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

In the Matter of the Accusation Against:	)	
Joseph Aurelius Risser, M.D..	)	**Case No. 800-2015-014904**
Physician's and Surgeon's Certificate No. G 70886	)	
Respondent	)	

DECISION

The attached 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 January 18, 2019.

IT IS SO ORDERED: December 19, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, J.D., Chair
Panel B

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

In the Matter of the Accusation Against: JOSEPH AURELIUS RISSER, M.D., Physician's and Surgeon's Certificate Number G70886, Respondent.	Case No. 800-2015-014904 OAH No. 2018030545

PROPOSED DECISION

Administrative Law Judge Carla L. Garrett, Office of Administrative Hearings, heard this matter on September 24, 25, and 26, 2018, at Los Angeles, California.

Karolyn M. Westfall, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board). Carolyn W. Lindholm, Attorney at Law, represented Joseph Aurelius Risser, M.D. (Respondent), who was present at hearing.

On September 24, 2018, Complainant moved for a protective order requesting that exhibits 4-14 and 16-17 be placed under seal because the documents contain confidential information that is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not have provided adequate privacy protection. Respondent did not oppose Complainant's motion. The ALJ granted the motion and issued a Protective Order placing the above-referenced exhibits under seal, as well as Respondent's exhibits C, E, H, and K, as they, as duplicates of other exhibits placed under seal, contained confidential information. Exhibits 4-14, 16-17, C, E, H, and K shall remain under seal and shall not be opened, except as provided by the Protective Order. A reviewing court, parties to this matter, their attorneys, and a government agency decision-maker or designee under Government Code section 11517 may review the documents subject to the Protective Order, provided that such documents are protected from release to the public.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on September 26, 2018.

FINDINGS OF FACT

1. Complainant filed the Accusation in her official capacity as Executive Director of the Board.

2. The Board issued Physician's and Surgeon's Certificate Number G70886 to Respondent on March 4, 1991. The certificate is renewed and current with an expiration date of September 30, 2020.

Background Summary

3. On July 1, 2015, the Board received a complaint alleging that Respondent had been overprescribing controlled substances at Irvine Urgent Care Clinic (IUCC), a walk-in clinic in which patients were seen by one of three physicians—Respondent, Dr. Omid Vesal, who was the owner and medical director of IUCC, and Dr. Diana Nguyen—depending on which physician was available at the time of the walk-in visit. The Board initiated an investigation which included a review of approximately 100 pages of Controlled Substance Utilization Review and Evaluation System (CURES)[1] reports concerning Respondent's prescribing practices at IUCC, and identified three patients to whom Respondent prescribed controlled substances in a manner in which the Board believed involved potential departures from the standard of care: Patients A, B, and C.[2]

Patient A

4. In December 2014, Patient A, a 52 year-old male, began treating at IUCC, and remained a patient there for approximately 11 months. Specifically, Patient A visited ICUU on at least 44 occasions from December 16, 2014 through November 27, 2015, primarily to address back pain, headaches, and high blood pressure. During this period, IUCC physicians wrote Patient A approximately 43 prescriptions for opiates, and Respondent wrote 23 of those prescriptions. During the same period in which Patient A received opioid prescriptions from IUCC, Patient A also procured opioid prescriptions from physicians at facilities other than IUCC on at least 28 different occasions.

5. Dr. Vesal served as Patient A's treating physician during his first visit to IUCC on December 16, 2014. All of IUCC's medical notes concerning Patient A were handwritten, maintained in chronological order, and, pursuant to a request made by the Board, were submitted by Respondent to the Board, along with his certification that the

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[1] CURES is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California. It serves the public health, regulatory oversight agencies, and law enforcement.

[2] Patients are identified by their initials to protect their privacy.

provided records were complete. Dr. Vesal's chart note stated that Patient A had a history of back pain, hypertension, and insomnia, and had been seen recently by a physician in the Los Angeles area. Dr. Vesal's note did not include any information concerning medications Patient A had received from other physicians. Dr. Vesal prescribed hydrocodone,[3] (30, 325 mg-10 mg tablets), also known as Norco or Vicodin, and carisoprodol,[4] (30, 350 mg tablets), also known as Soma, which is a muscle relaxant, to address Patient A's pain.

6. According to the CURES report concerning Patient A, Patient A had received hydrocodone or oxycodone[5] prescriptions from another doctor just days prior to his December 16, 2014 visit to IUCC, specifically on December 4 and 8, 2014.

7. Patient A returned to IUCC on December 19 and 30, 2014, and received Norco refills (30, 325 mg-10 mg tablets) from Dr. Vesal.

8. Patient A returned to IUCC on January 10, 2015, complaining of back pain and insomnia. Dr. Vesal treated Patient A on that day and ordered an x-ray of Patient A's back. The x-ray showed that Patient A had a mild to moderate disc space narrowing at the L5-S1 level (i.e., arthritis) and mild subchondral sclerosis in the lower lumbar (i.e., curvature of the spine). Dr. Vesal prescribed Ambien[6] (30, 10 mg tablets) to address Patient A's insomnia, and refilled Patient A's Norco prescription (30, 325 mg-10 mg tablets).

9. Patient A returned to IUCC on January 14, 2015, complaining that the medication was making him dizzy and drowsy. Respondent treated Patient A on that day. Respondent's chart notes did not list the medication that Patient A claimed made him dizzy and drowsy. The chart notes indicated that Patient A was unable to sleep for more than two hours a day and that Norco did not relieve his pain. Respondent noted that, upon examination, Patient A demonstrated moderate discomfort and decreased range of motion, and Respondent diagnosed Patient A with chronic back pain and insomnia. Respondent ceased Patient A's Norco medication because it was not helping enough, and started Patient

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[3] Hydrocodone is a Schedule III controlled substance, pursuant to Health and Safety Code section 11056, subdivision (e), and is considered a dangerous drug, pursuant to Business and Professions Code section 4022.

[4] Carisoprodol is a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Oxycodone is a Schedule II controlled substance, pursuant to Health and Safety Code section 11055, subdivision (b), and is considered a dangerous drug, pursuant to Business and Professions Code section 4022.

[6] Ambien is a dangerous drug pursuant to Business and Professions Code section 4022.

A on oxycodone-acetaminophen (i.e., Percocet) (30, 325 mg-10 mg tablets). Respondent also instructed Patient A to stop taking Ambien, and prescribed Lunesta[7] instead.

10. According to CURES reports, on January 20, 2015, Patient A received a prescription for Norco from a physician from a medical facility unaffiliated with IUCC.

11. On January 23, 2015, Patient A returned to IUCC complaining of insomnia, and was seen by Respondent. Patient A told Respondent that Lunesta worked better than Ambien, and requested an early refill of his Lunesta prescription because he was leaving town for two weeks. Respondent gave him an early refill (15, 3 mg tablets), but cautioned Patient A not to take it every day.

12. According to CURES reports, on January 24, 2015, Patient A received a prescription for Percocet from a physician from a medical facility unaffiliated with IUCC.

13. On January 29, 2015, Patient A returned to IUCC complaining of dizziness, headaches, and pain and tingling in his left arm, and was seen by Respondent. Patient A told Respondent that the Percocet that Respondent had prescribed him on January 14, 2015 was too strong. Respondent ordered an x-ray of Patient A's left arm, and switched Patient A's pain medication to Norco (30, 325 mg-10 mg tablets).

14. On February 4, 2015, Patient A returned to IUCC to address his back pain, and was seen by Respondent. Patient A conveyed that the Norco was helping, but he did not like the muscle relaxant he had been taking, and complained that the exercises that Respondent had previously instructed him to do caused him more pain. After examination, Respondent noted that there was a worsening of Patient A's back pain, recommended that he continue taking Norco, and wrote a prescription in that regard (30, 325 mg-10 mg tablets). Respondent noted in the chart that Patient A had not been seen by a pain management specialist as of yet.

15. Patient A returned to IUCC on February 16, 2015, seeking a refill of Norco to address his back pain, and was seen by Respondent. Patient A told Respondent that his back pain had improved and that he was sleeping better. Respondent refilled Patient A's prescription for Norco (30, 325 mg-10 mg tablets).

16. Dr. Vesal saw Patient A on February 24, March 4, and March 13, 2015, and prescribed Norco (30, 325 mg-10 mg tablets) at each of those visits.

17. On March 16, 2015, Patient A saw Respondent and told him that Norco did nothing to alleviate the headaches he had been experiencing. Respondent prescribed

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[7] Lunesta is a brand name for eszopiclone, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

Vicoprofen (i.e., hydrocodone and ibuprofen) (30, 7.5 mg-200 mg tablets), as Patient A had indicated that it had worked in the past.

18. Dr. Vesal saw Patient A on March 25, 2015, and prescribed Norco (45, 7.5 mg-200 mg tablets).

19. On April 2, 2015, Patient A returned to IUCC and saw Respondent. Patient A told Respondent that his back pain was getting worse. Respondent examined Patient A and gave him a prescription for Percocet (30, 325 mg-7.5 mg tablets) since, according to Respondent's testimony; the Vicoprofen had failed to control the pain. Patient A also received trigger point injections in his back that contained a mixture of Kenalog, a synthetic glucocorticoid that acts as an anti-inflammatory agent, and Lidocaine, which is a numbing agent.[8]

20. On April 11, 2015, Patient A returned to IUCC with a stab wound to his left thigh, inflicted by his girlfriend (i.e., Patient B).[9] Patient A declined to go to the emergency room because he did not want Patient B to "get in trouble." (Exhibit 10, page AGO 2152.) Respondent irrigated and stitched the wound, which was approximately five centimeters long. Respondent increased Patient A's Percocet (30, 30 mg tablets) prescription, because Patient A was in a lot of pain. Patient A also received trigger point injections in his back. On the same day, Patient A filled a prescription for hydrocodone written by a physician unrelated to IUCC.

21. Dr. Vesal treated Patient A on April 17, 2015, and again on April 23, 2015, when Patient A returned to IUCC complaining about persistent and throbbing pain. Dr. Vesal prescribed Percocet (45, 325 mg-7.5 mg tablets) on both occasions.

22. On April 29, 2015, Patient A returned to IUCC and was seen by Respondent. Respondent noted that Patient A's laceration continued to heal without infection, and decreased Patient A's pain medication (Percocet, 45, 325 mg-10 mg tablets) because his pain had subsided.

23. On May 4, 2015, Patient A returned to IUCC to follow up on his wound treatment. He also wished to discuss pain in his left hip, and to get a refill of Percocet. Patient A was seen by Respondent, and told Respondent that his leg wound was swollen and bruised, and prevented him from walking longer than a block. Patient A also complained of heartburn. Respondent prescribed Percocet (30, 325 mg-10 mg tablets) for the continued leg pain and Prevacid to address Patient A's heartburn.

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[8] All trigger point injections Patient A received at IUCC contained the same mixture of Kenalog and Lidocaine.

[9] Patient B will be discussed in a separate section below.

24. According to CURES, on three occasions in May 2015, Patient A received opioid prescriptions from physicians other than the ones affiliated with IUCC. Specifically, Patient A received oxycodone acetaminophen (i.e., Percocet) on May 11, 2015, acetaminophen-codeine phosphate on May 19, 2015, and hydrocodone bitartrate acetaminophen (i.e., Norco) on May 20, 2015.

25. According to CURES, on six occasions in June 2015, Patient A received opioid prescriptions from physicians other than the ones affiliated with IUCC. Specifically, he received hydrocodone bitartrate acetaminophen (i.e., Norco) on June 4, 12, and 15, 2015, and oxycodone acetaminophen (i.e., Percocet) on June 7, 17, and 19, 2015.

26. Dr. Vesal saw Patient A on June 25, 2015, and prescribed Percocet (45, 325 mg-10mg tablets). Patient A also received trigger point injections in his back and neck.

27. Dr. Nguyen saw Patient A on July 3, 2015, and again on July 10, 2015, and prescribed Percocet (45, 325 mg-10 mg tablets) on both occasions. Additionally, Dr. Nguyen treated Patient A with trigger point injections in his neck on both July 3, 2015, and July 10, 2015. Patient A also received trigger point injections in his neck and back on July 14, 2015.

28. On July 16, 2015, Patient A returned to IUCC and was seen by Respondent. Patient A reported that the trigger injections had helped. Upon examination, Respondent noted that Patient A's range of motion had improved. Respondent refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription.

29. Dr. Nguyen performed a physical examination of Patient A on July 28, 2015, ordered a urine drug screen for Patient A, and planned to run Patient A's CURES report. The results of the urine drug screen showed that the drugs in Patient A's system were inconsistent with the medications prescribed to him by physicians at IUCC. Specifically, it was expected that Patient A would have only Percocet in his system, but the results showed that he also had Norco in his system. Dr. Nguyen prescribed blood pressure medicine, but no narcotics on that day.

30. Patient A received trigger point injections in his back on July 22, and 30, 2015.

31. On August 7, 2015, Patient A saw Dr. Nguyen, who prescribed Percocet (45, 325 mg-10 mg tablets). Patient A also received trigger point injections in his back on that day.

32. Patient A returned to IUCC on August 13, 2015, and was seen by Respondent. Patient A told Respondent that he eventually wished to return to Norco, but not yet. Respondent refilled Patient A's prescription for Percocet (45, 325 mg-10 mg tablets).

33. Patient A received trigger point injections in his neck on August 15, 2015, and trigger point injections in his back on August 23, 2015.

34. On August 24, 2015, Patient A returned to IUCC seeking an early refill of his Percocet prescription, and was seen by Respondent. Patient A told Respondent that he needed his prescription filled one day early because he was planning to go out of town for work. Respondent refilled Patient A's prescription for Percocet (45, 325 mg-10 mg tablets).

35. On August 30, 2015, Patient A returned to IUCC and saw Respondent, who observed Patient A walking with obvious discomfort and a curvature of his back. Respondent ordered a back brace for Patient A, and refilled his Percocet (45, 325 mg-10 mg tablets) prescription. Patient A also received trigger point injections in his back and neck on July 30, 2015.

36. On September 5, 2015, Dr. Nguyen gave Patient A a Toradol[10] injection and prescribed Percocet. Patient A also received trigger point injections in his neck and back on September 9, 2015.

37. On September 10, 2015, Patient A returned to IUCC and was seen by Respondent. Respondent noted that Patient A did not wear his back brace. Respondent refilled Patient A's prescription for a Percocet (45, 325 mg-10 mg tablets).

38. On September 14, 2015, Patient A received trigger point injections in his neck and back, and on September 16, 2015, Respondent refilled his Percocet prescription (45, 325 mg-10 mg tablets).

39. On September 22, 2015, Dr. Nguyen treated Patient A with a Toradol injection and refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription. Patient A also received a trigger point injection.

40. On September 28, 2015, Respondent saw Patient A, who complained that his back pain had not improved despite the exercises Respondent instructed him to do, and noticed that Patient A had difficulty lifting up his torso while lying flat. Respondent refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription.

41. On September 30, 2015, Patient A received trigger point injections in his neck.

42. Respondent also refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription on October 4, 2015, when Patient A returned to IUCC and advised that he had to take his Percocet more often because he suffered aggravated pain as a result of muscle spasms in his back. Patient A also received trigger point injections in his neck and back.

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[10] Toradol is nonsteroidal anti-inflammatory medication used to treat pain, and a dangerous drug pursuant to Business and Professions Code section 4022.

43. Patient A returned to IUCC on October 9, 2015, to have his blood pressure checked and to have his pain prescriptions refilled. Respondent refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription on October 9, 2015.

44. On October 14, 2015, Dr. Nguyen saw Patient A for an early refill of his Percocet prescription. Dr. Nguyen instructed Patient A that he should be taking his medication as instructed, and then refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription on October 15, 2015.

45. On October 18, 2015, Patient A returned to IUCC complaining of a hurt right foot, and was seen by Respondent. Patient A told Respondent that he had dropped a dumbbell weight on his foot. Respondent ordered an x-ray, which revealed no broken bones or other injuries. Respondent temporarily increased Patient A's Percocet (45, 30 mg tablets).

46. Patient A received trigger point injections in his back on October 22, 2015.

47. On October 23, 2015, Patient A returned to IUCC and was seen by Dr. Vesal. Patient A sought a Percocet (45, 325 mg-10 mg tablets) refill, which Dr. Vesal provided. On October 30, 2015, Patient A received trigger point injections in his back.

48. On November 2, 2015, Respondent treated Patient A when he returned to IUCC complaining of coughing up blood. Respondent diagnosed Patient A with pneumonia, prompting Respondent to give Patient A an intravenous antibiotic, and he refilled Patient A's Percocet (45, 325 mg-10 mg tablets) prescription.

49. On November 5, 2015, Dr. Vesal treated Patient A, who told him that he had lost his medication. Dr. Vesal prescribed clonazepam (30, 1 mg tablets),[11] which is a benzodiazepine and anti-anxiety medication, and on November 6, 2015, he prescribed Percocet (45, 325 mg-10 mg tablets).

50. On November 16, 2015, Patient A returned to IUCC and was seen by Respondent. Patient A told Respondent that he had been suffering from anxiety since he began coughing up blood two weeks prior. Respondent noted that Patient A's cough was resolving, but that Patient A's blood pressure was elevated. Respondent refilled Patient A's clonazepam (30, 2 mg tablets) to address Patient A's anxiety, as well as a prescription for hypertension medication. Additionally, Patient A received trigger point injections in his neck and back.

51. According to CURES, from November 6, 2015 to November 16, 2015, multiple physicians outside of IUCC prescribed opiates to Patient A on three occasions, and

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[11] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022.

benzodiazepines on three occasions. There is a risk to patients receiving opiates and benzodiazepines together, because the combination increases the risk of fatal overdose.

52. On November 20, 2015, Patient A received trigger point injections in his neck.

53. On November 22, 2015, Respondent treated Patient A for atypical migraine headaches and dehydration. Specifically, Respondent gave Patient A intravenous fluids, a refill of his Percocet (45, 325 mg-10 mg tablets) prescription, and some anti-vomiting medication.

54. On November 28, 2015, Patient A returned to IUCC and complained about chronic headaches and lower back pain. Respondent referred Patient A to a neurologist to address his headaches, and to a pain management specialist to address his headaches and back pain. Respondent refilled Patient A's Percocet prescription (45, 325 mg-10 mg tablets). Patient A also received trigger point injections in his neck.

55. Thereafter, in November 2015, IUCC discharged Patient A because it learned that Patient A had been seeking out other doctors to prescribe him pain medication. IUCC documented nothing in Patient A's records indicating that it had discharged Patient A or why it had discharged him.

56. At no time during the time Patient A treated at IUCC did his charts or records contain a pain care agreement signed by Patient A that outlined the steps of compliance with opiate therapy.

57. At no time during the time Patient A treated at IUCC did his charts or records document any CURES queries or any discussion with Patient A regarding aberrant behaviors.

Patient B

58. In February 2015, Patient B, an 18 year-old female, began treating at IUCC, and remained a patient there for approximately nine months. Specifically, Patient B visited IUCC on at least 31 occasions from February 24, 2015 through November 27, 2015, primarily to address back pain, headaches, and anxiety. During the period in which Patient B treated at IUCC, IUCC physicians wrote her approximately 37 prescriptions for opiates, and Respondent wrote 19 of those prescriptions. Additionally, Patient B received seven prescriptions for alprazolam[12] (i.e., Xanax) from IUCC physicians, including four written by Respondent. Patient B was a cash-paying patient, as she had no health insurance.

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[12] Alprazolam is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

59. Dr. Vesal served as Patient B's treating physician during her first visit to IUCC. All of IUCC's medical notes concerning Patient B were handwritten, maintained in chronological order, and, pursuant to a request made by the Board, were submitted by Respondent to the Board, along with his certification that the provided records were complete. Dr. Vesal's chart note stated that Patient A had come to IUCC for a general check-up and to discuss allergies, as well as her Attention Hyperactivity Deficit Disorder (ADHD) and her history of anxiety and depression. Dr. Vesal completed an adult ADHD symptom checklist that demonstrated that Patient B had symptoms consistent with ADHD. Dr. Vesal ran a CURES report on Patient B that showed that Patient B had filled no prescriptions from November 24, 2014 through February 24, 2015. Dr. Vesal prescribed Xanax to address Patient B's anxiety.

60. Patient B returned to IUCC on March 28, 2015, complaining of a soccer injury that she had sustained one year prior, and had caused her back pain. Patient B was seen by Respondent. Patient B told Respondent that she had tried Motrin, flexeril, and tramadol to control the pain. Respondent performed an examination, noted that Patient B had scoliosis along with decreased range of motion, and diagnosed her with chronic low back pain. Respondent prescribed Norco (45, 325 mg-10 mg tablets) to Patient B. At hearing, Respondent explained that because Patient B was a cash-paying patient, Respondent required Patient B to return to the clinic every two weeks for prescription refills, as opposed to once per week as he required other pain patients to do, because Respondent was cognizant of IUCC charges of $100-$128 per office visit.

61. Patient B returned to IUCC on March 31, 2015, and was seen by Dr. Vesal. Patient B complained of continued back pain, and advised that the Norco did not work. Dr. Vesal prescribed Percocet (30, 325 mg-10 mg tablets).

62. On April 4, 2015, Patient B returned to IUCC for medication for her back pain, and complained of anxiety and back spasms. Respondent prescribed Xanax (30, 1 mg tablets) to address her anxiety and Percocet (30, 325 mg-10 mg tablets) to address her back pain.

63. According to CURES, on April 18, 2015, Patient B filled a prescription for clonazepam (anti-anxiety medication) that was prescribed by a physician unaffiliated with IUCC.

64. Patient B returned to IUCC on April 21, 2015, and was seen by Dr. Vesal. Patient B complained of continued back pain. Dr. Vesal prescribed Percocet (30, 325 mg-10 mg tablets).

65. On April 27, 2015, Patient B returned to IUCC complaining of back pain and anxiety, and was seen by Respondent. Respondent referred Patient B to a chiropractor, because Patient B had experienced some success alleviating pain in the past with a chiropractor. Respondent also referred Patient B to a pain management specialist to address

her prolonged back pain. Respondent refilled Patient B's Xanax (30, 1 mg tablets) and Percocet (30, 325 mg-10 mg tablets) prescriptions.

66. Patient B returned to IUCC on May 9, 2015, to address her anxiety and back pain, and saw Dr. Vesal. Dr. Vesal refilled Patient B's Xanax (30, 1 mg tablets) and Percocet (30, 325 mg-10 mg tablets) prescriptions.

67. On May 17, 2015, Patient B returned to IUCC complaining of back pain, and was seen by Respondent. Patient B told Respondent that she had seen a chiropractor and experienced minimum relief, but advised that she could not afford the costs of continued chiropractic care. Patient B also advised that she could not afford x-rays or pain management visits. Respondent discussed sending Patient B to physical therapy and also discussed clinical trials in which Patient B could potentially participate. Respondent refilled Patient B's Xanax (30, 1mg tablets) and Percocet (30, 325 mg-10 mg tablets) prescriptions.

68. Patient B returned to IUCC on May 24, 2015, to address her anxiety and back pain, and saw Dr. Vesal. Dr. Vesal refilled Patient B's Xanax (30, 1 mg tablets) and Percocet (30, 325 mg-10 mg tablets) prescriptions.

69. On May 31, 2015, Patient B returned to IUCC to discuss increased anxiety and increased back pain, and was seen by Respondent. Respondent refilled Patient B's Xanax (30, 1 mg tablets) and Percocet (30, 325 mg-10 mg tablets) prescriptions. Respondent also indicated in the chart that Patient B required a urine drug screen and laboratory work completed on her next visit. At hearing, Respondent explained that, at a minimum of one time per year, IUCC performed urine drug screenings and laboratory work on patients receiving controlled substances. The urine drug screening tests cost $400, which could not be waived, because the urine drug screening tests were completed by an outside company. Respondent testified that if urine drug screening results showed a possibility that the patient was abusing, selling, or overdosing on opiate medication, all opiate drug treatment would cease.

70. On June 10, 2015, Patient B returned to IUCC and told Respondent that she felt like her "hormones were off" and wondered whether she felt that way because of her anxiety. Respondent ordered hormone tests. Patient B also advised that she could not afford a urine drug screening test. Consequently, Patient B did not undergo a urine drug screening. Respondent refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription.

71. Patient B returned to IUCC on June 23, 2015, complaining of headache, sinusitis, and chronic back pain, and was seen by Dr. Nguyen. Dr. Nguyen refilled Patient B's Percocet prescription (30, 325 mg-10 mg tablets), as well as gave Patient B a prescription for antibiotics to address her sinusitis.

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72. On June 28, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B discussed her anxiety. Respondent shared the results of Patient B's hormone test showing that her hormones were normal. Respondent refilled Patient B's Percocet (30, 325 mg-10 mg tablets) and Xanax (30, 1 mg tablets) prescriptions.

73. Patient B returned to IUCC on July 12, 2015, complaining of ongoing pain, and was seen by Dr. Nguyen. Patient B explained that physical therapy had proven to be too expensive for her. Dr. Nguyen refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription.

74. On July 19, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B complained of back and neck pain. Additionally, Patient B complained of increased anxiety due to family strife. Respondent strongly encouraged Patient B to seek psychological counseling, and gave Patient B a referral in that regard. Respondent refilled Patient B's Xanax (30, 1 mg tablets) prescription.

75. Patient B returned to IUCC on July 25, 2015, seeking a refill of her medication, and was seen by Dr. Vesal. Dr. Vesal refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription.

76. On August 9, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B complained of back pain. Respondent refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription, and told Patient B not to take the Percocet at the same time she took Xanax. Respondent had also refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription on August 3, 2015. Respondent encouraged Patient B to decrease the frequency in which she took Percocet.

77. Patient B returned to IUCC on August 15, 2015, and saw Dr. Nguyen. Dr. Nguyen ceased Patient B's Xanax, and started her on Lexapro. Dr. Nguyen also refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription.

78. Patient B returned to IUCC on August 28, 2015, and saw Dr. Nguyen. Patient B complained of neck and back pain. Dr. Nguyen increased the number of tablets of Patient B's Percocet, from 30, 325 mg-10 mg tablets to 45, 325 mg-10 mg tablets. Dr. Nguyen also told her to perform back stretches at home and to avoid heavy lifting.

79. On September 2, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B complained of back pain with spasms. Respondent refilled Patient B's Percocet prescription (45, 325 mg-10 mg tablets), and discussed Patient B engaging in pool exercises.

80. Patient B returned to IUCC on September 8, 2015, and was seen by Dr. Vesal. Patient B complained of insomnia, and also sought to refill her pain medication. Dr. Vesal refilled Patient B's Percocet (45, 325 mg-10 mg tablets) prescription.

81. On September 13, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B complained of persistent and stabbing back pain and requested stronger medication. Patient B told Respondent that she had to take her pain medication more often. Respondent refilled Patient B's Percocet (45, 325 mg-10 mg tablets) prescription, and instructed her to take it every four hours.

82. Patient B returned to IUCC on September 18, 2015, and was seen by Dr. Nguyen. Patient B advised that she was about to travel and that she got anxious when flying, and therefore wanted Ambien to address that problem. She also requested pain medication for back pain. Dr. Nguyen gave Patient B a prescription for Ambien, and refilled Patient B's Percocet (45, 325 mg-10 mg tablets) prescription. She also discussed Patient B undergoing physical therapy as well as receiving trigger point injections.

83. On September 24, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B sought a refill of her pain medication. Patient B told Respondent that Percocet relieved more of her pain. Respondent refilled Patient B's Percocet (45, 325 mg-10 mg tablets) prescription, and instructed her to take Ambien and not Xanax.

84. According to CURES, Patient B filled a prescription for hydrocodone on September 27, 2015, which she had received from a physician unaffiliated with IUCC.

85. Patient B returned to IUCC on September 30, 2015, and saw Dr. Nguyen. Patient B complained of back pain and difficulty sleeping. Dr. Nguyen refilled Patient B's Percocet (30, 325 mg-10 mg tablets) prescription, and documented that Patient B should not receive any further refills for anxiety medication for two months.

86. On October 7, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B complained of a lump on her groin. Respondent examined the lump and concluded that it was a benign nodule. Patient B told Respondent that taking Percocet every four hours worked better for her, and stated that she did not want to change or increase the strength of her medication. Respondent also discussed with Patient B the possibility of seeing a chiropractor. Respondent refilled Patient B's Percocet (45, 325 mg-10 mg tablets) prescription.

87. Patient B returned to IUCC on October 25, 2015, and saw Dr. Vesal. Patient B complained of back pain. Dr. Vesal refilled Patient B's Percocet (45, 325 mg-10 mg tablets).

88. On November 15, 2015, Patient B returned to IUCC and was seen by Respondent. Patient B complained that her pain medication had stopped working and that she needed more pain medication or different medication. However, she told Respondent that she wanted to take less pain medication, and that the chiropractor had helped. Respondent stopped the Percocet, and prescribed Norco (30, 325 mg-10 mg tablets) instead.

89. Patient B returned to IUCC on November 21, 2015, and saw Dr. Nguyen. Patient B complained that her medication had not been working. Dr. Nguyen referred Patient B to a pain management specialist. Dr. Nguyen noted that, in the meantime, she would refill Patient B's Percocet (45, 325 mg-10 mg tablets) prescription, and recommended that Patient B perform stretches, and to undergo physical therapy for core strengthening.

90. Patient B returned to IUCC on November 27, 2015, and saw Dr. Vesal. Patient B told Dr. Vesal that she had been going to a pain management facility, but needed pain medication "to hold her over." Dr. Vesal prescribed Percocet (45, 325 mg-10 mg tablets) to Patient B. The November 27, 2015 visit was Patient B's final visit to IUCC.

91. At no time during the time Patient B treated at IUCC did her charts or records contain a pain care agreement signed by Patient B that outlined the steps of compliance with opiate therapy.

92. At no time during the time Patient B treated at IUCC did her charts or records document any CURES queries or any discussion with Patient B regarding aberrant behaviors.

Patient C

93. In July 2013, Patient C, a 37 year-old female, began treating at IUCC, and remained a patient there for approximately 18 months. Specifically, Patient C received treatment primarily for anxiety and left arm pain radiating to her neck. During the period in which Patient C treated at IUCC, IUCC physicians primarily wrote prescriptions for hydrocodone to address her pain, and alprazolam to address her anxiety.

94. Dr. Vesal served as Patient C's treating physician during her first visit to IUCC on July 24, 2013. All of IUCC's medical notes concerning Patient C were handwritten, maintained in chronological order, and, pursuant to a request made by the Board, were submitted by IUCC to the Board, along with his certification that the provided records were complete. Patient C had come to IUCC complaining of a severe sore throat, body chills, and fever. Dr. Vesal conducted an examination, and gave her a prescription for Norco (30, 325 mg-10 mg tablets).

95. Patient C returned to IUCC on August 9, 2013, and again on August 22, 2013, and saw Dr. Vesal both times. She complained of having a possible urinary tract infection and a red right eye, respectively. Dr. Vesal refilled Patient C's prescription for Norco (20, 325 mg-10 mg tablets) on August 9, 2013.

96. On December 2, 2013, Patient C returned to IUCC and saw Dr. Vesal. She complained of suffering from left shoulder pain for four days that radiated towards her neck. Dr. Vesal ordered x-rays of Patient C's cervical spine. The x-rays showed that Patient C had degenerative disc and endplate changes at C6-7 and to a lesser degree at C5-6. Dr. Vesal refilled Patient C's prescription for Norco (30, 325 mg-10 mg tablets).

97. On December 12, 2013, Patient C returned to IUCC and was seen by Dr. Vesal. She complained that her neck pain had not gotten any better. Dr. Vesal ordered an MRI of Patient C's cervical spine. The MRI indicated that Patient C had multilevel degenerative disc disease, strongly indicative of osteoarthritis, and a disc herniation with possible nerve impingement. Dr. Vesal refilled Patient C's prescription for Norco, and also prescribed carisoprodol (i.e., Soma) (30, 355 mg tablets).

98. On December 18, 2013, Patient C returned to IUCC and was seen by Respondent. She complained of neck pain. Respondent refilled Patient C's prescription for Norco (30, 325 mg-5 mg tablets).

99. On December 28, 2013, Patient C returned to IUCC and was seen by Dr. Vesal. She complained of congestion, cough, and headache. Dr. Vesal refilled Patient C's prescription for Norco (30, 325 mg-10 mg tablets).

100. Patient C returned to IUCC on January 8, 2014, and was seen by Respondent. She still had a bad cough and congestion, and complained of not feeling better. She also complained of neck pain. Respondent prescribed an antibiotic and a steroid to help relieve some of her congestion, which were administered intravenously in the office. On January 11, 2014, Respondent refilled Patient C's prescription for Norco (30, 325 mg-10 mg tablets).

101. Patient C returned to IUCC on a number of occasions thereafter, and saw Dr. Vesal. Specifically, Patient C returned on January 16, 24, and 31, 2014; February 8, 18, and 27, 2014; March 7, 12, 20, and 24, 2014; April 7, 18, 24, and 30, 2014; May 8, 20, and 28, 2014; June 3, 19, 20, 2014; and July 1 and 8, 2014. Most of these visits concerned Patient C's complaints of neck pain and/or anxiety, which resulted in Dr. Vesal refilling Patient C's Norco (30, 325 mg-10 mg tablets) prescription at nearly every visit, and filling her carisoprodol (i.e., Soma) (30, 350 mg tablets) prescription on February 18, and May 12, 2014, and alprazolam (i.e., Xanax) (30, 1 mg tablets) prescription on February 27, March 6 and 24, April 7 and 30, , June 3, and July 1, 2014. Dr. Vesal also ordered a Toradol and Solumedrol[13] intramuscular injection, designed to reduce pain with their anti-inflammatory properties.

102. On February 7, 2014, Patient C signed a "Controlled Medication Agreement" for IUCC, which outlined the steps of compliance of opiate therapy.

103. On July 16, 2014, Patient C returned to IUCC and was seen by Respondent. She complained of neck pain and stiffness. Respondent noted on the chart that he was considering prescribing a long-acting opioid instead of Norco, which is a short acting opioid. Respondent also ordered a Toradol and Solumedrol intramuscular injection, designed to reduce pain with their anti-inflammatory properties.

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[13] Solumedrol is an anti-inflammatory corticosteroid, and a dangerous drug pursuant to Business and Professions Code section 4022.

104. Patient C returned to IUCC on a number of occasions thereafter, and saw Dr. Vesal. Specifically, Patient C returned on July 22, August 11 and 25, September 12 and 28, October 14 and 23, and November 19, 2014. Most of these visits concerned Patient C's complaints of neck pain and/or anxiety, which resulted in Dr. Vesal refilling Patient C's Norco (30, 325 mg-10 mg tablets) prescription at nearly every visit, and filling her Xanax (30, 1 mg tablets) prescription on July 22, August 11, September 12, and November 19, 2014. Dr. Vesal also ordered a Toradol and Solumedrol intramuscular injection on July 22 and September 28, 2014.

105. On December 8, 2014, Patient C returned to IUCC and was seen by Respondent. She complained of feeling nauseous after wearing a pain patch (i.e., Butrans, a long acting opioid), and of feeling fatigued and low on energy. Respondent stopped the Butrans, refilled her Norco (30, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions.

106. Patient C returned to IUCC on a number of occasions thereafter, and saw Dr. Vesal. Specifically, Patient C returned on December 18 and 31, 2014, and January 13, 2015. Most of these visits concerned Patient C's complaints of neck pain and/or anxiety, which resulted in Dr. Vesal refilling Patient C's Norco (45, 325 mg-10 mg tablets) and ?(90, 325 mg-10 mg tablets) prescriptions. Dr. Vesal also ordered a Toradol and Solumedrol intramuscular injection on December 31, 2014, and January 13, 2015.

107. On January 21, 2015, Patient C returned to IUCC and was seen by Respondent. She sought refills of her anxiety and back pain medications. Respondent refilled her Norco (45, 325 mg-10 mg tablets) as well as her Xanax prescriptions.

108. On January 28, 2015, Patient C returned to IUCC and was seen by Respondent. She complained of cough and congestion, and explained that her neck pain was aggravated by her cough. Respondent gave Patient C an antibiotic and an over the counter cough suppressant. Respondent also refilled her Norco (45, 325 mg-10 mg tablets) prescription.

109. On February 4, 2015, Patient C returned to IUCC and was seen by Respondent. She advised Respondent that her medications were working and she needed refills. Respondent refilled her Xanax (30, 2 mg tablets) prescription.

110. On February 11, 2015, Patient C returned to IUCC and saw Respondent. She wanted a B-12 injection and follow up regarding her neck pain. Respondent gave her a B-12 injection, and Respondent refilled her Norco (45, 325 mg-10 mg tablets) prescription.

111. On February 19, 2015, Patient C returned to IUCC and was seen by Respondent. She complained of headaches and neck pain. Respondent refilled her Norco (45, 325 mg-10 mg tablets) prescription. Respondent also ordered a Toradol and Solumedrol intramuscular injection.

112. On February 25, 2015, Patient C returned to IUCC and saw Respondent. They discussed Patient C's medication. At one point, Respondent cautioned Patient C against being on both Xanax and Soma medications simultaneously. Patient C told Respondent, "I never take Xanax and Soma at the same time." Respondent refilled her Norco (45, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions.

113. On March 5, 2015, Patient C returned to IUCC and was seen by Respondent. She sought medication refills for her back pain. Respondent noted that he would be refilling Patient C's Norco (45, 325 mg-10 mg tablets) and Soma prescriptions.

114. On March 12, 2015, Patient C returned to IUCC and saw Respondent. She complained of increased muscle spasms. Consequently, Respondent increased Patient C's Xanax (30, 2 mg tablets) to twice per day.

115. On March 24, 2015, Patient C returned to IUCC and was seen by Dr. Vesal. She sought a refill of her muscle relaxant and pain reliever. Dr. Vesal refilled her Norco (45, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions.

116. On April 15, 2015, Patient C returned to IUCC and saw Respondent. She advised that she felt as though she was getting sick, as she had upper respiratory infection symptoms. Respondent also noted that Patient C had decreased mobility to bend forward and back, with nerve tendon involvement. Respondent refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Soma (30, 350 mg tablets) prescriptions.

117. On April 22, 2015, Patient C returned to IUCC and saw Dr. Vesal. She sought a refill of her medications. Dr. Vesal refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Soma (30, 350 mg tablets) prescriptions.

118. On May 1, 2015, Patient C returned to IUCC and was seen by Respondent. Patient C complained of persistent neck and back pain. She stated that her back hurt more, and wondered whether she needed another MRI. Patient C underwent a MRI on May 4, 2015, and the results revealed that Patient C had a disc bulge, among other things. Respondent discussed Patient C's MRI results when she returned on May 11, 2015. Respondent refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions.

119. On May 24, 2015, Patient C returned to IUCC and saw Dr. Vesal. She sought medication for her anxiety and a refill of her pain medication. Dr. Vesal refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions.

120. On May 28, 2015, Patient C returned to IUCC and saw Respondent. Patient C stated that her medications were working well and sought a refill. She reported that her anxiety was better and that the pain medication had reduced her pain by 60 to 70 percent. Respondent refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions. Patient C stated that she would return for physical therapy.

Respondent saw Patient C again on June 4, 2015, and Patient C reported that her pain relief was at about 75 percent. Respondent stated in the notes that CURES needed to be checked, and that Patient C was due to take a urine drug screening test.

121. On June 6, 2015, Patient C received a trigger point injection of a mixture of Kenalog and Lidocaine in her back.

122. On June 12, 2015, Patient C returned to IUCC and was seen by Respondent. Patient C sought a refill of her Norco and Soma medications. She reported that physical therapy was helping, and that she was not taking Xanax regularly. Respondent ordered a Toradol and Solumedrol intramuscular injection, and refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Soma (30, 350 mg tablets) prescriptions.

123. On June 20, 2015, Patient C returned to IUCC and was seen by Dr. Vesal. She complained that her anxiety attacks made her feel like her heart would jump out of her chest. Dr. Vesal refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Soma (30, 350 mg tablets) prescriptions.

124. On June 28, 2015, Patient C returned to IUCC and saw Respondent. Patient C sought refills of her prescriptions and reported that her anxiety was much better, but that her lower back pain had increased. Respondent refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Soma prescriptions (30, 350 mg tablets), and ordered a trigger point injection of a mixture of Kenalog and Lidocaine in Patient C's back.

125. On July 7, 2015, Patient C returned to IUCC and saw Dr. Nguyen for refills of her prescriptions. Dr. Nguyen refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Xanax (30, 2 mg tablets) prescriptions, and ordered a trigger point injection of a mixture of Kenalog and Lidocaine in Patient C's back.

126. On July 11, 2015, Patient C received a trigger point injection of a mixture of Kenalog and Lidocaine in her neck.

127. On July 15, 2015, Patient C returned to IUCC and saw Dr. Vesal for her refills. Dr. Vesal refilled Patient C's Norco (45, 325 mg-10 mg tablets).

128. On July 19, 2015, Patient C received a trigger point injection of a mixture of Kenalog and Lidocaine in her back.

129. On July 23, 2015, Patient C returned to IUCC and was seen by Respondent. Patient C complained of chest and nasal congestion and cough. Respondent gave Patient C a nebulizer treatment, an antibiotic, and a steroid.

130. On July 31, 2015, Patient C returned to IUCC and saw Respondent. Patient C complained of pain and anxiety. Respondent instructed Patient C to stop taking Soma. Respondent refilled her Xanax (30, 2 mg tablets) and Norco (45, 325 mg-10 mg tablets)

prescriptions. Patient C received a trigger point injection of a mixture of Kenalog and Lidocaine in her neck.

131. Patient C received a trigger point injection of a mixture of Kenalog and Lidocaine in her back on August 4, 2015.

132. On August 8, 2015, Patient C returned to IUCC and was seen by Respondent. Patient C wished to follow up on treatment for her neck and back. She stated that she did not want to take stronger pain medications. Respondent ordered a Toradol and Solumedrol intramuscular injection for its anti-inflammatory properties. Respondent had already refilled her Soma (30, 350 mg tablets) and Norco (45, 325 mg-10 mg tablets) prescriptions on August 6, 2015.

133. Patient C received trigger point injections of a mixture of Kenalog and Lidocaine in her back on August 8 and 20, 2015, and in her neck on August 12 and 28, 2015.

134. Patient C returned to IUCC on a number of occasions thereafter, and saw Dr. Vesal or Dr. Nguyen. Specifically, Patient C returned on August 16 and 24, September 1, 9, 17, and 25, and October 3, 11, and 19, 2015. Most of these visits concerned Patient C's complaints of neck pain and/or anxiety, which resulted in Dr. Vesal or Dr. Nguyen refilling Patient C's Norco prescription (45, 325 mg-10 mg tablets) on nearly every visit, and/or filling her Xanax (30, 2 mg tablets) or Soma (30, 350 mg tablets) prescriptions. Dr. Vesal and/or Dr. Nguyen ordered a Toradol and Solumedrol intramuscular injection for anti-inflammatory purposes on September 1 and 25, and on October 3 and 11, 2015. Dr. Vesal and/or Dr. Nguyen ordered trigger point injections of a mixture of Kenalog and Lidocaine in Patient C's back on September 5 and 25, and October 7, 2015, and in her neck on September 13 and October 15, 2015.

135. On October 26, 2015, Patient C returned to IUCC and was seen by Respondent. Patient C shared that she felt much better after treatment (i.e., physical therapy and electrode stimulation). Respondent ordered a Toradol and Solumedrol intramuscular injection for anti-inflammatory purposes, and ordered trigger point injections of a mixture of Kenalog and Lidocaine in her neck.

136. Patient C returned to IUCC on a number of occasions thereafter, and saw Dr. Vesal or Dr. Nguyen. Specifically, Patient C returned on November 3, 11, and 19, and December 3, 2015. Dr. Vesal and/or Dr. Nguyen ordered a Toradol and Solumedrol intramuscular injection for anti-inflammatory purposes on November 3 and 19, and December 3, 2015. Dr. Vesal and/or Dr. Nguyen refilled Patient C's Norco (45, 325 mg-10 mg tablets) prescription on nearly every visit, and/or refilled her Xanax (30, 2 mg tablets) or Soma (30, 350 mg tablets) prescriptions. Dr. Vesal or Dr. Nguyen ordered trigger point injections of a mixture of Kenalog and Lidocaine in Patient C's back on October 23, and November 7, 15, and 23, 2015, and in her neck on October 26, and November 23, 2015.

137. On December 10, 2015, Patient C returned to IUCC and was seen by Respondent. Patient C complained of her anxiety being higher than normal. She also shared that her back pain had gotten worse with increased activity. Respondent discussed weaning Patient C off of Xanax. Respondent refilled her Xanax (30, 1 mg tablets) and Norco (45, 325 mg-10 mg tablets) prescriptions.

138. On December 15, 2015, Patient C received a trigger point injection of a mixture of Kenalog and Lidocaine in her neck.

139. On December 19, 2015, Patient C returned to IUCC and saw Dr. Vesal. Patient C sought therapy and injections. Dr. Vesal ordered a Toradol and Solumedrol intramuscular injection, and refilled Patient C's Norco (45, 325 mg-10 mg tablets) prescription.

140. On January 5, 2016, Patient C returned to IUCC and saw Dr. Nguyen. Patient C complained of stomach flu. Dr. Nguyen refilled Patient C's Norco (45, 325 mg-10 mg tablets) and Soma (30, 350 mg tablets) prescriptions. Respondent testified this January 5, 2016 was Patient C's final visit to IUCC. However, CURES shows that Dr. Nguyen prescribed Patient C Norco (45, 325 mg-10 mg tablets) and Xanax (30, 1 mg tablets) on January 14, 2016, and Respondent prescribed Norco (45, 325 mg-10 mg tablets) on January 21 and 28, 2016, and Soma (30, 350 mg tablets) on January 22 and 30, 2016, but there are no corresponding notes documenting the same in Patient C's chart or progress notes.

141. Respondent's progress notes failed to document any discussion with Patient C regarding the risks and benefits of the dangerous combinations of opiate and non-opiate medications prescribed by him, regarding any referral to pain management, or regarding any discussion of Patient C's functional improvement from the opiate, injection, and benzodiazepine therapy.

Respondent's Testimony

A. Respondent's Background

142. Respondent has been practicing medicine for more than 27 years. He earned both his bachelor's degree in physiology and his doctor of medicine from the University of Hawaii in 1983 and 1988, respectively. Respondent completed his residency in pediatrics at the Kapiolani Medical Center in Hawaii in 1991. In 1993, Respondent became board-certified in preventative medicine, with a clinical focus on internal medicine and chronic pain care. Respondent remains up to date on the latest information regarding the safe management of chronic pain, evidenced by his annual completion of continuing education courses in the area of opiate prescribing.

143. In 1994, Respondent earned his master's degree in public health. Respondent has served as a staff physician at IUCC since 2014, where he has provided urgent, emergent, and general medical care. Since 1998, he has mentored and lectured pre-medical students,

medical students, interns, and residents. He has written 10 published articles, primarily on the topic of weight loss, and has made a number of presentations regarding obesity and weight loss.

144. Respondent has served as a staff physician at Gateway Research Center since 2013, where he serves as an investigator for clinical trials. Additionally, since 1991, Respondent has served as the director of clinical research at the Linda Vista Health Care Community Clinic. Since 2010, Respondent has conducted 21 clinical trials of various treatments. At hearing, Respondent explained that clinical research studies serve as good options for some of his patients to get the latest and best treatment they cannot afford. Respondent further explained that in order to be qualified to conduct clinical trials, a physician must demonstrate a "very good track record" with no current discipline.

B. Background Information Re: IUCC

145. At hearing, Respondent explained that even though IUCC is an urgent care center, approximately 40 percent of patients use it as their primary care facility. As a staff physician, Respondent sees approximately 40 to 50 patients per day, and 20 percent of them are chronic pain patients. Respondent defined chronic pain as pain lasting more than three months, at least three days per week.

146. Respondent testified that IUCC's policy and procedure required chronic pain patients receiving pain medication to return to IUCC once per week in order to receive more medication, as IUCC physicians prescribed enough to last only one week. Respondent explained that the rationale for this policy stemmed from IUCC's desire to follow chronic pain patients closely, and to prevent these patients from diverting the prescribed drugs by abusing them or illegally selling them. Respondent further stated that IUCC patients are advised of this policy from the beginning, and told that they are expected to return to IUCC once per week if they wished to receive a refill on any pain medication.

147. Respondent testified that when he first began working at IUCC in 2014, he introduced urine drug screening tests, pain contracts, medication lists, and CURES reviews to IUCC's overall practice.

C. Respondent's Custom and Practice

148. Respondent testified that it has always been his custom and practice to review a patient's records before seeing the patient. Respondent also testified that since 2009, it has been his practice to review CURES reports before prescribing pain medication, to help ensure that his patients were not obtaining pain medication from different doctors (i.e., "doctor shopping"), among other things; however, he does not make a practice of including copies of the CURES reports in patients' charts or stating in chart notes that he has reviewed CURES reports. From his experience, CURES report entries do not appear for a couple of days after issuing a prescription.

149. It is Respondent's custom and practice to perform an examination of his patients before prescribing medication of any sort, including those patients he treats for chronic pain. In assessing a patient's level of pain, Respondent testified that he rarely uses pain scales (i.e., a tool used by physicians to assess a patient's level of pain), because research has shown that they are "woefully inadequate" in assessing pain. Respondent further shared that there is a "great debate" occurring in the medical community regarding the overall use and effectiveness of pain scales.

150. Respondent explained that it is his custom and practice to discuss the risks and benefits of opiate use with his patients every time he sees patients who have been or will be prescribed opioid medications. This discussion includes side effects of the medication, including impaired motor function, and the potential for misuse and addiction. It is also his custom and practice to assess a patient for addiction before prescribing any opiates to that patient. That assessment includes asking the patient questions related to any history of substance abuse, current drug or alcohol use, treatment history, health history, patterns of behavior, and symptoms.

151. When prescribing opiates, Respondent is cognizant of the *Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain* and the Board's guidelines for prescribing controlled substances for pain. Respondent explained that he considers them tools, as opposed to strict rules, and prescribes opiates on a case by case basis, as the medical circumstances dictate. Respondent is also cognizant that "nothing will give a chronic pain patient 100 percent pain relief." Rather, Respondent asserts that the goal in prescribing pain medication is to get at least a minimum of 50 percent pain relief.

152. Respondent testified that he routinely discussed with his patients the goal of reducing pain medication. Additionally, because there is no "one size fits all" when it comes to managing chronic pain, Respondent often changed a patient's medication based on how the patient was feeling, while always seeking an opportunity to prescribe the patient the lowest dose to manage the patient's chronic pain, with the goal of eventually prescribing no medication at all.

B. Records

153. Pursuant to the Board's request, Respondent provided the medical records of Patients A, B, and C. In that regard, Respondent had office staff copy the records for him, and then Respondent signed a "Certification of Records" certifying that the records provided to the Board were complete records. However, at hearing, Respondent explained that he did not recall reviewing the records before signing the declaration, and subsequently determined that all of the records were not provided to the Board. Specifically, the records Respondent provided to the Board did not include medication sheets that were typically attached to the left side of the patients' chart folders. The medication sheet included the medications and dosages prescribed. Other information missing from the records, according to Respondent, included insurance and billing information, some laboratory and imaging reports, and in

some cases, CURES reports. Respondent never provided these missing records to the Board, and did not produce them at hearing.

154. In light of the instant disciplinary matters against Respondent, Respondent has changed the manner in which he prescribes opioid medications. Specifically, Respondent has become more risk averse in prescribing opioid medications. In that regard, the patient records at IUCC are now thicker, as they include CURES reports, pain contracts, and opioid risk tools as a matter of course.

C. Patient A

155. With respect to Patient A, Respondent testified that after the stabbing incident in April 2015, Patient A started frequenting the emergency room to manage his pain. Respondent told Patient A that he could not use the emergency room to manage his pain while simultaneously treating at IUCC for chronic pain. Patient A told Respondent that he would stop frequenting the emergency room for pain. Respondent did not document this conversation in Patient A's medical records. When IUCC learned in November 2015 that Patient A had begun frequenting other physicians to manage his pain, Respondent confronted him. Patient A apologized and told Respondent that he just could not handle the pain. Respondent did not document this conversation in Patient A's medical records. Thereafter, IUCC discharged Patient A from its care.

156. Respondent did not suspect Patient A of engaging in any drug seeking behavior because, at some points, Patient A had reported that his pain was lessening, while at other points, he had reported that the pain had gotten worse. In Respondent's experience, individuals seeking drugs typically reported their pain getting worse, and never better. Another reason Respondent did not believe that Patient A was "drug seeking" was because Respondent saw Patient A once per week and did not observe Patient A displaying aberrant behaviors, such as claiming he lost his pills, or that someone had stolen his pills, or that he had been using other controlled substances.

D. Patient B

157. With respect to Patient B, Respondent "discovered somewhere down the line" that Patient B and Patient A were in a romantic relationship, and that she was the one who had stabbed Patient A.

158. Respondent did not suspect Patient B of abusing medication he prescribed to her, or engaging in any drug seeking behavior.

E. Patient C

159. When Respondent first began treating Patient C, he learned that Patient C had been on short-acting opioids for a significant period to time. However, with evidence of Patient C's neck pain worsening, given her x-ray and MRI results, he considered Patient C a

likely candidate for surgery. In the meantime, Respondent believed the best way to manage Patient C's pain was to introduce long-acting opioids into her treatment plan.

160. Respondent did not suspect Patient C of abusing medication he prescribed to her, or engaging in any drug seeking behavior, as her examinations and complaints were consistent with the results of the x-rays and MRIs.

Complainant's Expert: Dr. James J. Huang

161. After the Board received medical records from Respondent concerning Patients A, B, and C, it retained Dr. James J. Huang to conduct a medical expert review of those records, and others, to determine whether Respondent departed from the standard of care in his care and treatment of those patients, particularly in the manner he prescribed controlled substances to those patients.

162. Dr. Huang, who testified at hearing, is board certified in internal medicine, and has been an attending staff physician providing primary care at Loma Linda Veteran's Administration Medical Center (VA Hospital) since 2000. Dr. Huang is also an assistant professor of medicine at Loma Linda School of Medicine, and a clinical assistant professor of internal medicine at University of California at Riverside. He earned his bachelor's degree from Boston University in 1986, and earned his doctor of medicine from the Boston University School of Medicine. He completed his internship and residency in internal medicine at the University of California at Los Angeles/VA West Los Angeles Medical Center in 1993, and completed a fellowship in gastroenterology at the University of Southern California/Los Angeles County Medical Center in 1994.

163. Dr. Huang has served as a medical expert reviewer for the Board since 2004, and has reviewed 30 to 40 cases in that capacity. He has also served as the VA Hospital's hospitalist of inpatient medicine and as its preceptorship of the medical resident continuity clinic since 2000. Dr. Huang has earned awards and honors, including Loma Linda University School of Medicine's Outstanding Teaching Award in 2009. Dr. Huang has also published articles in the Open Journal of Clinical Medical Case Report in 2016 and 2017.

164. Dr. Huang sees 10 to 16 patients per day, and has seen thousands of patients over his career. He has treated more than half of his patients for chronic pain.

165. Dr. Huang reviewed the following pertinent materials:[14] (1) CURES reports for Respondent; (2) medical records of Patient A; (3) medical records of Patient B; (4) medical records of Patient C; (4) CURES reports pertaining to Patients A, B, and C;

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[14] With respect to the medical records, Dr. Huang noted that they were primarily handwritten chart notes and often illegible or very difficult to read. However, most of the illegible notes were those prepared by Dr. Vesal. As such, it was difficult for Dr. Huang to ascertain what kind of therapies, if any, Dr. Vesal engaged when treating Patients A, B, and C.

(5) curriculum vitae of Respondent; (6) Respondent's continuing medical education certificates; (7) copies of CURES reports found in the charts of patients; (8) transcription of Respondent's interview with the Board; (9) receipts for original prescriptions taken from CVS and Ralphs pharmacies; and (10) a digital recording of Respondent's interview with the Board. Thereafter, Dr. Huang prepared a written report setting forth his conclusions.

166. Dr. Huang identified six medical issues concerning Respondent's care and treatment of Patients A, B, and C: (1) evaluation and non-opiate management of chronic pain; (2) initiation and monitoring of opiate pain management; (3) informed consent and pain care agreements; (4) concurrent usage of benzodiazepines and opiates; (5) proper medical records maintenance; and (6) management of generalized anxiety disorder by primary care physician.

1. Evaluation and Non-Opiate Management of Chronic Pain

167. With respect to the first issue, evaluation and non-opiate management of chronic pain, Dr. Huang shared that several guidelines regarding the evaluation and management of chronic pain have been published over the last five years to guide physicians, including the Board's guidelines issued in 2014, and the CDC's guidelines issued in 2016. Dr. Huang stated that the guidelines codify many physicians' management strategies already in practice, but they also highlight new medical evidence to help physicians navigate through the risks and benefits of long-term opiate therapy.

168. In light of these guidelines, particularly those published by the Board, Dr. Huang stated that the standard of care requires an initial evaluation of chronic pain that includes a complete history, a physical examination, and appropriate radiologic and laboratory testing to determine if the chronic pain is caused by cancer. For non-cancer chronic pain, Dr. Huang noted that the first line of treatment is not opiate therapy, due to its risks of addiction, drug overdose, and respiratory depression. Rather, non-pharmacologic therapy and non-opiate therapy are preferred. Dr. Huang listed examples of non-pharmacologic therapy as weight loss, aerobic exercises, aquatic pool therapy, and cognitive therapy. Examples of non-opiate medications include non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and even anti-seizure medications, as they all "can significantly reduce pains and restore the patients' functionality." (Exhibit 16, page AGO-2373.) Dr. Huang also stated the following:

> Patients do not need to sequentially fail all these therapies before opiate therapy is tried, if the benefits of narcotics outweigh its dangers. However, if opiate therapy is chosen, it is most beneficial when combined with non-pharmacologic therapy and non-opiate medications.

(*Ibid.*)

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2. Initiation and Monitoring of Opiate Pain Management

169. With respect to the second issue, initiation and monitoring of opiate pain management, Dr. Huang stated that the standard of care require that opiates with the lowest potency and addiction potential should always be tried first for a defined period of time, usually one to three months. The patient's progress should be monitored for both benefit and harm, including the patient's level of pain, function, and quality of life and adverse events. Dr. Huang stated that if the patient is continued on opiate therapy, the patient should experience a fulfillment of functional goals. Dr. Huang also stated the following:

> If both the patient and physician agreed to continue opiate therapy beyond 90 days, the titration of pain medication dosage should be slow. Ideally, the morphine equivalent dose (MED) of the patient's daily opiate therapy should not exceed 80-90 mg per day. Risk of drug overdose and death and adverse effects increase significantly beyond this dosage.

(*Ibid.*)

170. Dr. Huang also explained that the physician should also assess the patient's risk of drug addiction and aberrancy prior to starting long-term opiate therapy. In that regard, the physician should employ risk stratification tools to mitigate potentially adverse consequences of opiate therapy. Risk stratification includes performing a psychological evaluation assessing risks of addictive behaviors, typically done by using a set questionnaire like Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), Patient Health Questionnaire 9 (PHQ-9).

171. Dr. Huang explained that once a patient's pain is adequately controlled on a safe dosage of opiate therapy, that patient should be monitored on a regular basis, at least every one to three months. These periodic assessments allow physicians to determine if the pain medications are meeting the patient's goals of improved pain and functional status. They also allow physicians to discontinue or to taper off a patient's opiates if harm outweighs the benefits.

172. Dr. Huang testified that physicians should focus on activities of daily living, adverse side effects of opiates, and aberrant behaviors during clinical visits. Strategies for monitoring compliance include regular consultations with the CURES database, urine drug testing, and pill counting. If drug abuse or diversion is confirmed, the physician should immediately arrange a face-to-face meeting with the patient to reevaluate the treatment plan and taper off opiate therapy if appropriate.

3. Informed Consent and Pain Care Agreements

173. With respect to the third issue, informed consent and pain care agreements, Dr. Huang stated the standard of care requires that when considering long-term use of

opiates, the physician discuss the risks and benefits of the treatment plan with the patient. He explained that informed consent involves addressing the risks and side effects of opiate medications, including constipation, sexual dysfunction, osteoporosis, and cognitive impairment. It also emphasizes risks of over-sedation, drug interactions, respiratory depression, impaired driving motor skills, and opiate dependency and addiction.

174. In regard to pain management agreements, Dr. Huang explained that they typically outline the joint responsibilities of the physician and the patient, including replacement and early refills of lost medication. Pain management agreements also emphasize the patient's responsibility to obtain his or her prescribed opiate medication from only one physician or practice and discuss periodic drug testing and CURES report reviews. Dr. Huang testified that pain care agreements have been shown to improve narcotic patients' compliance with treatment goals and objectives and to reduce their risk of engaging in aberrant behaviors.

4. Concurrent Usage of Benzodiazepines and Opiates

175. With respect to the fourth issue, concurrent usage of benzodiazepines and opiates, Dr. Huang stated the standard of care requires that physicians strongly avoid prescribing both narcotics and benzodiazepines at the same time, as the risks outweigh the benefits. Specifically, Dr. Huang explained that benzodiazepines and opiate medications both cause central nervous system depression and can decrease respiratory drive. Concurrent use is likely to put patients at greater risk for fatal overdose—four times more than opiate prescriptions alone.

176. Dr. Huang explained that when a physician encounters a patient with both medications, the physician should taper the patient off of the opiate medication first. If a patient wishes to continue opiate therapy instead, the physician should slowly taper off the patient's benzodiazepine.

5. Proper Medical Records Maintenance

177. With respect to the fifth issue, proper medical records maintenance, Dr. Huang stated the standard of care requires that a physician maintain accurate and adequate medical records. For a physician treating a patient with opiate medications, an adequate medical record includes the documentation of medical history, results of physical examination, and all the necessary laboratory and radiologic tests. Dr. Huang also explained that physicians should also document a patient's consent for using controlled substances, and the records should include a pain management agreement. The records should reflect all treatments provided, including all medications prescribed and related consultations. Additionally, the records should document the results of ongoing monitoring of patient progress in pain management and functional improvement. The records should also include any steps taken in response to any aberrant behaviors in opiate usage. Dr. Huang also stated that CURES data searches and urine drug testing should be documented. Finally, the

medical records should be up-to-date and maintained in an accessible manner so that they can be reviewed readily.

6. Management of Generalized Anxiety Disorder by Primary Care Physician

178. With respect to the sixth issue, management of generalized anxiety disorder by a primary care physician, Dr. Huang stated the standard of care requires physicians to assess the severity and extent of a patient's functional impairment caused by the anxiety disorder. The physician must, together with the patient, choose between behavioral therapy or medications, or a combination of both.

179. Dr. Huang explained that if medication is the chosen route, most experts recommend an initial treatment with a selective serotonin reuptake inhibitor (SSRI) or a selective norepinephrine reuptake inhibitor (SNRI), as they are the best-studied treatments found to be efficacious for anxiety disorder. Because of their variable responses to these medications, patients often need to try several different medications over several months to find the one SSRI or SNRI that works the best for them.

180. Dr. Huang stated that benzodiazepines play an important role in the management of generalized anxiety disorder, but concerns about risks of dependency and tolerance have limited their use. Other concerns about benzodiazepines include abuse, amnesia, and withdrawal symptoms.

7. Dr. Huang's Analysis of Respondent's Care of Patient A

181. From his review of the records, Dr. Huang noted that, in regard to the evaluation and non-opiate management of chronic back pain, Respondent performed an appropriate physical examination and radiologic evaluation of Patient A's chronic back pain, and also offered non-pharmacologic therapy, including physical therapy and muscle trigger point injections. However, there was an inadequate trial of non-opiate medications, such as NSAIDs, anti-seizure medications, or SSRIs for the management of pain. Dr. Huang also noted that Respondent's care of Patient A lacked consultations with pain management specialists for epidural injections or surgery. Given these factors, Dr. Huang concluded that Respondent committed a simple departure from the standard of care.

182. Dr. Huang noted that, in regard to the initiation and monitoring of pain management, Respondent made several omissions. According to Dr. Huang, Respondent failed to properly assess Patient A's risks of addiction prior to starting opiate therapy, evidenced by the lack of a formalized risk assessment score noted in the chart. Respondent also failed to start Patient A's opiate therapy with lower potency opiates, and instead escalated Patient A's opiate therapy at a rapid rate. Specifically, Respondent started Patient A on 7.5 mg tablets of hydrocodone (i.e., Norco) at 30 mg daily, or a morphine equivalency dose (MED) of 30 mg. However, the following month, Respondent escalated Patient A to 10 mg tablets oxycodone (i.e., Percocet), averaging four tablets per day, for a MED of 60 mg.

Dr. Huang noted that Patient A was prescribed six tablets daily during the second half of 2015, for a MED of 90 mg.

183. Additionally, despite Respondent's representations to the contrary, Dr. Huang concluded that Respondent did not routinely check CURES reports concerning Patient A, as Respondent failed to detect aberrant opiate refill patterns in May, June, and November 2015. During one week in May, specifically from May 11, 2015 to May 20, 2015, Patient A had received narcotic prescriptions from several different physicians unaffiliated with IUCC, which should have been a warning sign to Respondent that Patient A was exhibiting diversion or addiction behaviors. Dr. Huang stated that Respondent should have ordered a urine drug test immediately, and on a more regular basis for future opiate refills. Additionally, Respondent should have counseled Patient A about the risks of opiate abuse and addiction, and referred Patient A to an addiction psychiatrist or a drug treatment program. Dr. Huang concluded that these failures along with Respondent's failures set forth in Factual Finding 182, regarding the initiation and monitoring of pain management, constituted an extreme departure from the standard of care.

184. In regard to informed consent, Dr. Huang noted that a review of the records showed that Patient A never signed a pain care agreement outlining the steps of compliance with opiate therapy. He stated that having a pain care agreement was especially important with a patient such as Patient A, especially given Patient A's high risk for abuse. Dr. Huang concluded that Respondent's failure to require Patient A to sign a pain care agreement constituted a simple departure from the standard of care.

185. In regard to proper medical records maintenance, Dr. Huang noted that many of Respondent's progress notes failed to document any functional improvement from the opiate therapy. They did not reflect any steps taken by Respondent to address Patient A's aberrant behaviors, and the records did not include any CURES queries documented in the chart. Dr. Huang concluded that these failures constituted a simple departure from the standard of care.

8. Dr. Huang's Analysis of Respondent's Care of Patient B

186. From his review of the records, Dr. Huang noted that, in regard to the evaluation and non-opiate management of chronic back pain, Respondent failed to appropriately evaluate Patient B's soccer back injury by obtaining more details and requesting old medical records, if available. Additionally, Respondent failed to provide non-opiate therapy for Patient B's back pain, such as NSAIDs, anti-seizure medications, tricyclics, or SSRIs for the management of pain. Even though the records show that Patient B received recommendations for exercises and chiropractic services, there is no evidence that Patient B ever engaged in these activities. As such, Respondent should have made stronger efforts to convince Patient B of the benefits of such non-opiate therapies. Dr. Huang concluded that these failures constituted a simple departure from the standard of care.

187. Dr. Huang also noted that, in regard to the initiation and monitoring of pain management, Respondent failed to properly assess Patient B's opiate addiction risks prior to prescribing narcotic medication. He also noted that there was no documentation of Patient B's risk assessment. Dr. Huang stated that because of Patient B's young age (i.e., 18 years old) and psychiatric history (i.e., generalized anxiety), Patient B clearly had an above average risk of opiate addiction. Despite this, Respondent, during his initial visit with Patient B, started Patient B on Norco (45, 325 mg-10 mg tablets), averaging approximately 60 mg MED, and then a week later, Respondent escalated the medication to more potent and addictive oxycodone (i.e., Percocet) tablets. Dr. Huang testified that Respondent could have prescribed less potent opiate therapy, as the escalation to Percocet was too fast. Despite prescribing an average of 60 mg MED per week, Respondent failed to order urine drug tests regularly, as well as failed to query the CURES database on a regular basis to check for aberrant behaviors. Dr. Huang stated that instead, Respondent and the other physicians at IUCC continued to refill Patient B's opioid medications. Dr. Huang concluded that Respondent's overall care was an extreme departure from the standard of care for his inadequate risk assessment, his failure to try non-opiate medications, his rapid escalation of opiate dosages, his lack of routine drug testing, and his continued practice of prescribing narcotics to Patient B.

188. Dr. Huang noted that, in regard to informed consent and pain care agreements, those tools were essential to enforce compliance and to prevent aberrant behaviors. However, Respondent obtained no informed consent or pain care agreement from Patient B, as nothing in that regard existed in Patient B's records. Dr. Huang concluded that those factors constituted a simple departure from the standard of care.

189. Dr. Huang also noted that, in regard to the concurrent usage of benzodiazepines and opiates, given the well-known fact that combination usage of opiate and benzodiazepine medications increase risk of overdose and death significantly, Respondent should have first used alternatives to benzodiazepines for anxiety management. Instead, Patient B continued receiving benzodiazepines (i.e., Xanax) and opiate prescriptions. Dr. Huang concluded that these factors constituted a simple departure from the standard of care.

190. Dr. Huang noted that, in regard to proper medical records maintenance, although Respondent saw Patient B regularly for opiate prescription refills, Respondent failed to reflect in many of his progress notes any functional improvement experienced by Patient B as a result of the opiate therapy. Additionally, the records lacked any queries of CURES, lacked evidence of any urine drug testing, and lacked documentation of any discussion about the risks and benefits of opiate medications. Dr. Huang concluded that these factors constituted a simple departure from the standard of care.

191. Dr. Huang also noted that, in regard to the management of generalized anxiety disorder by a primary care physician, Respondent's prescription of Xanax for initial management of Patient B's generalized anxiety was a simple departure from the standard of care. Dr. Huang reiterated that because of the addiction and dependency potential of benzodiazepines, safer alternatives like SSRIs, SNRIs, or psychotherapy should have been

recommended first. Furthermore, because of Patient B's usage of opiate medications, Respondent should have refrained from prescribing benzodiazepines in order to minimize the risk of overdose.

9. Dr. Huang's Analysis of Respondent's Care of Patient C

192. From his review of the records, Dr. Huang noted that, in regard to the evaluation and non-opiate management of chronic back pain, Patient C's neck and low back pains had been fully evaluated prior to seeing Respondent in 2015, including the performance of x-rays and a MRI on Patient C. However, Respondent simply refilled her opiate therapy, with no records showing that Respondent tried to control Patient C's pain through anti-seizure medications or tricyclics or SSRIs, or that Respondent provided pain management consultation for epidural injections.

193. With respect to non-opiate management of pain, Dr. Huang found concerning Patient C's routine intramuscular injections of Solumedrol 125 mg together with Toradol 60 mg. Specifically, Patient C received a total of 14 injections throughout 2015, even though long term use of Solumedrol, which is a potent corticosteroid, can lead to side effects including cataracts, hyperglycemia, osteoporosis, increased infections, steroid psychosis, and weight gain. Additional, Toradol, which is a potent anti-inflammatory, can lead to side effects of kidney failure and intestinal bleeding. Given these side effects, such injections should be limited to five shots per year, and blood count and metabolic panels should be performed regularly to monitor for possible kidney damage or blood loss. Dr. Huang stated, in short, that "routine usage of these two medications on a recurring basis have no role in chronic management of back pains." (Exhibit 16, page AGO-2379.) Dr. Huang concluded that Respondent's routine injections of these two medications and his failure to monitor their side effects, as well as the lack of pain management consultation, constituted an extreme departure from the standard of care.

194. Dr. Huang noted that, in regard to the initiation and monitoring of opiate usage, Respondent simply refilled Patient C's Norco and Xanax prescriptions on a regular basis, and then added a potent muscle relaxant, Soma. Dr. Huang stated that a combination of all three of these medications could result in a drug overdose. However, according to Dr. Huang, Respondent's monitoring of Patient C's opiate use was inadequate, as there were no urine drug tests performed or routine CURES queries documented in Patient C's chart. These factors constituted a simple departure from the standard of care.

195. Dr. Huang also noted that, in regard to informed consent and pain care agreements, Patient C's records included no pain contract or any documented discussions regarding the risks of her cocktail of medications of Norco, Soma, and Xanax. These factors constituted a simple departure from the standard of care.

196. Dr. Huang noted that, in regard to concurrent usage of benzodiazepines and opiates, Respondent should have tried to taper off Patient C's Xanax usage and tried non-benzodiazepine medications to reduce her anxiety, given the significant risk of drug overdose

from the concurrent use of benzodiazepines and opiates. Respondent's failure to reduce or eliminate Patient C's concurrent use of benzodiazepines and opiates constituted a simple departure from the standard of care.

197. Dr. Huang also noted that, in regard to proper medical records maintenance, Respondent failed to document in many of his notes the routine refills of opiates and benzodiazepines, and failed to document whether the opiate and benzodiazepines therapies helped Patient C's functionality. Dr. Huang also noted that despite Patient C's routine injections of Solumedrol and Toradol, the notes consistently failed to reflect whether Patient C had benefited from the injections. Finally, Patient C's records included no evidence of urine drug testing or documentation of any CURES queries. These factors constituted a simple departure from the standard of care.

198. Finally, Dr. Huang noted that, in regard to the management of generalized anxiety by a primary care physician, Respondent should not have prescribed benzodiazepines as an initial measure, given Patient C's dependence on opiate therapy, and the dangers of the concurrent usage of opiates and benzodiazepines. These factors constituted a simple departure from the standard of care.

Respondent's Expert: Dr. Standiford Helm, II

199. Standiford Helm, II, M.D., who offered expert testimony on Respondent's behalf, is a licensed physician and a diplomate of the American Board of Anesthesiology, with a subspecialty certification in pain medicine, a diplomate of the American Board of Pain Medicine, a diplomate of Interventional Pain Physicians, with competency certification in regenerative medicine in interventional pain management, and a fellow of interventional pain practice. He earned his bachelor's degree from Harvard College in 1972, his doctor of medicine from Tufts University in 1977, and completed his internship in internal medicine, and his residency in anesthesiology, at Boston City College in 1978, and the University of California at Los Angeles in 1980, respectively. Dr. Helm also earned his masters' of business administration from Pepperdine University in 1988. Dr. Helm also serves as a qualified medical evaluator with the Board, and has reviewed approximately dozens of medical matters for the Board.

200. Dr. Helm has earned a number of awards and honors, such as the Outstanding Achievement Award in 2017, Castle & Connolly Orange County Top Doctors in 2016, Castle & Connolly San Diego's Top Doctors in 2013, and Castle & Connolly Los Angeles' Top Doctors in 2013. Dr. Helm has published more than 80 articles, most of which focused on the topic of pain, and has given more than 100 lectures on the same.

201. Dr. Helm, who is board-certified in anesthesiology, pain medicine, and in addiction medicine, limits his practice to interventional pain management and addiction medicine. He spends more than 90 percent of his time in the clinical practice of medicine.

202. Dr. Helm reviewed the medical records of Patients A, B, and C, the Board's investigation files, Dr. Huang's written report, Respondent's interview with the Board, and the Accusation in this matter, and prepared a written report setting forth his conclusions and opinions.

203. Dr. Helm noted that the Accusation alleged gross negligence, repeated negligent acts, and failure to maintain adequate and accurate records concerning Patients A, B, and C. Dr. Helm offered his conclusions about whether Respondent committed acts of gross negligence, acts of repeated negligence, and failed to maintain adequate and accurate records.

1. Gross Negligence

A. Patient A

204. With respect to allegations that Respondent engaged in gross negligence of his care and treatment of Patients A, B, and C, Dr. Helm concluded that Respondent committed no such violation. Specifically, with respect to Patient A, Dr. Helm noted that Patient A presented at IUCC with no history of substance abuse, that Respondent changed Patient A's medication from Percocet to Norco when Percocet proved to be too strong, that Patient A was seen continuously by Respondent and the other physicians at IUCC, and that, according to Respondent's interview with the Board, CURES reports were obtained concerning Patient A. Dr. Helm asserts that such factors demonstrate that Respondent was attentive to Patient A's care and treatment and committed no gross negligence in that regard.

205. With respect to criticism regarding the lack of a pain agreement in Patient A's records, Dr. Helm noted that, according to Respondent's interview, it was Respondent who had introduced the use of pain agreements to IUCC's practice, as well as CURES reports and urine drug screening tests. As such, Dr. Helm concluded that the absence of any pain agreement in Patient A's records was a failure of ICUU's practice, and not of an individual employee physician such as Respondent.

206. Similarly, with respect to criticism regarding the failure to detect aberrant behaviors, presumably due to the failure to procure or review CURES reports, Dr. Helm asserted that because Respondent was responsible for introducing CURES reports to IUCC's practice, any failure to procure those reports was more of a failure of IUCC's practice, and not of an individual employee physician such as Respondent.

B. Patient B

207. With respect to Patient B, Dr. Helm noted that Patient B presented at IUCC with no history of substance abuse, and asserted that any allegations of gross negligence concerning the monitoring of Patient B are not attributable to Respondent. Specifically, Dr. Helm stated the following:

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> While there were frequent refills, the CURES reports indicate that [Patient B] did get controlled substances elsewhere and a [urine drug screen] was not obtained, these issues appear to be more structural, relating to the way the Clinic handled information.

(Exhibit K, page 003.)

208. Similarly, Dr. Helm contended that any failure to obtain a release to obtain Patient B's old medical records, procure a pain contract, or obtain CURES reports was more of a failure of IUCC, and not of an individual employee physician such as Respondent.

C. Patient C

209. With respect to Patient C, Dr. Helm noted that the Accusation alleged that Respondent committed gross negligence by routinely prescribing intramuscular injections without obtaining routine laboratory work (i.e., urine drug screening tests) to monitor the side effects on Patient C, or referring Patient C to pain management. However, Dr. Helm asserted that any failure to obtain a urine drug screen to monitor the side effects of trigger point injections, intramuscular injections, and/or benzodiazepine therapy, was the responsibility of IUCC, and not attributable to Respondent as an individual employee of IUCC.

210. In regard to referring Patient C to pain management, Dr. Helm stated the following:

> Regarding the referral to pain management, there are simply not enough pain management physicians to handle all patients on controlled substances. My message to primary care physicians when I have the opportunity to speak to them on this topic is to continue to provide opioids to patients who require only low doses and who continue to function well. I also ask that they comply with the current [Board's] guideline. Thus, I would respectfully submit that referral to a pain management physician is not necessary.

(Exhibit K, Page 004.)

211. In regard to trigger point injections, Dr. Helm stated that the records did not indicate whether any steroid was used, and Respondent's interview did not mention whether steroids were used in the trigger point injections. Dr. Helm stated that "steroid use is the limiting factor." (*Ibid.*) Dr. Helm stated that in the absence of any information regarding steroids, "it is not possible to comment on whether there is a departure from the standard of care regarding trigger point injections." (*Ibid.*) He further stated that "in the absence of any such information, there is no basis for criticism of [Respondent] regarding the number of trigger point injections provided." (*Ibid.*)

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B. Repeated Negligent Acts

212. With respect to Patient A, Dr. Helm noted that the Accusation alleges that Respondent failed to utilize or consider non-opioid treatment, failed to obtain a pain agreement, failed to document functional improvement, failed to make CURES queries, and failed to discuss aberrant behaviors. However, Dr. Helm stated that his comments regarding those issues in relation to allegations of gross negligence discussed above, are applicable here. In other words, the repeated acts alleged in the Accusation were primarily due to IUCC's failures as a practicing clinic, as opposed to Respondent's as one of its individual employees.

213. With respect to Patient B, Dr. Helm noted that the Accusation alleges that Respondent failed to appropriately evaluate Patient B's back injury before prescribing opioids, failed to consider the use of non-opioid treatment, failed to obtain a pain care agreement, failed to consider non-opioid alternatives before prescribing opioids, failed to document functional improvement, failed to discuss the benefits and risks of opioid therapy, failed to obtain CURES reports, and failed to first consider non-benzodiazepine treatment before prescribing benzodiazepine to treat Patient B's generalized anxiety disorder. In addition to his conclusions and opinions offered in response to the gross negligence allegations, Dr. Helm stated that, in relation to using benzodiazepines as a first-line treatment for generalized anxiety disorder, he agrees with the Board in that, as a matter of best practice, alternatives should be considered first. However, in looking at the standard of care, which Dr. Helm defined as "what a reasonably trained physician in the community would do in similar circumstances," and looking at the amount of alprazolam (i.e., Xanax) prescribed nationally, "it seems that the standard of care allows the initial use of alprazolam." (*Id.* at page 005.)

214. With respect to Patient C, Dr. Helm noted that the Accusation alleges that Respondent prescribed opioids and benzodiazepines without appropriate monitoring, failed to discuss the risks and benefits of opioids and benzodiazepines, prescribed Xanax for generalized anxiety disorder without considering non-benzodiazepine treatment, and failed to properly document functional improvement from the opioids, injections, and benzodiazepine therapies. However, Dr. Helm stated the following:

> The current [Board] Guidelines states, regarding the concomitant use of benzodiazepines and opioids, that with opioids and benzodiazepines, physicians should consider a trial of tapering. While this reviewer agrees that the combination of the two should be avoided, the Guidelines do not provide a bright line against their concomitant use.

(*Id.*)

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C. Failure to Maintain Adequate and Accurate Records

215. With respect to Patients A, B, and C and the allegations concerning Respondent's failure to maintain adequate and accurate records regarding them, Dr. Helm asserted that Respondent worked as an employee physician at IUCC, and, as such, the format and kind of the records used was not Respondent's decision to make. Dr. Helm stated that Respondent should not be held liable for decisions that he did not have the authority to make.

D. Dr. Helm's Overall Conclusion

216. In sum, Dr. Helm concluded that the bulk of the allegations against Respondent appeared to be related to structural problems with IUCC, including its failure to use electronic medical records and to obtain CURES reports. He concluded that Respondent appeared to be a functioning, well-trained, and compassionate physician who had spent the bulk of his career attempting to help the most vulnerable part of the population, and did not appear to be a risk to the public.

217. Dr. Helm also further stated the following:

> While I agree that the Clinic needs to come into compliance with current prescribing guidelines, deficiencies in that compliance did not seem to lie at [Respondent's] feet. In fact, [Respondent] has been instrumental in introducing opioid compliance tasks such as urine drug screens, pain agreements and review of CURES reports to the Clinic. His actions warrant praise rather than criticism.

(Exhibit K, page 006.)

Challenges to Dr. Helm's Credibility

218. During his testimony, Dr. Helm testified that the Boardguidelines regarding the prescribing and monitoring of controlled substances, including opiates, is not the standard of care. Rather, they serve as guidelines. Dr. Helm testified, however, that if a physician departs from the guidelines, the physician should cite the reason for the departure.

219. During cross-examination, however, Dr. Helm acknowledged that as an expert reviewer for the Board in prior matters, particularly on the topic of prescribing controlled substances, including opiates, he had written repeatedly in his reports that the Board's guidelines did, in fact, constitute the standard of care, and even quoted the pertinent sections of the guidelines in his reports.

Rebuttal to Dr. Helm's Testimony

220. Dr. Huang reviewed Dr. Helm's report and prepared a written report rebutting Dr. Helm's contentions.

A. Patient A

221. With respect to Patient A, Dr. Huang stated that Patient A was clearly an opiate addict based on the activity set forth in his CURES report. Specifically, Patient A obtained opiate prescriptions from multiple physicians outside of IUCC on consecutive days, particularly between May 2015 and November 2015, which Dr. Huang identified as clear aberrant behaviors. Dr. Huang acknowledged that there may be structural deficiency in IUCC in obtaining CURES reports, but emphasized that it is still the ultimate responsibility of the prescribing physician to check the narcotic database to ensure patient compliance. Dr. Huang stated further the following:

> Even though physicians were not legally required to check the CURES database until October 2016, most California physicians who were prescribing opiates in 2015 were already checking the database periodically to monitor for aberrant behaviors. If [Respondent] did indeed check the CURES database as he claimed, he should have identified the addictive and abusive pattern of the patient's narcotic activities between May and June of 2015. He should have discussed this concern with the patient and offered help for his addiction. Instead he continued to prescribe narcotics until the end of November when the patient moved out of California.

(Exhibit 17, page AGO-2430.)

B. Patient B

222. With respect to Patient B, Dr. Huang noted that it was easy for Patient B to obtain narcotic prescriptions as there was no adequate trial of non-opiate medications and therapy. Dr. Huang stated that with Patient B's psychiatric history (i.e., generalized anxiety), she had elevated risks for opiate addiction, yet Respondent failed to recognize the increased risks and continued to offer opiate medications. Dr. Huang also stated the following:

> [Respondent's] own expert witness argued that pain management specialty could not possibly see every patient with chronic low back pains as there were not enough pain specialists in the country. However, for patients at elevated risks of opiate addiction like Patient B, successful epidural injection by pain management specialty would have reduced her need for pain medications.

(*Id.* at page AGO-2431.)

C. Patient C

223. With respect to Patient C, Dr. Huang stated the following:

> The patient regularly received intramuscular injections of Solumedrol and Toradol 30-60 mg IM monthly for at least 12 consecutive months. These are not the typical trigger

> point injections as described by [Respondent's] defense expert witness, injected into areas of tight muscle knots or spasms. Those trigger point injections usually involved mixture of local anesthetics and low dose corticosteroids injected directly into specific local areas of tenderness.

(*Id.* at page AGO-2431.)

224. Dr. Huang further stated the following:

> The regular injections that [Patient C] received at the clinic contained very high dose corticosteroids and anti-inflammatory medications. They are meant for systemic absorption of the medications injected. They have serious side effects and required blood monitoring. Regardless of the routes of steroid injection (epidural or intra-articular or trigger points or intramuscular), most medical experts recommended no more than 3 or 4 injections per year due to concerns with long term side effects. Since Toradol is a very potent NSAID, it can cause acute pains, not for long term management of chronic pains. The usage of these two medications on a chronic basis on an almost monthly interval was definitely a concern.

(*Id.* at page AGO-2431-2432.)

Credibility Findings[15]

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[15] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected

225. Dr. Huang was a very credible and persuasive witness, as he testified in a clear, concise, and forthright manner, and demonstrated his wealth of pertinent knowledge in the area of pain management, buttressed by decades of experience, experience in teaching and training medical students as an assistant professor and a preceptor for nearly 20 years, and his experience treating thousands of patients over the decades.

226. Dr. Helm, on the other hand, despite his equally impressive credentials, particularly his decades of treating patients, his expertise in pain management, and his extensive publications and presentations on the matter, failed to testify in a credible manner. Specifically, Dr. Helm testified that the Board's guidelines were not the standard of care, presumably to challenge Dr. Huang's reliance on the guidelines when Dr. Huang formed his opinions. However, Dr. Helm had previously established in written expert reports he had prepared for the Board regarding opiate therapy matters, that the Board's guidelines did, indeed, establish the standard of care, and even quoted the pertinent sections of the guidelines in his reports. This blatant contradiction rendered Dr. Helm's overall testimony unreliable. Even without the contradiction, Dr. Helm's testimony was unpersuasive, particularly his conclusion that IUCC was primarily responsible for the failures set forth in the Accusation. Such a position completely ignores physicians' overall responsibility of caring and treating patients in a safe and competent manner. Because of these factors, Dr. Helm's testimony was afforded very little weight. Dr. Huang's testimony, on the other hand, given its independent strength combined with the lack of any credible challenge, was afforded great weight.

Character Evidence

227. Linda Hill, M.D., who specializes in general preventative medicine, provided character testimony, as well as submitted a letter of reference, on Respondent's behalf. Dr. Hill has known Respondent since 1991, when Respondent commenced his residency program at the University of California at San Diego from 1991 to 1993, and then became a staff physician in its health center, where Respondent and Dr. Hill have both practiced. Respondent has been an active member of the staff, participating in continuing medical education and in services, and providing thorough and thoughtful feedback. She has observed Respondent in his practice for more than 20 years, and found him to be a caring and thoughtful practitioner, kind and attentive to his patients. Additionally, Dr. Hill considers

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material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

Respondent's performance of clinical trials with diverse populations a great asset to the community and a wonderful contribution to the medical community as a whole.

228. Dr. Hill was aware of the Accusation filed against Respondent, and testified that Respondent has expressed his full responsibility and remorse for his conduct. She is aware that Respondent has changed his prescribing practice, and Dr. Hill believes that "there is no way that he would engage in similar conduct." (Exhibit M, page 2.)

CONCLUSIONS OF LAW

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence acts, as set forth in Factual Findings 3 through 226 and Legal Conclusions 12 and 13 below..

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts, as set forth in Factual Findings 3 through 226 and Legal Conclusions 14 through 17 below.

3. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for failure to maintain adequate records, as set forth in Factual Findings 3 through 226 and Legal Conclusion 18 below

The Applicable Law

4. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

5. The purpose of the Medical Practice Act[16] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from

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[16] Business and Professions Code sections 2000 through 2521.

ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. "The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.)" (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); (d) incompetence; and (e) the commission of any act involving dishonesty which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

10. Business and Professions Code section 2266 states that that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct."

11. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Analysis

A. Gross Negligence

12. Complainant met her burden of establishing, by clear and convincing evidence, that Respondent engaged in acts of gross negligence, with respect to Patients A, B,

and C, in violation of Business and Professions Code sections 2227 and 2234, subdivision (b). The record firmly established through the testimony of Dr. Huang, based on his thorough review of all of the pertinent records, that Respondent's care and treatment of Patients A, B, and C fell outside of the standard of care. Specifically, Dr. Huang persuasively established that Respondent's opiate monitoring of Patients A and B constituted an extreme departure from the standard of care, given Respondent's obvious failure to review CURES reports revealing Patient A's and Patient B's aberrant behaviors. The CURES reports showed repeated refills of opiate prescriptions written by physicians unaffiliated with IUCC during the same period in which Respondent and the other IUCC physicians treated and prescribed opiates to those patients. As such, Respondent's testimony that he, pursuant to his custom and practice, routinely reviewed CURES reports prior to seeing his patients, was either inaccurate or it demonstrated that Respondent ignored the information presented in the CURES reports. Additionally, Dr. Huang established through the medical records that Respondent failed to conduct an opioid risk assessment of these patients, failed to begin opiate therapy with lower potency opiates, and failed to obtain a pain agreement before prescribing any opiate medication. (Factual Findings 3 through 226.)

13. Similarly, Respondent committed an extreme departure from the standard of care with respect to Patient C and the routine intramuscular injections of Solumedrol and Taradol she received. Specifically, Patient C received a total of 14 intramuscular injections in 2015, when those injections, according to the uncontroverted testimony of Dr. Huang, should have been limited to no more than five per year to avoid serious side effects, such as kidney failure and intestinal bleeding. (Factual Findings 3 through 226.)

B. Repeated Negligent Acts

14. Complainant met her burden of establishing, by clear and convincing evidence, that Respondent engaged in repeated negligent acts, with respect to Patients A, B, and C, in violation of Business and Professions Code sections 2227 and 2234, subdivision (c). Specifically, as established by the credible testimony of Dr. Huang, Respondent engaged in multiple departures from the standard of care with respect to his failure to monitor opiate therapy appropriately, his failure to detect his patients' addictive behaviors, his failure to perform an opioid risk assessment prior to prescribing opiates, his failure to begin opiate therapy with lower potency opiates, and his failure to obtain a pain agreement before prescribing any opiate medication. Additionally, Respondent and his IUCC colleagues prescribed steroid and Toradol injections on a monthly basis for more than a year, far exceeding the maximum of five steroid injections an individual should receive in a one-year period, and failed to perform laboratory work to ascertain whether the side effects of the injections were adversely affecting the patients' kidneys and intestines.

15. Moreover, the record established that, with respect to Patients A, B, and C, Respondent committed simple departures from the standard of care in relation to the non-opiate management of chronic pain, in that Respondent failed to explore non-opiate medications to manage Patients A's, B's, and C's pain. Respondent also failed to obtain

signed pain care agreements or informed consent from Patients A, B, or C regarding the steps of compliance with opiate therapy.

16. Also with respect to Patients B and C, the record established that Respondent committed simple departures from the standard of care in prescribing benzodiazepines concurrently with opiates. Dr. Huang persuasively established that it is a well-known fact that the combination usage of opiate and benzodiazepine medication increases the risk of overdose and death significantly. Additionally, Respondent committed a simple departure by managing Patient B's and C's generalized anxiety with Xanax initially, as opposed to introducing non-benzodiazepine medication(s) first. Dr. Huang convincingly testified that because of the addiction and dependency potential of benzodiazepines, alternatives to benzodiazepines should be considered first to manage generalized anxiety.

17. The above factors, as well as Respondent's failure to maintain proper medical records as discussed in more detail below, firmly establish that Respondent engaged in repeated acts of negligence. (Factual Findings 3 through 226.)

C. Proper Medical Records

18. Complainant met her burden of establishing, by clear and convincing evidence, that Respondent failed to maintain adequate records, with respect to Patients A, B, and C, in violation of Business and Professions Code sections 2227 and 2266. The evidence clearly shows that Respondent's progress notes mostly failed to document clear functional improvement from the opiate therapy, failed to include CURES queries, and failed to document any discussions about the risks and benefits of opiate therapy and/or intramuscular injections. (Factual Findings 3 through 226.)

Appropriate Level of Discipline

19. Complainant seeks revocation of Respondent's license. While revocation falls within the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly given the gross negligence involved, such discipline is not warranted in this matter. Respondent has enjoyed a long period of practice with no prior record of discipline, and the unprofessional conduct in this matter occurred several years ago. Additionally, Respondent has maintained a positive reputation in his field, evidenced by the character witness who testified and provided a letter of reference on Respondent's behalf. Moreover, Respondent has changed the manner in which he practices medicine, such that the patient records at IUCC are now more comprehensive, as they include CURES reports, pain contracts, and opioid risk tools to assess the risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. (Factual Findings 3 through 228.)

20. Business and Professions Code section 2229 provides that protection of the public is paramount, but the Board should take action that will stress education to address deficiencies in practice.

21. Given these factors, and noting that the purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.), the public would be adequately protected by the imposition of a five-year period of probation, with specific terms and conditions, including a condition concerning education.

ORDER

Certificate No. G70886 issued to Respondent Joseph Aurelius Risser, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five 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 programs or courses which shall not be less than 40 hours per year, for each year of probation. The educational programs or courses shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational programs or courses 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 months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the 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. **Professionalism Program (Ethics Course).** Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure. A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. **Notification.** Within seven 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 in hospitals, other facilities, or insurance carrier.

6. **Supervision of Physician Assistants.** During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. **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.

8. **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.

9. **General Probation Requirements.**

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

b. *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).

c. *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.

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

e. *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 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.

10. **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

11. **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 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; and General Probation Requirements.

12. **Solo Practice**

Respondent is prohibited from engaging in the solo practice of medicine.

13. **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.

14. **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.

15. **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.

16. **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.

DATED: November 5, 2018

DocuSigned by:
Carla L. Garrett
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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Jan 4 2018
BY D. Richards ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2015-014904
JOSEPH AURELIUS RISSER, M.D. **Linda Vista Health Care Center** **6973 Linda Vista Road** **San Diego, CA 92111** **Physician's and Surgeon's Certificate No. G70886,** Respondent.	**A C C U S A T I O N**

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 March 4, 1991, the Medical Board issued Physician's and Surgeon's Certificate No. G70886 to Joseph Aurelius Risser, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2018, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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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.

"..."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. G70886 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, and C,[1] as more particularly alleged hereinafter:

[1] To protect the privacy of all patients involved, patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

Patient A

8. Between in or around December 2014, and in or around November 2015, Patient A, a then fifty-two (52) year old male, received treatment at Irvine Urgent Care (IUC) from multiple physicians at the clinic, including Respondent. Patient A had a medical history which included regular prescriptions of Hydrocodone[2] combinations or Oxycodone[3] from various physicians prior to presenting at IUC. Throughout his treatment at IUC, Patient A received treatment and prescription medications from various other physicians outside of IUC.

9. Between in or around December 2014, and in or around November 2015, Patient A received treatment at IUC on approximately forty-four (44) clinical visits, primarily for treatment of back pain, headaches, and high blood pressure. During that time period, IUC accepted patients by walk-in appointment only, and patients were seen by the next available physician. During that time period, the medical records maintained by IUC were hand-written chart notes maintained in chronological order. During that time period, physicians at IUC required patients to sign pain care agreements outlining steps of compliance with opiate therapy, and regularly ran CURES[4] reports on their patients.

10. Between in or around December 2014, and in or around November 2015, Patient A received approximately forty-six (46) different prescriptions for Oxycodone from approximately eight (8) different physicians, for a total of approximately 2,043 tablets. Physicians from IUC wrote approximately thirty-three (33) of those prescriptions. Respondent wrote approximately nineteen (19) of those prescriptions, for a total of approximately 795 tablets.

11. Between in or around December 2014, and in or around November 2015, Patient A received approximately twenty-five (25) different prescriptions for Hydrocodone from

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[2] Hydrocodone combination products are Schedule III controlled substances pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] CURES, the Controlled Substance Utilization Review and Evaluation System, is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

approximately nine (9) different physicians, for a total of approximately 711 tablets. Physicians from IUC wrote approximately ten (10) of those prescriptions. Respondent wrote approximately four (4) of those prescriptions, for a total of approximately 120 tablets.

12. In addition to receiving various controlled substances for the treatment of pain, between in or around December 2014, and in or around November 2015, Patient A received trigger point injections containing a mixture of Kenalog[5] and Lidocaine[6] in his neck and back at IUC on approximately twenty-two (22) occasions.

13. On or about December 16, 2014, Patient A presented for the first time at IUC with complaints of back pain and insomnia, and was seen by O.V., M.D. (Dr. O.V.). At this initial appointment, Dr. O.V. prescribed Patient A thirty (30) tablets of Hydrocodone, and thirty (30) tablets of Carisoprodol[7] for the treatment of pain. The patient's chart for this date makes no mention of any discussion with the patient regarding non-opiate medications, any assessment of the patient's risk for addiction, or the completion of a pain care agreement outlining steps of compliance with opiate therapy.

14. On or about January 10, 2015, Patient A received x-ray imaging of the lumbar spine at IUC, which revealed mild lumbar levoscoliosis, but no discernible acute bony abnormality.

15. On or about January 14, 2015, Patient A was seen for the first time by Respondent at IUC, with complaints of back pain and insomnia. Patient A complained that his medications were making him dizzy and drowsy. Respondent told Patient A to discontinue his use of Ambien and Hydrocodone, and he prescribed the patient Lunesta,[8] and thirty (30) tablets of Oxycodone. The patient's chart for this date makes no mention of any discussion with the patient regarding non-

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[5] Kenalog is a synthetic glucocorticoid corticosteroid with anti-inflammatory action.

[6] Lidocaine is a medication used to numb tissue in a specific area.

[7] Carispoprodol, brand name Soma, is a muscle relaxant, and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Lunesta is a brand name for Eszopiclone, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

opiate medications, any assessment of the patient's risk for addiction, or the completion of a pain care agreement outlining steps of compliance with opiate therapy.

16. On or about January 23, 2015, Patient A returned to IUC and was seen by Respondent. Patient A requested an early refill of Lunesta, claiming he was leaving town for two weeks. Respondent refilled the Lunesta prescription, and advised the patient not to take it every day.

17. Six (6) days later, on or about January 29, 2015, Patient A returned to IUC and was seen by Respondent. Patient A complained that Oxycodone was "too strong" and worsened his fatigue. Respondent switched the patient back to Hydrocodone.

18. On or about February 4, 2015, Patient A returned to IUC for a follow-up on back pain and was seen by Respondent. Respondent noted Patient A had not seen a pain management specialist, but refilled the patient's Hydrocodone prescription.

19. On or about April 2, 2015, Patient A returned to IUC with complaints of back pain and was seen by Respondent. Respondent prescribed Patient A 30 tablets of Oxycodone.

20. On or about April 11, 2015, Patient A returned to IUC with a stab wound to the leg and was seen by Respondent. In addition to his other pain medications, Respondent refilled the patient's prescription for Oxycodone. On that same date, the patient filled a prescription for Hydrocodone, that was written by another physician outside of IUC.

21. On or about April 29, 2015, Patient A returned to IUC for follow-up on his stab wound, and was seen by Respondent. At this appointment, Respondent refilled the patient's prescription for Oxycodone, but increased it to forty-five (45) tablets.

22. Throughout the month of May 2015, Patient A filled approximately eight (8) prescriptions for controlled substances written by approximately five (5) different physicians, including a prescription for Oxycodone written by Dr. O.V.

23. On or about May 7, 2015, Dr. O.V. reviewed a CURES report on Patient A and noted that the patient had been receiving controlled substances from other physicians. On the CURES report, which was placed into the patient's chart, a note was included that if the patient sees other doctors for medications, that he would be discharged from IUC.

24. Throughout the month of June 2015, Patient A filled approximately seven (7) prescriptions for controlled substances written by approximately six (6) different physicians, including a prescription for Oxycodone written by Respondent.

25. On or about July 16, 2015, Patient A returned to IUC with complaints of back pain and migraines, and was seen by Respondent. At this appointment, Respondent refilled the patient's Oxycodone prescription.

26. On or about July 28, 2015, Patient A returned to IUC with complaints of back pain and was seen by D.N., M.D. (Dr. D.N.). At that visit, a CURES report was run, and Dr. D.N. ordered the patient's first and only urine drug screen by any physician at IUC. The results of the urine screen were consistent with the prescribed medications.

27. On or about August 24, 2015, Patient A returned to IUC with a request for an early refill of pain medications and was seen by Respondent. At this appointment, Respondent discussed obtaining an MRI of the lower spine, and refilled the patient's Oxycodone prescription.

28. On or about August 30, 2015, Patient A returned to IUC with complaints of back pain and was seen by Respondent. At this appointment, Respondent encouraged the patient to use a back brace, and refilled the patient's Oxycodone prescription.

29. On or about September 10, 2015, Patient A returned to IUC with complaints of back pain and headaches, and was seen by Respondent. The patient indicated that the Lidocaine injections he was receiving at IUC were helping, but that he was not using the back brace. Respondent then refilled the patient's Oxycodone prescription.

30. On or about October 4, 2015, Patient A returned to IUC with complaints of back pain and headaches, and was seen by Respondent. The patient indicated that he was having to take Oxycodone more often to achieve pain relief. Respondent discussed alternative pain medications, but then refilled the patient's Oxycodone prescription. The patient's chart for this date makes no mention of the prescription.

31. On or about October 14, 2015, Patient A returned to IUC for an early medication refill and was seen by Dr. D.N. Dr. D.N. advised the patient to take the medication as prescribed, but then refilled the patient's Oxycodone prescription.

32. Throughout the month of November 2015, Patient A filled approximately nineteen (19) prescriptions for controlled substances written by approximately five (5) different physicians, including Respondent.

33. On or about November 2, 2015, Patient A returned to IUC with complaints of back pain and headaches, and was seen by Respondent. At this appointment, Respondent refilled the patient's Oxycodone prescription.

34. On or about November 16, 2015, Patient A returned to IUC with complaints of back pain and headaches and was seen by Respondent. Respondent prescribed Patient A thirty (30) tablets of Clonazepam.

35. On or about November 22, 2015, Patient A returned to IUC for a prescription refill and with complaints of migraine, and was seen by Respondent. At this appointment, Respondent refilled the patient's Oxycodone prescription.

36. On or about November 28, 2015, Patient A returned to IUC with complaints of migraines and to request a medication change, and was seen by Respondent. At this appointment, Respondent referred the patient to a neurologist and pain management for the first time, but refilled the patient's Oxycodone prescription.

37. Between in or around December 2014, and in or around November 2015, Patient A's chart contained no pain care agreement signed by the patient, outlining steps of compliance with opiate therapy.

38. Between in or around December 2014, and in or around November 2015, Respondent's progress notes in Patient A's chart failed to document any functional improvement from the opiate therapy, any discussion with the patient regarding aberrant behaviors, or any CURES queries.

39. Respondent committed gross negligence in his care and treatment of Patient A by failing to properly monitor the patient's use of opiate pain medications, while he continued to prescribe the patient high amounts of opiate pain medication.

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Patient B

40. Between in or around February 2015, and in or around November 2015, Patient B, a then eighteen (18) year old female, received treatment at IUC from multiple physicians at the clinic, including Respondent. Patient B reported a medical history which included allergies and a history of attention deficit disorder and anxiety. Patient B was a "cash pay" patient, and paid approximately $100-$125 for each clinical visit at IUC.

41. Between in or around February 2015, and in or around November 2015, Patient B received treatment at IUC on approximately thirty-one (31) clinical visits, primarily for treatment of back pain, headaches, and anxiety. During that time period, IUC accepted patients by walk-in appointment only, and patients were seen by the next available physician. During that time period, the medical records maintained by IUC were hand-written chart notes maintained in chronological order. During that time period, physicians at IUC required patients to sign pain care agreements outlining steps of compliance with opiate therapy, and regularly ran CURES reports on their patients.

42. Between in or around February 2015, and in or around November 2015, Patient B received approximately thirty-four (34) different prescriptions for Oxycodone from different physicians at IUC, for a total of approximately 1,245 tablets. Respondent wrote approximately seventeen (17) of those prescriptions, for a total of approximately 600 tablets.

43. Between in or around February 2015, and in or around November 2015, Patient B received approximately three (3) prescriptions for Hydrocodone from physicians at IUC, for a total of approximately 90 tablets. Respondent wrote approximately two (2) of those prescriptions, for a total of approximately 75 tablets.

44. Between in or around February 2015, and in or around November 2015, Patient B received approximately seven (7) different prescriptions for Alprazolam[9] from different

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[9] Alprazolam, brand name Xanax, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

physicians at IUC, for a total of approximately 210 tablets. Respondent wrote approximately four (4) of those prescriptions, for a total of approximately 120 tablets.

45. On or about February 24, 2015, Patient B presented for the first time at IUC, for a general check-up, and to discuss allergies and anxiety. At this initial appointment, Patient B was seen by Dr. O.V., who prescribed the patient Alprazolam for her anxiety.

46. On or about March 28, 2015, Patient B returned to IUC, and was seen by Respondent. At this second appointment, in addition to complaints of allergies, depression, and anxiety, Patient B complained of back pain from a soccer injury that occurred one year prior. Respondent did not obtain any imaging of the patient's back on this date or any date thereafter, but prescribed the patient forty-five (45) tablets of Hydrocodone for pain. The patient's chart for this date makes no mention of any discussion with the patient regarding non-opiate medications, any assessment of the patient's risk for addiction, or the completion of a pain care agreement outlining steps of compliance with opiate therapy.

47. Three days later, on or about March 31, 2015, Patient B returned to IUC with complaints of back pain, and was seen by Dr. O.V. At this appointment, Dr. O.V. prescribed the patient thirty (30) tablets of Oxycodone for pain.

48. On or about April 4, 2015, Patient B returned to IUC with complaints of continued back pain and worsening anxiety, and was seen by Respondent. Respondent refilled the patient's Oxycodone prescription for pain, and prescribed the patient thirty (30) tablets of Alprazolam for anxiety. The patient's chart for this date makes no mention of the Oxycodone prescription. The chart note for this date does not include any discussion with the patient regarding non-benzodiazepine treatment modalities for the management of her anxiety.

49. On or about April 18, 2015, Patient B filled a prescription for 28 tablets of Clonazepam[10] that she received from a different physician outside of IUC.

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[10] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

50. On or about April 27, 2015, Patient B returned to IUC with complaints of back pain and anxiety, and was seen by Respondent. At this appointment, Respondent referred the patient to a chiropractor and pain management, and refilled her Oxycodone and Alprazolam prescriptions.

51. On or about May 17, 2015, Patient B returned to IUC with complaints of back pain, and was seen by Respondent. Patient B expressed that she was unable to afford x-rays, chiropractic treatment, or to see a pain management specialist. Respondent discussed physical therapy treatment with the patient, and refilled her Oxycodone prescription.

52. On or about May 31, 2015, Patient B returned to IUC for follow-up on her anxiety, and was seen by Respondent. The chart notes for this visit indicate that labs and a urine drug screen needed to be completed at the next visit.

53. On or about June 10, 2015, Patient B returned to IUC with complaints of mood swings, and was seen by Respondent. A urine drug screen was not completed at this visit, or any visit thereafter, but Respondent refilled the patient's Oxycodone prescription.

54. On or about June 28, 2015, Patient B returned to IUC with complaints of anxiety, and was seen by Respondent. At this appointment, Respondent refilled the patient's Oxycodone and Alprazolam prescriptions.

55. On or about July 13, 2015, Patient B filled a prescription for ten (10) tablets of Diazepam[11] that she received from a different physician outside of IUC.

56. On or about July 19, 2015, Patient B returned to IUC with complaints of back and neck pain, and increased anxiety. The chart notes for this visit document for the first time that Respondent encouraged the patient to seek psychological counseling, but Respondent then refilled the patient's Oxycodone and Alprazolam prescriptions.

57. On or about August 9, 2015, Patient B returned to IUC with complaints of back pain and headache, and was seen by Respondent. At this appointment, Respondent encouraged the

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[11] Diazepam, band name Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

patient to decrease her frequency of use of Oxycodone when possible, but refilled her prescription.

58. Six (6) days later, on or about August 15, 2015, Patient B returned to IUC with complaints of back pain and headache, and was seen by Dr. D.N. At this appointment, Dr. D.N. refilled the patient's Oxycodone, but increased it to forty-five (45) tablets.

59. On or about September 24, 2015, Patient B returned to IUC with complaints of back pain, and was seen by Respondent. At this appointment, Respondent refilled the patient's prescription for forty-five (45) tablets of Oxycodone.

60. Three (3) days later, on or about September 27, 2015, Patient B filled a prescription for fifteen (15) tablets of Hydrocodone that she received from a different physician outside of IUC.

61. On or about September 30, 2015, Patient B returned to IUC with complaints of back pain and trouble sleeping, and was seen by Dr. D.N. At this appointment, Dr. D.N. refilled the patient's prescriptions for Ambien and Oxycodone, but documented in the patient's chart that she was asking for too many refills, and should not receive any more refills for the next two (2) months.

62. One week later, on or about October 7, 2015, Patient B returned to IUC with concerns regarding a lump in her groin area, and was seen by Respondent. At this appointment, Respondent again encouraged the patient to seek out chiropractic care for her pain, but then refilled her prescription for forty-five (45) tablets of Oxycodone.

63. Between in or around February 2015, and in or around November 2015, Patient B's chart contained no pain care agreement signed by the patient, outlining steps of compliance with opiate therapy.

64. Between in or around February 2015, and in or around November 2015, Respondent's progress notes in Patient B's chart fail to document any functional improvement from the opiate therapy, any discussion with the patient regarding aberrant behaviors, or any CURES queries.

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65. Respondent committed gross negligence in his care and treatment of Patient B by failing to properly monitor the patient's use of opiate pain medications, while he continued to prescribe the patient high amounts of opiate pain medication.

Patient C

66. Between in or around July 2013, and in or around January 2015, Patient C, a then thirty-seven (37) year old female, received treatment at IUC from multiple physicians at the clinic. Patient C had a medical history which included complaints of left arm pain radiating to her neck, and anxiety. Patient C's treatment at IUC throughout that time period included regular Hydrocodone prescriptions in approximately seven (7) to ten (10) day intervals, for the treatment of pain, and regular Alprazolam prescriptions in approximately thirty (30) day intervals, for the treatment of anxiety.

67. On or about December 12, 2013, Patient C received x-ray and MRI imaging of the cervical spine at IUC, which revealed a disc herniation with possible nerve impingement.

68. On or about February 7, 2014, Patient C signed a "Controlled Medication Agreement," for IUC, outlining steps of compliance with opiate therapy.

69. Between in or around January 2015, and in or around January 2016, Patient C received treatment at IUC on approximately forty-two (42) clinical visits, primarily for treatment of pain and anxiety. During that time period, IUC accepted patients by walk-in appointment only, and patients were seen by the next available physician. During that time period, the medical records maintained by IUC were hand-written chart notes maintained in chronological order. During that time period, physicians at IUC required patients to sign pain care agreements outlining steps of compliance with opiate therapy, and regularly ran CURES reports on their patients.

70. Between in or around January 2015, and in or around January 2016, Patient C received treatment from Respondent on approximately twenty-one (21) of her clinical visits at IUC.

71. Between in or around January 2015, and in or around January 2016, Patient C received approximately forty-six (46) different prescriptions for Hydrocodone from different

physicians at IUC, for a total of approximately 2,055 tablets. Respondent wrote approximately twenty-seven (27) of those prescriptions, for a total of approximately 1,215 tablets.

72. Between in or around January 2015, and in or around January 2016, Patient C received approximately nineteen (19) different prescriptions for Carisoprodol from different physicians at IUC, for a total of approximately 570 tablets. Respondent wrote approximately eleven (11) of those prescriptions, for a total of approximately 330 tablets.

73. Between in or around January 2015, and in or around January 2016, Patient C received approximately fourteen (14) different prescriptions for Alprazolam from different physicians at IUC, for a total of approximately 420 tablets. Respondent wrote approximately nine (9) of those prescriptions, for a total of approximately 270 tablets.

74 In addition to receiving various controlled substances for the treatment of pain, between in or around January 2015, and in or around January 2016, Patient C received approximately thirteen (13) intramuscular injections of Solumedrol[12] 125 mg together with Toradol[13] 60 mg. Respondent ordered approximately four (4) of those injections. Throughout that time, lab work was never ordered or obtained from any physician at IUC.

75. In addition to receiving various controlled substances for the treatment of pain, between in or around June 2015, and in or around December 2015, Patient C received trigger point injections containing a mixture of Kenalog and Lidocaine in her neck and back at IUC on approximately twenty-two (22) occasions.

76. On or about January 21, 2015, Patient C presented at IUC to request a medication refill for back pain and anxiety, and was seen by Respondent. Respondent had only seen this patient on two prior occasions throughout her treatment at IUC. Respondent refilled the patient's prescriptions for forty-five (45) tablets of Hydrocodone and thirty (30) tablets of Alprazolam. Respondent's chart note for this date, and every date thereafter, fails to include any discussion

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[12] Solumedrol is an anti-inflammatory corticosteroid, and a dangerous drug pursuant to Business and Professions Code section 4022.

[13] Toradol is nonsteroidal anti-inflammatory medication used to treat pain, and a dangerous drug pursuant to Business and Professions Code section 4022.

with the patient regarding non-benzodiazepine treatment modalities for the management of her anxiety.

77. One week later, on or about January 28, 2015, Patient C returned to IUC with complaints that a cough she was experiencing was aggravating her neck pain, and was seen by Respondent. At this appointment, Respondent refilled the patient's Hydrocodone prescription.

78. On or about March 24, 2015, returned to IUC for a medication refill, and was seen by Dr. O.V. At this appointment, Dr. O.V. refilled the patient's Hydrocodone prescription, and also prescribed thirty (30) tablets of Carisoprodol.

79. On or about April 16, 2015, Patient C returned to IUC with complaints that she feels she is getting sick, and was seen by Respondent. At this appointment, Respondent refilled the patient's Carisoprodol prescription.

80. On or about May 4, 2015, Patient C received MRI imaging of the lumbar spine at IUC, which revealed a circumferential disc bulge at L4-L5, and mild right neural foraminal narrowing.

81. On or about June 4, 2015, Patient C returned to IUC for a medication refill, and was seen by Respondent. The chart notes for this date indicate that Respondent checked the patient's CURES report, and indicated that a urine drug test screen was due. A urine drug screen was not conducted at that visit, or any visit thereafter.

82. Between in or around January 2015, and in or around January 2016, Respondent's progress notes in Patient C's chart fail to document any discussion with the patient regarding the risks and benefits of the dangerous combinations of opiate and non-opiate medications prescribed, any referral to pain management, or any discussion regarding the patient's functional improvement from the opiate, injection, and benzodiazepine therapy.

83. Respondent committed gross negligence in his care and treatment of Patient C by routinely prescribing intramuscular injections, without referring the patient to pain management, and without obtaining routine lab work to monitor the side effects on the patient.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

84. Respondent has further subjected his Physician's and Surgeon's Certificate No. G70886 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, and C, as more particularly alleged hereinafter:

Patient A

85. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included but was not limited to, the following:

A. Paragraphs 8 through 39, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to consider or utilize non-opiate treatment modalities for the treatment of chronic pain;

C. Failing to obtain a pain care agreement from a patient at high risk for abuse that outlines the steps of compliance with opiate therapy; and

D. Failing to document any functional improvement from the opiate therapy, any discussion with the patient regarding aberrant behaviors, or any CURES queries.

Patient B

86. Respondent committed repeated negligent acts in his care and treatment of Patient B, which included but was not limited to, the following:

A. Paragraphs 40 through 65, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to appropriately evaluate the patient's back injury before prescribing opiate medication for the treatment of pain, and failing to consider or utilize non-opiate treatment modalities for the treatment of chronic pain;

C. Failing to obtain a pain care agreement from a patient at high risk for abuse that outlines the steps of compliance with opiate therapy;

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D. Prescribing dangerous combinations of opiate and non-opiate medications without first considering and recommending alternatives;

E. Failing to appropriately document any functional improvement from the opiate therapy, any discussion with the patient regarding risks and benefits of opiate therapy, or any CURES queries; and

F. Prescribing the patient Alprazolam for the management of generalized anxiety without first considering and recommending non-benzodiazepine treatment.

Patient C

87. Respondent committed repeated negligent acts in his care and treatment of Patient C, which included but was not limited to, the following:

A. Paragraphs 66 through 83, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Prescribing dangerous combinations of opiate and non-opiate medications without appropriate monitoring;

C. Failing to discuss with the patient the risks and benefits of the dangerous combinations of opiate and non-opiate medications prescribed;

C. Prescribing the patient Alprazolam for the management of generalized anxiety without considering and recommending non-benzodiazepine treatment; and

D. Failing to appropriately document functional improvement from the opiate, injection, and benzodiazepine therapy.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

88. Respondent has further subjected his Physician's and Surgeon's Certificate No. G70886 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of patients A, B, and C, as more particularly alleged in paragraphs 8 through 87, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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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. G70886, issued to Respondent Joseph Aurelius Risser, M.D.;

2. Revoking, suspending or denying approval of Respondent Joseph Aurelius Risser, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Joseph Aurelius Risser, 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: January 4, 2018

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

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