating moved to exclude these records on the grounds that they were improperly and illegally obtained by the Board in violation of both the physician-patient privilege and the patients' right to privacy. The administrative hearing was limited to the admissibility of these records. The Board had obtained the medical records by subpoena duces tecum, without first contacting any of the patients. At the hearing, eight of the 10 patients testified and waived the physician-patient privilege and right to privacy and agreed to the introduction of medical records. The ALJ denied Pating's motion to exclude the medical records of these eight patients and granted the motion without prejudice as to the other two patients. The trial court determined that the hospital charts were admissible, but that the Board had abused its discretion in refusing to exclude the office charts of all 10 patients.

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[13] The *Lewis* Court did not decide what effect if any, the subsequent consent of three of the patients had on the physician's standing because he would still be entitled to assert the rights of the nonconsenting patients.

[14] Addressing the merits of Lewis' constitutional claim, the Court held that the Board did not violate his patients' right to privacy because, even assuming the Board's actions constituted a serious intrusion on a legally protected privacy interest, its review of these records was justified by the state's dual interest in protecting the public from the unlawful use and diversion of a particularly dangerous class of prescription drugs and protecting patients from negligent or incompetent physicians." (*Lewis*, *supra* at 572.)

On appeal, as relevant to this case, the court noted that Pating's standing argument was based on his "cavalier assertion that he is protecting the third-party patient's privacy rights," while citing a case which only recognized a hospital's standing to assert the rights of absent nonconsenting patients.[15] The court rejected Pating's argument, and held that he did not have standing to assert the constitutional rights of the eight patients who had appeared and consented to the use of their medical records. As to the office records, the Court found reasonable the Board's argument that, "having allegedly victimized his patients, Pating should not be permitted standing to thus assert their privacy rights for his own protection." (*Pating*, *supra* at 620.)

89. The cases cited in *Lewis* recognized a physician's standing to raise the privacy rights of "absent patients," and involved situations in which the Board had issued administrative subpoenas either without notice to the patient or with notice and an express objection to release. The Court cited *Wood* specifically for the principle that a physician has standing in such cases where the privacy interests of the patients "are coincident with the interests of the doctor." (*Lewis*, *supra* at 570.)

90. The facts in this case are distinguishable from those presented in *Lewis*. Unlike the patients in that case, the investigation into respondent's treatment of SF was not initiated by subpoena for access to respondent's CURES records. Rather, SF voluntarily initiated contact with the Board when he filed his complaint against respondent. In that context, SF signed an Authorization for Release of his medical records that was attached to the complaint in which he clearly identified respondent and his medical office. SF's interests in complaining to the Board about respondent are not coincident with respondent's efforts to keep the Board from examining the care he provided to SF.

91. Respondent's citation to *Sehlmeyer* in his motion does not support the exclusion of SF's medical records. As noted by the court in *Whitney, supra*, at 916, the *Sehlmeyer* "case stands for the unremarkable proposition that a patient must be given advance notice of a subpoena of medical records under Code of Civil Procedure section 1985.3." As is clear from the evidence outlined above, and as further discussed below, this case never involved an administrative subpoena and the Release of Authorization provided to respondent was obtained based upon SF's consent.

92. When all the evidence in considered in this matter, it is apparent that respondent's interests in pursuing his dismissal motion are sharply at odds with those of SF, who filed a Consumer Complaint alleging facts against respondent that involved not only potential criminal charges, but also quality of care issues relating to his treatment.

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[15] *Pating* cited *Gherardini*, *supra*, at 669, in which the court held only that a hospital as a third-party custodian of privileged matter has standing to assert the statutory privilege of absent nonconsenting patients and to object to the vicarious exclusionary rule to admission of evidence obtained in violation of the patient's constitutional right of privacy. The court in *Pating* held that, "assuming, without deciding, that Pating had standing, there is no legal ground for his challenge to the administrative subpoenas. . . ."

Respondent's effort to cloak himself in SF's privacy rights is patently designed to keep the Board from addressing his treatment of SF. As such, it is at odds with and directly contradicts SF's intention as unequivocally expressed in his complaint. For these reasons, respondent does not have standing to raise SF's privacy rights.

93. Finally, even assuming he has standing, respondent did not establish that the Board violated SF's privacy rights. As explained in *Williams v. Superior Court* (2017) 3 Cal.5th 531, at 552: "The party asserting a privacy right must establish a legally protected privacy interest, an objectively reasonable expectation of privacy in the given circumstances, and a threatened intrusion that is serious" (Citing *Hill v. National Collegiate Athletic Assn.* (1994) 7 Cal.4th 1, 35-37). Respondent did not establish that SF had "an objectively reasonable expectation of privacy in the given circumstances." To the contrary, the evidence is clear and convincing that SF wanted the Board to have his medical records to facilitate its investigation of respondent and that he authorized the release of his medical records to the Board. The following factors were considered in reaching these conclusions. First, when SF signed and partially completed the Authorization for Release, it was an integral part of the four-page Consumer Complaint pamphlet. That pamphlet must be read and interpreted as a whole and, as such, SF's intention to have respondent release his medical records to the Board is clear. Second, Investigator Vanderveen's testimony regarding her communications with SF, his reasons for wanting the delay, and the fact that he never withdrew his authorization was credible and persuasive.[16] In this regard, it is noteworthy that SF continued to communicate with her, including by providing her his updated address and telephone information. This effort to keep the Board apprised of his whereabouts reinforces the conclusion that SF wanted Investigator Vanderveen to be able to contact him as she investigated his complaint. Third, the evidence supports a finding that DF was SF's wife and was treated as such by respondent until after the filing of the Accusation. While DF's communications with Inspector Veverka cannot be used as direct evidence, they corroborate the conclusion that SF intended to release his records to the Board.

For these reasons, respondent's motion to exclude SF's medical records, to strike Dr. Olson's testimony and to dismiss the first three causes for discipline is denied.

B. Expert Opinion Testimony

94. As the only expert witness in this case, Dr. Olson's testimony is persuasive absent unusual circumstances. As reflected in Finding 33, the evidence established that Dr. Olson was well qualified to address respondent's care and treatment of SF. It was also persuasively established that his opinions were untainted by the unsubstantiated prejudicial information that resulted in the exclusion of Exhibit 7. As part of his review, Dr. Olson was provided and reviewed the Draft Investigative Report (Exhibit 21). This report was admitted

[16] Contrary to respondent's assertion in his closing brief, the undersigned's exclusion of Exhibit 7 was not based upon, or accompanied by, a finding that Investigator Vanderveen's testimony was not credible. The reasons for the exclusion of that exhibit are set forth in Footnote 5, *ante*.

to allow an analysis of any potential bias from exposure to Exhibit 7. A review of this redacted report reveals that the information which resulted in the exclusion of Exhibit 7 was redacted from the copy provided to Dr. Olson for review. Finally, Dr. Olson's testimony that his opinions were based solely on his review of the medical records was persuasive and well-corroborated.

With two exceptions, Dr. Olson's opinions establish cause for discipline as outlined in the Accusation's first through third causes for discipline. First, during his testimony, Dr. Olson identified several treatment visits after SF's initial visit which he opined constituted extreme departures from the standard of care. Dr. Olson's reasons for finding extreme departures as to these visits were not substantially different from the reasons he had previously determined them to be examples of repeated simple departures from the standard of care. His testimony to this effect was contrary to the opinions expressed in his report, had not been disclosed to respondent as required by Business and Professions Code section 2334, and was an expansion of the allegations in the Accusation. Second, the Accusation only alleged a single extreme departure from the standard of care based on respondent's conduct of failing to perform and/or to document performing a complete history and physical before he began prescribing narcotics to SF in late April 2012. Dr. Olson's additional opinion that respondent's treatment as a whole constituted a distinct extreme departure from the standard of care was not alleged in the Accusation and complainant did not amend the Accusation to conform to proof. Consequently, no cause for discipline can be sustained based on these opinions.

95. When all the evidence is considered in light of the Accusation, based on Dr. Olson's report and testimony, it was established by clear and convincing evidence that respondent engaged in a single extreme departure from the standard of care on April 30, 2012, by failing to perform and/or to document performing a complete history and physical before he began prescribing narcotics to SF.

96. Dr. Olson's testimony further established, by clear and convincing evidence, that respondent engaged in repeated simple departures in his treatment of SF from April 30, 2012 through May 30, 2014, by: (a) failing to perform and/or document a complete medical history and physical regarding pain management; (b) failing to create and/or document creating a pain management treatment plan; and (c) failing to perform and/or document performing periodic reviews of SF's pain management therapy.

97. Finally, Dr. Olson's testimony established, by clear and convincing evidence, that respondent's medical records for SF from April 30, 2012 through May 30, 2014, did not document standard pain management guidelines, failed to document SF's pain and were cursory in nature.

II. COOPERATION WITH BOARD INTERVIEW

98. Respondent seeks dismissal of the fourth cause for discipline which alleges that he engaged in unprofessional conduct by failing to cooperate and participate with the

Board investigation process. As detailed above, he argued that his failure to cooperate and participate in the initial Board interview was due solely to his suspicion that he was still under criminal investigation and that the interview entailed more than a quality of care inquiry. In this regard, respondent suggested that there was an effort "to Al Capone him," by finding problems with his medical care when the criminal allegations could not be substantiated. He argued that, following that interview, he relied reasonably on an attorney who did not adequately represent him.

99. Regardless of the reasonableness of respondent's actions in terminating the June 20, 2017 interview, unprofessional conduct under Business and Professions Code section 2234, subdivision (h), cannot be established based on a single refusal to participate in an interview. This section requires a finding that the licensee engaged in a repeated failure to attend and participate in an interview by the Board in the absence of good cause.

Respondent's efforts to blame his refusal to cooperate and participate in an interview after the June 20, 2017 date on Mr. King are not persuasive. He received the uncertified copy of Investigator Vanderveen's June 26, 2017 letter. He was aware of the July 14, 2017 interview date, and wrote "Refused" on the certified copy of this letter. (Finding 79.) He was aware of the subpoena for the August 15, 2017 interview shortly after it was served on Mr. King. He failed to contact the Board or Investigator Vanderveen after repeatedly calling Mr. King's office and being told he was on vacation. (Finding 80.) While his participation in the ABIM would likely have constituted good cause to change the August 15, 2017 date, respondent made no efforts to inform the Board of this situation after learning that Mr. King was on vacation. In light of these admitted facts, respondent's reliance on Mr. King was not reasonable. When all the evidence is considered, respondent repeatedly failed to attend and participate in an interview with the Board after the June 20, 2017 failed interview. Regardless of the outcome of his State Bar complaint against Mr. King, respondent did not establish good cause for his repeated failure to attend and participate in a Board interview. Respondent's motion to dismiss the fourth cause for discipline is denied.

III. APPROPRIATE DISCIPLINE

100. It was established that respondent engaged in one extreme departure (gross negligence) and repeated simple departures (repeated negligent acts) from the standard of care in his treatment of a single patient over a two-year period, that his medical records were inadequate and that he repeatedly refused to participate in an interview with the Board without good cause. It was also established that, during his treatment of SF, respondent successfully cut SF's daily narcotic dosage from 120 to 76 MED. Dr. Olson acknowledged that, except for issues regarding SF's pain control assessment and management, respondent's physical examinations and care of SF were appropriate. Under these circumstances, the public can adequately be protected by conditions which include requiring respondent to obtain a practice monitor and to complete a prescribing course and a medical record keeping course.

101. Questions have been raised about respondent's behavior and stability during the investigation, the July 20, 2017 attempted interview, and the hearing. Throughout the hearing, respondent was highly engaged in his defense in a situation where he was opposed by a seasoned attorney in a matter directly affecting his licensure as a physician. Respondent's behavior was often characterized by interruptions, requests for breaks, and accusations challenging the honesty and integrity of the Board's witnesses. Respondent's behavior at other times was civil, courteous, and grateful. During the investigation, respondent frequently interacted cooperatively with Investigator Vanderveen. While seemingly unreasonable, respondent's behavior during the July 20, 2017 attempted interview can plausibly be attributed to his concern about being criminally "set up," based on his confusion about the dual nature of the investigations.

Complainant requests that a psychological evaluation be ordered; respondent objects to this request. When all the evidence is considered, it is not appropriate to order a psychological evaluation as a condition of probation. There was no allegation in the Accusation under Business and Professions Code section 822; there was no expert testimony addressing respondent's mental health; and the Board retains authority to require a mental health examination under Business and Professions Code section 820 as appropriate.

LEGAL CONCLUSIONS

1. The Board is responsible for enforcing disciplinary and criminal provisions of the Medical Practice Act, among other duties. (Bus. & Prof. Code, § 2004.) The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Disciplinary proceedings protect the public from incompetent practitioners by eliminating those individuals from the roster of state-licensed professionals. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) In exercising its disciplinary functions, the Board "shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee," including by imposing restrictions on the scope of practice; however, "protection of the public" shall be the Board's "highest priority." Where rehabilitation and protection are inconsistent, protection of the public "shall be paramount." (Bus. & Prof. Code, §§ 2001.1; 2229).)

2. Burden and Standard of Proof: To revoke or suspend respondent's medical license, complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

3. Gross Negligence: Business and Professions Code section 2234, subdivision (b), provides that unprofessional conduct includes, but is not limited to, gross negligence. Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196.)

4. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly in Findings 94 through 95, complainant established by clear and convincing evidence that respondent engaged in gross negligence on April 30, 2012, in the manner alleged in the Accusation's First Cause for Discipline.

5. Repeated Negligent Acts: Business and Professions Code section 2234, subdivision (c), provides that unprofessional conduct includes, but is not limited to, "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. Negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm. A physician is required to exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by other prudent physicians under similar circumstances. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 998.)

6. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly in Finding 96, complainant established by clear and convincing evidence that respondent engaged in repeated negligent acts from April 30, 2012, through May 30, 2014, in the manner alleged in the Accusation's Second Cause for Discipline.

7. Failure to Maintain Adequate and Accurate Medical Records: As relevant to this matter, Business and Professions Code section 2266 provides: "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." (Bus. & Prof. Code, § 2266.)

8. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly in Finding 97, complainant established by clear and convincing evidence that, from April 30, 2012, through May 30, 2014, respondent repeatedly failed to maintain adequate and accurate records relating to the provision of services to SF in the manner alleged in the Accusation's Third Cause for Discipline.

9. Failure to Participate in Board Interviews: Business and Professions Code section 2234, subdivision (h), provides that unprofessional conduct includes, but is not limited to, the "repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board." (Bus. & Prof. Code, § 2234, subd. (h).)

10. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly in Finding 99, complainant established by clear and convincing evidence that respondent repeatedly failed to attend and participate in an interview by the board, without good cause, in the manner alleged in the Accusation's Fourth Cause for Discipline.

11. When all the evidence is considered, the public will be protected by allowing respondent to continue to practice under a probationary license, subject to the terms and conditions outlined below.

ORDER

Physician and Surgeon's Certificate Number A 70232, issued to respondent Granville H. Marshall, M.D., is revoked pursuant to Legal Conclusions 4, 6, 8 and 10; however, the revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions.

1. 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.

2. 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.

3. 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.

4. 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.

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

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

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

6. 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.

7. Supervision of Physician Assistants and Advanced Practice Nurses: During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. 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.

9. 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.

10. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

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

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

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

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

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

11. 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.

12. 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 Board'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.

13. 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.

14. 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.

15. 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.

16. 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.

DATED: August 24, 2018

DocuSigned by:
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MARILYN A. WOOLLARD
Administrative Law Judge
Office of Administrative Hearings

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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: **Granville H. Marshall, M.D.** 170 Russell St., Ste L Susanville, CA 96130 Physician's and Surgeon's Certificate No. No. A 70232, Respondent.	Case No. 800-2014-008397 **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 November 5, 1999, the Medical Board issued Physician's and Surgeon's Certificate Number A 70232 to Granville H. Marshall, M.D. ("Respondent"). The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides in pertinent part, 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, in pertinent part:

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

"...

"(b) Gross negligence.

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

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

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

"...

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

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

PERTINENT DRUG INFORMATION

7. 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).[1] 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).

8. 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).

9. 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.

[1] 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.

10. Oxycodone and Oxycodone ER – Generic name for Oxy Contin, Roxicodone, and Oxecta. High risk for addiction and dependence. 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 ER is a long acting opioid analgesic used to treat moderate to sever 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).

11. 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).

12. 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence during the care of Patient S.F. ("S.F.")[2] The circumstances are as follows:

14. On or about April 30, 2012, Respondent saw S.F. for a new patient consultation and documented an initial visit. Respondent documented that S.F. was taking "Norco" and

[2] All witnesses and patients will be identified in discovery.

"morphine." Respondent's hand written progress note was documented on a pre-printed template entitled "Office S.O.A.P. note." Respondent documented that S.F. had a prior history of Asthma, C.O.P.D. (chronic obstructive pulmonary disease, H.T.N. (hypertension), pulmonary nodules, and brain tumors. Respondent also documented that he had a social history that involved smoking, Etoh (ethyl alcohol), and made an illegible entry. Respondent documented a physical examination including the chest, central nervous system, abdomen, musculoskeletal system, and extremities. Respondent did not document a physical exam related to pain that would support the prescribing of narcotics. Respondent documented under the "accesment"(sic) that he would "control tumors" and the plan included treatment for asthma. Respondent documented that he would prescribe "Norco" and that he would request a CT of S.F.'s chest. Respondent documented that he would follow up in one week with S.F.

15. Respondent did not document whether S.F. was in pain and/or what level of pain he was in at the initial visit. Respondent did not document the character, frequency, and site of any pain that would support the prescription of narcotics. Respondent did not perform and/or document a substance abuse history or review and/or document a review of past prior pain treatments that had been performed on S.F. The record is silent on whether S.F. had experienced success from prior pain interventions and whether there was a rationale for continuing narcotic treatments. Respondent prescribed 180 tablets of 10/325 mg. hydrocodone with acetaminophen to S.F. despite the lack of pain management history. Respondent provided three refills. The 180 pills were supposed to last thirty days and S.F. was directed to take two tablets, three times day. Respondent did not document whether opiates were indicated to treat S.F.

16. Respondent's treatment of S.F. as described above represents an extreme departure from the standard of care by failing to perform and/or document performing a complete history and physical before Respondent began prescribing narcotics to S.F.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

17. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts during the care and treatment of S.F. The circumstances are as follows:

18. Complainant realleges paragraphs 13 through 16, and those paragraphs are incorporated by reference as if fully set forth herein.

19. On or about April 30, 2012, Respondent failed to record a treatment plan and/or describe the stated objectives of pain management in S.F.'s medical records. The record is silent on what narcotics were being used to treat, specifically whether they were to improve physical and/or psychological function, improve the ability to perform certain tasks, and/or improve S.F.'s ability to perform daily life activities. The April 30, 2012, progress note does not document any plans for diagnostic evaluations and treatments, such as a rehabilitation program, and does not include any mention of non-opiate therapies to be considered. Respondent did not document that he provided an informed consent to S.F. before prescribing hydrocodone with acetaminophen either verbally or in writing.

20. On May 4, 2012, Respondent saw S.F. in his office for a follow-up appointment. He documented the same medical history from the April 30, 2012 visit. A physical examination was not documented. Current medications were documented including "Norco" and "Morphine ER". S.F. had previously been receiving a morphine ER prescription from another physician before seeing Respondent. Respondent prescribed 180 tablets of 10/325 mg. hydrocodone with acetaminophen and 60 tablets of 30 mg. morphine sulfate ER to S.F. Respondent did not perform and/or document a physical and did not perform and/or document a history of pain treatment before prescribing morphine sulfate ER to S.F. Respondent did not create and/or document creating a treatment plan regarding his prescription of both hydrocodone with acetaminophen and morphine sulfate ER to S.F. Respondent did not document any pain management treatment objectives. Respondent did not document that he provided an informed consent to S.F. before prescribing morphine sulfate either verbally or in writing. On June 26, 2012, Respondent

received a fax from a CVS pharmacy in Oceanside, California regarding S.F.'s hydrocodone prescription and a request by S.F. for an early refill of S.F.'s prescription.

21. Respondent next saw S.F. in his office for a follow-up appointment on July 9, 2012. Respondent documented the same medical history from the April 30, 2012, and May 4, 2012, visits. Respondent performed a physical examination. Respondent noted that S.F. was on "Norco" and "Morphine ER" under current medications. Respondent failed to create and/or document a treatment plan for pain management. Respondent failed to review and/or document pain management treatment objectives. Respondent failed to perform a periodic review of the pain therapy S.F. was receiving. Specifically, Respondent didn't document whether the patient was in pain or not in pain, whether pain management was providing relief, whether S.F. was making progress on pain management therapy, and whether other treatments should be considered. Respondent failed to address and/or document addressing the request for an early refill on June 26, 2012. Respondent prescribed 60 tablets of 30 mg. morphine sulfate to S.F.

22. Respondent next saw S.F. on July 20, 2012 for a follow-up visit. Respondent documented the same medical history from previous visits. Respondent documented C.T.A. (computed tomography angiography) next to chest but did not perform a full physical examination. Respondent documented that S.F. was on "Norco" and "Morphine Sulfate ER." Respondent did not create and/or document a pain management treatment plan, did not review and/or document reviewing pain management objectives, and/or did not perform and/or document performing a periodic review of S.F.'s pain management therapy. Respondent provided a prescription for 180 pills of 10/325 mg. hydrocodone with acetaminophen to S.F.

23. On or about August 7, 2012, Respondent saw S.F. for a follow-up. Respondent documented that S.F. had a complaint of brain lesions and documented the same past medical history as previous visits. Respondent documented that S.F. was taking "Norco" and "Morphine Sulfate ER". Respondent performed a physical examination. Respondent referred to a July 18, 2012, imaging study that had been performed on S.F. to review C.O.P.D. Respondent did not create and/or document a pain management treatment plan, did not review and/or document reviewing pain management objectives, and did not perform and/or document performing a

periodic review of S.F.'s pain management therapy. Specifically, Respondent didn't document whether the patient was in pain or not in pain, whether pain management was providing relief, whether S.F. was making progress on pain management therapy, and whether other treatments should be considered. Respondent provided a prescription for 180 pills 10/325 mg. of hydrocodone with acetaminophen and 60 pills of 30 mg. morphine sulfate ER to S.F.

24. On August 27, 2012, Respondent saw S.F. for a follow up appointment. Respondent documented that S.F. had a history of present illness as follows, "B.O.B. go to locet (sic) K.r.z (sic.) smoker." Respondent documented a past medical history of "multiple brain lesions, C.O.P.D./asthma, and H.T.N. Respondent documented that S.F. was on "Norco" and "Morphine Sulfate ER." Under the template title Accesment (sic) Respondent wrote "S.O.B. → Due next treatment 5mm pclmnt (sic) Nb" Respondent then documented "Multiple Brain lesions → Pain Control Butran 10 mcg./hr" and "Norco" for "breakthrough pain." Respondent provided a prescription for a total of 4 10 mcg./hr. Butrans patch and 100 10/325 mg. hydrocodone with acetaminophen. Respondent did not create and/or document a pain management treatment plan, did not review and/or document reviewing pain management objectives, and did not perform and/or document performing a periodic review of S.F.'s pain management therapy. Specifically, Respondent didn't document whether the patient was in pain or not in pain, whether pain management was providing relief, whether S.F. was making progress on pain management therapy, and whether other treatments should be considered. Respondent did not document why he was changing S.F.'s prescription from Morphine Sulfate E.R. to Butrans.

25. Between September 7, 2012, and May 22, 2014, Respondent documented 38 outpatient visits with S.F. Between September 7, 2012, and May 22, 2014, Respondent continued to prescribe narcotics to S.F., refill S.F.'s narcotic prescriptions and/or initiate new narcotic prescriptions to S.F. In total, between September 7, 2012, and May 22, 2014, S.F. received 2,375 10/325 mg. hydrocodone with acetaminophen tablets, 20 20 mcg./hr. Butrans patches, 150 15 mg. oxycodone HCL tablets, 220 10/325 mg. oxycodone with acetaminophen tablets, 120 40 mg. OxyContin tablets, 90 tablets of 15 mg. morphine sulfate, and 226 tablets of 2 mg. hydromorphone HCL. At times, Respondent provided multiple short-acting opioid prescriptions

to S.F. For example, on August 8, 2013, S.F. received 120 tablets of 10/325 mg. oxycodone with acetaminophen and on August 14, 2013, S.F. received 120 tablets of 10/325 hydrocodone with acetaminophen. Between September 7, 2012, and May 22, 2014, during 38 outpatient visits, Respondent did not create and/or document a pain management treatment plan, did not review and/or document reviewing pain management objectives, and did not perform and/or document performing a periodic review of S.F.'s pain management therapy. Specifically, Respondent didn't document whether the patient was in pain or not in pain, whether pain management was providing relief, whether S.F. was making progress on pain management therapy, and whether other treatments should be considered despite titrating new medications and changing dosages. Respondent repeatedly failed to document providing S.F. with a written or verbal informed consent before titrating new medications.

26. On May 30, 2014, Respondent documented that S.F. was engaging in drug seeking behavior. Respondent documented that S.F. had requested medication refills, that his wife had asked for his pain medications, and that S.F. had attempted to blackmail Respondent. Respondent documented that he discharged S.F. from his medical practice.

27. Respondent's license is subject to disciplinary action because he committed the following repeated negligent acts during the care of S.F.:

a.) As more fully described in paragraphs 13 through 16, by failing to perform and/or document a complete medical history and physical, in particular a history of pain management, at S.F.'s initial clinical visit before prescribing controlled substances represents a departure from the standard of care;

b.) As more fully described in paragraphs 19 through 26, by failing to create and/or document creating a pain management treatment plan and/or list and/or document listing the objectives of S.F.'s pain management therapy from April 30, 2012, to May 30, 2014, in any of the progress notes in 45 outpatient clinic visits represents multiple and repeated separate departures from the standard of care;

c.) As more fully described in paragraphs 19 through 26, by failing to perform and/or document performing a periodic review of Patient S.F.'s pain management therapy from April 30,

2012, to May 30, 2014, in any of the progress notes that documented 45 outpatient clinic visits represents multiple and repeated separate departures from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping)

28. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate records. The circumstances are as follows:

29. Complainant realleges paragraphs 13 through 27, and those paragraphs are incorporated by reference as if fully set forth herein.

30. A review of the medical records from April 30, 2012, to May 30, 2014, reveals that the records were handwritten and often illegible. As noted above the records did not document standard pain management guidelines, failed to document S.F.'s pain and were cursory in nature.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Attend and Participate in an interview with the Board)

31. On June 20, 2017, HQIU ("Health Quality Investigations Unit") Investigator ("Inv.") A.V. met with Respondent and his attorney in Susanville, California. DAG Gatschet and a medical consultant, Dr. K.M., were teleconferenced in to the interview from the Sacramento District Office. Respondent began asking questions of Dr. K.M. and DAG Gatschet, in particular regarding their respective roles in the proceeding. Inv. A.V. asked Respondent where he went to medical school. Respondent then stated,

> "I would – I want to ask some questions. How could I verify who those two on the phone are? I didn't order a telephone interview. How could I verify who is – who am I talking to? Is "S.F." down there listening?"

Respondent was assured that DAG Gatschet and Dr. K.M. were the only two people in the room in Sacramento, California listening in on the interview with Respondent that was taking place in Susanville, California. Respondent asked additional questions and requested additional information in writing from the Board.

32. An additional explanation was provided explaining that the Board wished to proceed with an interview regarding the care and treatment Respondent provided to patient S.F. and S.F.'s

wife. Respondent's attorney agreed that the interview would proceed on that basis. Inv. A.V. asked again where Respondent went to medical school. Respondent stated that he was, "...pleading the Fifth. I'm, pleading the Fifth.' Respondent claimed that it was a criminal investigation and that Inv. A.V., DAG Gatschet and Dr. K.M. were lying. Respondent claimed that Inv. A.V. had lied to him about other parts of her investigation. Respondent was again informed that the interview was related to an administrative proceeding and that Respondent had two options to proceed with regarding an interview with the Board. He could either agree to complete the voluntary interview or an interview would be compelled by administrative subpoena at a later time.

33. Respondent continued to question whether the interview was proper, expressed frustration that DAG Gatschet and Dr. K.M. were on a teleconference, and stated that Inv. A.V. had repeatedly lied to him during the investigation. After approximately 18 minutes, Respondent stated,

> "I'm not gonna(sic) sit here and then answer questions from somebody on the telephone, and not, not, and I don't know who you are, and then incriminate myself! On top of that, you're asking me questions about a matter you won't tell me!"

Respondent and Inv. A.V. discussed the fact that he had not received a letter setting up the interview for June 20, 2017, and then Respondent stated, "I'm leaving." Respondent left the interview at that point. Respondent's attorney confirmed that Respondent would not proceed with a voluntary interview.

34. On June 26, 2017, a certified letter was sent to Respondent's attorney requesting a voluntary interview that would occur on July 14, 2017, in either Sacramento or in Susanville. The letter set forth the Board's authority to conduct a subject interview with Respondent and conduct a confidential investigation. The letter was also faxed to Respondent's attorney. Staff working for Respondent's attorney returned the certified mailing return receipt on June 28, 2017. The letter requested a response within ten days in order to finalize scheduling. Respondent and his attorney failed to respond within ten days to the certified letter requesting a voluntary interview on July 14, 2017. The July 14, 2017, interview was cancelled. Inv. A.V. learned that a

fire had occurred on or about July 1, 2017, that had forced Respondent's attorney to evacuate his office.

35. On July 17, 2017, an administrative subpoena was issued to Respondent and personally served on his attorney to appear for an interview with the Board. The administrative subpoena set the interview date for August 15, 2017, at the Susanville Department of Motor Vehicles. On or about July 24, 2017, Respondent's attorney sent a letter stating that he felt the investigation and Inv. A.V.'s actions were "unethical and border on fraud." Respondent's attorney also stated in the letter that,

> "(a)bsent changes reflecting an ethical and transparent investigation we will contest this matter to the fullest extent possible and pursue all remedies after this matter concludes."

36. On August 14, 2017, Respondent's attorney sent a letter to DAG Gatschet stating that Respondent would be unable to attend the investigatory interview set for August 15th, 2017. Respondent's attorney asked to reschedule the interview for a different time. Respondent's attorney stated that Respondent was taking his Internal Medicine Boards on August 16, 2017, at 8:00 a.m. and that a "potentially stressful, contentions interview" the day before his test was likely to negatively affect his performance.

37. Respondent's repeated failure to attend and participate in an interview with the Board as described above represents unprofessional conduct.

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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 70232, issued to Granville H. Marshall, M.D.;

2. Revoking, suspending or denying approval of Granville H. Marshall, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Granville H. Marshall, 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: September 5, 2017

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

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