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

In the Matter of the Accusation Against: Daniel S. Sewell, M.D. Physician's and Surgeon's License No. A 87909 Respondent.	Case No. 800-2016-026947

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 5, 2020.

IT IS SO ORDERED: October 6, 2020.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

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

In the Matter of the Accusation Against: **DANIEL S. SEWELL, M.D.** **13555 Bowman Rd., Ste. 100** **Auburn, CA 95603-9560** **Physician's and Surgeon's Certificate No. A 87909** Respondent.	Case No. 800-2016-026947 OAH No. 2020020429 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). This action was brought by then Complainant Kimberly Kirchmeyer solely in her official capacity.[1] Complainant is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Aaron L. Lent, Deputy Attorney General.

[1] Ms. Kirchmeyer became the Director of the Department of Consumer Affairs on October 28, 2019.

2. Respondent Daniel S. Sewell, M.D. (Respondent) is represented in this proceeding by attorney Nicholas J. Leonard, whose address is: 2150 River Plaza Drive, Ste. 250, Sacramento, CA 95833.

3. On or about January 30, 2004, the Board issued Physician's and Surgeon's Certificate No. A 87909 to Daniel S. Sewell, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-026947, and will expire on April 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-026947 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 4, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2016-026947 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-026947. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2016-026947, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2016-026947 and that he has thereby subjected his license to disciplinary action.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2016-026947 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 87909 issued to Respondent Daniel S. Sewell, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. STANDARD STAY ORDER. However, revocation stayed and Respondent is placed on probation for three years upon the following terms and conditions.

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

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider

with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

5. 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 (6) 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 (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (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.

6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including

but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60

calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

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

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

9. 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.

10. 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.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

12. 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.

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

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

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

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

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

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14. 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.

15. 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.

16. 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.

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

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18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2016-026947 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 8/7/20

DANIEL S. SEWELL, M.D.
Respondent

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

DATED: 8/7/20

NICHOLAS J. LEONARD
Attorney for Respondent

ENDORSEMENT

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

DATED: 8/7/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

AARON L. LENT
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-026947

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct 4 2019
BY D. Richards ANALYST

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

In the Matter of the Accusation Against: **Daniel S. Sewell, M.D.** 13555 Bowman Rd., Ste. 100 Auburn, CA 95603-9560 Physician's and Surgeon's Certificate No. A 87909, Respondent.	Case No. 800-2016-026947 **ACCUSATION**

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 June 30, 2004, the Medical Board issued Physician's and Surgeon's Certificate No. A 87909 to Daniel S. Sewell, M.D. (Respondent). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

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JURISDICTION

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

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

STATUTORY PROVISIONS

5. Section 2228.1 of the Code states, in pertinent part:

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:
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> (1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:
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> (D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.
>
> (2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.
>
> (b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

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(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

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

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

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

(b) Gross negligence.

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

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

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

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7. Section 2266 of the Code states, in pertinent part:

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

8. Section 3502 of the Code states, in pertinent part:

(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b)(1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c)(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2)(A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

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9. Section 3502.1 of the Code states, in pertinent part:

(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502 , while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations . Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that

meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations , and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the

manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

10. Section 3527[1] of the Code states, in pertinent part:

...

(c) The Medical Board of California may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

...

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1399.541, states, in pertinent part:

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician...

...

PERTINENT DRUG INFORMATION

12. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting

[1] Effective: January 1, 2013. The previous language of section 3527, as set forth between January 1, 2008, to December 31, 2012, underwent stylistic changes but no substantive changes occurred.

opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

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

14. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b)..

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

16. Pethidine – Also known as meperidine, generic name for the drug Demerol. Pethidine is a synthetic opioid pain medication of the phenylpiperidine class. Pethidine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Pethidine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a transdermal patch, buprenorphine is used to treat chronic pain. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

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

19. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section

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

21. Alprazolam – Generic name for Xanax. Alprazolam is a member of the benzodiazepine family and is a short-acting medication commonly used for the short-term management of anxiety disorders, specifically panic disorder or generalized anxiety disorder. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

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

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

24. Amphetamine Salts – Generic name for Adderall. Amphetamine salts are used in the treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. It is also used recreationally as an aphrodisiac and euphoriant. It works as a central nervous system stimulant. Amphetamine salts are a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Cyclobenzaprine – Generic name for Flexeril. Cyclobenzaprine is a medication used to treat muscle spasms from musculoskeletal conditions of sudden onset. Cyclobenzaprine may have drug interactions with central nervous system depressants. Cyclobenzaprine is a dangerous drug pursuant to Business and Professions Code section 4022.

26. Trazodone Trazodone is an antidepressant medication used to treat major depressive disorder, and anxiety disorder. Trazodone is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

Patient 1[2]

27. On or about August 16, 2014, Patient 1 began receiving care at Vista Complete Care, a primary care and urgent care clinic located in Auburn, California. Respondent is a physician at Vista Complete Care ("clinic"). Respondent uses mid-level practitioners such as nurse practitioners and physician assistants to see patients at the clinic.[3] According to the August 16, 2014, progress note Physician Assistant A saw Patient 1 regarding a chief complaint of urethritis. Patient 1 related that he was a long-haul truck driver who had unprotected sexual intercourse with an unknown female at an out-of-state truck stop. Physician Assistant A prescribed antibiotics and 40 tablets of 5/325 mg Norco to Patient 1. Physician Assistant A documented that Patient 1 smoked, denied a history of illicit drug use, and that he was a social drinker. A "Continuity of Care" document from Sutter Healthcare, dated April 26, 2015, actually documented Patient 1's alcohol intake as "1.5 to 2 pints daily." Respondent counter-signed the progress note on or about August 23, 2014.

28. On or about September 13, 2014, Respondent saw Patient 1 in clinic for a chief complaint of "infection in genital area." Respondent documented that Patient 1 had penile fissures and continued antibiotics. Respondent also prescribed Lexapro,[4] 30 tablets of .5 mg alprazolam, and he continued a prescription for 40 tablets of 5/325 mg Norco to Patient 1. While

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[2] All patients and witnesses will be fully identified in discovery. Patients will be identified by numeric pseudonyms to protect confidentiality.

[3] Delegation Service Agreements and Medical Records indicated that Respondent was supervising each of the mid-level practitioners identified in this matter.

[4] Lexapro (escitalopram) is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Escitalopram affects chemicals in the brain that may be unbalanced in people with depression or anxiety.

Respondent listed a thorough ROS[5] and a complete physical, Respondent failed to document any issues related to anxiety, depression or mental health symptoms in the ROS or in the physical.[6]

29. Patient 1 was next seen in clinic by Physician Assistant A on or about November 14, 2014. Physician Assistant A documented that Patient 1 was present for a medication consultation and a review of problems which included mixed anxiety and depressive disorder and chronic intractable pain. Physician Assistant A documented that Patient 1 reported "arthralgias/joint pain and back pain" and that the complaints were chronic in nature. Physician Assistant A documented a complete physical that revealed a normal musculoskeletal examination. Physician Assistant A prescribed 90 tablets of 5/325 mg hydrocodone with acetaminophen and 60 tablets of .5 mg alprazolam to Patient 1. Physician Assistant A documented that Patient 1 was advised of Vista Complete Care clinic's controlled drug policies and that he accommodated Patient 1's work schedule for refills of medications. Respondent did not review or sign off on this visit. Physician Assistant A signed off on the November 14, 2014, visit on or about December 9, 2014.

30. Physician Assistant A next saw Patient 1 on December 26, 2014. Physician Assistant A increased the dosage of both hydrocodone and alprazolam; prescribing 90 tablets of 10/325 mg Norco and 60 tablets of 1 mg alprazolam. Physician Assistant A documented that Patient 1 felt his medication was "appropriate at the current dosage and regimen," but that Patient 1 was reporting increased tension and claimed a "longer recovery/calm-down" period. Physician Assistant A did not document any other reasons for doubling Patient 1's Norco and alprazolam prescription. Physician Assistant A signed the progress note on January 15, 2015. Respondent did not counter-sign the progress note from December 26, 2014.

31. On or about May 4, 2015, Patient 1 was seen in clinic by Respondent. Between December 27, 2014, and May 4, 2015, Patient 1 had filled multiple prescriptions from Physician Assistant A that totaled 180 tablets of 1 mg alprazolam, 180 tablets of 10/325 mg Norco, 120 tablets of 5 mg oxycodone, 60 tablets of 10 mg oxycodone, and 30 tablets of 1 mg lorazepam. A

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[5] Review of Systems

[6] The Problems list included "problems not review (last reviewed August 18, 2014)" and bullet pointed "Anxiety state." Under Constitutional: "Level of Distress," Respondent documented NAD for No Acute Distress. Under Psychiatric, Respondent documented, "normal mood and affect and active and alert."

review of the medical records showed no documentation from Physician Assistant A regarding the oxycodone or lorazepam prescriptions that Patient 1 had received. Respondent documented the chief complaint for the May 4, 2015, as "trouble sleeping, depressed." Respondent did not document or mention any of the prior medication switches and refills by Physician Assistant A in his progress note. Respondent documented that Patient 1 had a significant change in his weight,[7] was alcohol-free, and had anxiety/depression/insomnia due to a job change. Respondent documented a ROS and physical examination that were very similar to prior examinations. Respondent ordered labs but no x-rays. Respondent started the patient on 10 mg of Paxil[8] and 50 mg of trazodone. Respondent did not prescribe controlled substances at the May 4, 2015, visit. Pharmacy records show that Patient 1 filled controlled substance prescriptions from other providers on or about June 5, 2015, and December 11, 2015.

32. On or about November 14, 2015, Physician Assistant B saw Patient 1 in clinic. Respondent did not counter-sign the progress note. Patient 1's weight was documented as 172 pounds. The ROS and physical were documented as normal with "no significant weight loss" entered. Under the physical exam portions titled "Psychiatric," Physician Assistant B documented that Patient 1 had "normal mood and affect and active and alert," and under the portion titled "Constitutional" that Patient 1 had "NAD" (No Apparent Distress). The normal documented examination was in contrast to the past problem list of major depressive episodes, anxiety, and mixed anxiety and depressive disorder. Physician Assistant B doubled Patient 1's Paxil prescription without medical justification.

33. On or about December 19, 2015, Patient 1 was seen by Nurse Practitioner C in the clinic. Respondent countersigned the December 19, 2015, progress note. Patient 1's chief complaint was documented as having "heart palpitations, anxious, sweaty palms, and shaky hands." Patient 1's weight was documented as 167 pounds. Nurse Practitioner C did document in ROS and in the Physical Examination portions of the note that Patient 1 reported having a

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[7] 228.8 pounds on 8-16-2014, to 183.2 pounds on May 4, 2015.

[8] Paxil (paroxetine) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be unbalanced in people with depression, anxiety, or other disorders.

"racing heart," "restless sleep" and that he was "anxious: very talkative/rapid speech." Nurse Practitioner C restarted Patient 1 on a benzodiazepine and prescribed 90 tablets of .5 mg alprazolam.

34. On or about January 16, 2016, Patient 1 was seen by Physician Assistant D in the clinic. Patient 1 signed a pain contract. The chief complaint is listed as anxiety meds. Under HPI,[9] it lists that Patient 1 had been taking lorazepam for anxiety as well as Paxil. Under ROS, Physician Assistant D documented that Patient 1 had anxiety, but that Patient 1 was not suffering from any physical pain and did not suffer from fatigue. Physician Assistant D documented under the physical examination portion titled "Psychiatric" that Patient 1 had, "normal mood and affect and active and alert." Physician Assistant D prescribed a month's supply of 90 tablets of .5 mg alprazolam to be submitted on January 24, 2016, and provided two refills. Physician Assistant D did not document that he clarified with Patient 1 why Patient 1 made the statement that he was taking lorazepam when he had been previously prescribed alprazolam. Physician Assistant D documented in the notes that Patient 1 must do a "drug screen in 3 month follow up." Respondent did not counter-sign the progress note.

35. On or about March 21, 2016, Respondent saw Patient 1 in clinic for a chief complaint of "med refills." Respondent documented in the HPI that Patient 1 had "low back pain from long haul trucking up and down I5." Respondent also documented that Patient 1 had "increased back pain after lifting a heavy load." Yet, Respondent documented "no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain..." in the ROS. Respondent documented that Patient 1 was NAD (No Acute Distress) and documented a normal musculoskeletal examination. Respondent documented that Patient 1 had "pain with full flexion and right worse than left." Respondent continued Patient 1's Paxil prescription, doubled Patient 1's prescription of alprazolam by prescribing 90 tablets of 1 mg alprazolam per month and prescribed 30 tablets of 5/325 mg oxycodone with acetaminophen for fifteen days. Respondent did not document a drug screen, nor did he document why a drug screen was not being completed despite Physician Assistant D's progress note on January 16, 2016.

[9] History of Present Illness

36. On or about May 14, 2016, Physician Assistant E saw Patient 1 in clinic for a chief complaint of "none recorded." Under HPI, Physician Assistant E documented that Patient 1 reported musculoskeletal pain but that the back pain was stable on medications, and severity was improving. Patient 1 requested three months of medications due to his job as a truck driver and difficulty scheduling appointments. Physician Assistant E documented an extensive physical examination and noted the presence of "pain with full flexion and extension and right worse than left." Physician Assistant E also documented back tenderness and chronic back pain. Physician Assistant E prescribed a monthly prescription of 90 tablets of 10 mg oxycodone and provided three separate hard copy prescriptions that were postdated for Patient 1 to fill on May 14, 2016, June 14, 2016, and July 13, 2016. Physician Assistant E also continued the monthly prescription of 90 tablets of 1 mg alprazolam, and started Patient 1 on a monthly prescription of 90 tablets of 10 mg of diazepam. Physician Assistant E provided two refills each for the benzodiazepines. Physician Assistant E also continued Patient 1's 20 mg Paxil prescription and provided refills for a years' supply. Physician Assistant E failed to document why he was tripling Patient 1's opiate prescription from 10 mg to 30 mg of oxycodone per day and why he was prescribing an additional benzodiazepine to Patient 1's treatment regimen. Respondent did not counter-sign this progress note.

37. On or about May 26, 2016, Physician Assistant D saw Patient 1 for a chief complaint of "medication consult." Respondent counter-signed the May 14, 2016, progress note on May 30, 2016. The medications prescribed on May 14, 2016, are listed in Physician Assistant D's progress note. In the HPI, Physician Assistant D documented the following: (grammatical errors appear as they do in the progress note)

> 28 year old male pmh of chronic pain, axiety and insomnia here for a medication change. He says that oxycodone is not working but is not taking it as much as has been prescribed. When asked why pt has both alprazolam and valium he said 'Valium made me feel weird and I threw it out." When asked why he is not taking the full amount of oxycodone he was prescribed he said "I was wondering if you could prescribe me some dilaudid." Using alprazolam for sleep. Complains of low back pain 7/10. He says he has been told in the past that he has Hep C and Hep B.

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Physician Assistant D performed a physical examination and documented the presence of back pain. Physician Assistant D also documented that, "told pt he has enough pain medication for current conditions. He is not using NSAIDs. He is asking for more pain meds and more benzodiazepines with seeking type behavior and questions." Physician Assistant D ordered Patient 1 to get laboratory testing done but did not order a drug screen, and ordered that Patient 1 start taking naproxen.[10] Despite telling Physician Assistant D that he had thrown the prescription for Valium out, Patient 1 continued to refill both the diazepam and alprazolam prescriptions in June and July.

38. On or about July 22, 2016, Physician Assistant E saw Patient 1 for a chief complaint of "med refill." Respondent did not counter-sign the progress note from July 22, 2016. Patient 1 signed a pain contract. Under HPI, Physician Assistant E noted that Patient 1 reported his symptoms were well-controlled and that he denied intolerable side effects of medications. Physician Assistant E also documented that Patient 1 was "feeling well." Physician Assistant E's ROS was normal and the complete physical was similar in documentation to previous physicals, noting that Patient 1 had pain and tenderness. Physician Assistant E prescribed a monthly prescription of 90 tablets of 30 mg oxycodone and provided three separate hard copy prescriptions for Patient 1 that were postdated to be filled on August 12, 2016, September 12, 2016, and October 12, 2016. Physician Assistant E prescribed a monthly prescription of 90 tablets of 2 mg alprazolam and provided two refills and continued Patient 1's 90 tablet of 10 mg diazepam prescription with two refills. Physician Assistant E failed to document why he was again tripling Patient 1's oxycodone prescription from 30 mg a day to 90 mg a day and failed to explain why he was doubling Patient 1's alprazolam prescription from 3 mg a day to 6 mg a day. Physician Assistant E also did not document why Patient 1 needed to be prescribed two benzodiazepines while also being prescribed an opiate.

39. According to the medical records, Patient 1 was assaulted in Las Vegas on or about August 7, 2016, and suffered a broken jaw and had to have his jaw surgically wired shut. On or about August 16, 2016, Patient 1 was seen in clinic by Physician Assistant D. This progress note

[10] Naproxen is an over-the-counter nonsteroidal anti-inflammatory drug (NSAID).

was not counter-signed by Respondent. According to Patient 1, his pain was managed by the oxycodone and he was able to take his pain medication through a gap in his missing teeth. Physician Assistant D recommended that Patient 1 take NSAIDS and viscous lidocaine for pain and continue his opiate and benzodiazepine regime. On or about August 24, 2016, Patient 1's mother went to the clinic and explained that Patient 1 was abusing his medications, drank heavily and showed photos of Patient 1 passed out on the floor to office staff. On or about August 25, 2016, Patient 1's mother faxed a letter to the staff at the clinic that her son was an alcoholic, misusing his medications, and potentially at risk of killing himself and others in his job as a long haul truck driver. On or about September 3, 2016, Patient 1's step-father went to the clinic and stated that Patient 1 was mixing medications in pill bottles and currently in the hospital. Patent 1's step-father requested a call back from office staff.

40. On or about September 13, 2016, Respondent saw Patient 1 in clinic for a chief complaint of "medication consult." Respondent documented that Patient 1's pain level was 3 out of ten, and that Patient 1 wished to taper his pain medications and discontinue Valium. Respondent documented that Patient 1 had not had a "drink in over a month" and continued to list that Patient 1 was a social drinker under social history despite new evidence that Patient 1 was abusing alcohol. Under the assessment and plan, Respondent document that Patient 1 had low back pain, a jaw fracture, spasms of his back muscles, anxiety, alcoholism, and constipation. Respondent documented that Patient 1 had filled a prescription for 90 tablets of 30 mg oxycodone on September 12, 2016. Respondent instructed Patient 1 to perform exercises, take NSAIDs, taper his oxycodone to 15 mg or half a tablet every 8 hours, discontinue Valium, continue 6 mg alprazolam daily, and abstain from alcohol. Respondent documented that Patient 1 would be rechecked in a month for a tapering dose, that they would consider "10 mg tid" (oxycodone) at the next visit and that Patient 1 was to bring in any hard copies of medications next month and all remaining medications. Respondent documented that there was a discussion regarding patient's chronic and new diagnoses. Respondent also documented that a CURES[11] report was reviewed

[11] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice which tracks all controlled drug prescriptions that are dispensed in the State of California.

and appropriate. Respondent documented that there are "no discrepancies" despite Patient 1 exhibiting drug seeking behavior and the complaints of his parents regarding misuse. Respondent documented urine testing was randomly tested, despite the fact there were no urine drug and/or alcohol screening results in the chart between August 16, 2014, and September 13, 2016. Respondent documented that a follow-up appointment for Patient 1 was scheduled for October 12, 2016.

41. On or about October 5, 2016, Respondent saw Patient 1 in clinic. Respondent documented that Patient 1 reported that his chronic pain level was 2 out of 10, that he was not abusing his medications, that he was not drinking alcohol, and that he was tapering his medications. According to Respondent's documented progress note, Patient 1 wanted to get off some of his pain medications and that he was ready to drop to 10 mg tablets. Respondent prescribed 90 tablets of 10 mg oxycodone to be filled on October 12, 2016, and prescribed 45 tablets of 10 mg oxycodone to be filled on November 4, 2016, to continue Patient 1's taper program. Respondent also prescribed 90 tablets of 2 mg alprazolam to be filled on October 5, 2016, and November 21, 2016. Respondent documented that urine drug testing was being randomly tested but there are no documented results in Patient 1's chart from on or about the October 5, 2016, visit.

42. According to the medical records, Patient 1 visited an emergency room on or about October 22, 2016, suffering from acute psychosis and hallucinations and he was admitted to inpatient psychiatry. On or about November 4, 2016, Patient 1 was again treated for hallucinations and he was sent to an inpatient psychiatric facility under Welfare and Institutions Code section 5150. Following an 18-day stay in an inpatient psychiatric facility, Patient 1 was released and appeared to have immediately filled the controlled drug prescriptions he had received from Respondent during his October 5, 2016, visit on or about November 21, 2016, according to pharmacy records. On or about November 22, 2016, Patient 1 returned to the emergency room due to an overdose.

43. On or about November 23, 2016, Physician Assistant B saw Patient 1 in clinic. Under HPI, Physician Assistant B noted a "long history of abuse of medications," that Patient 1

reported he was in the emergency room the night before, and that he was out of Xanax and having severe anxiety. Physician Assistant B also noted that the emergency room report specifically stated there was a concern that Patient 1 had been taking illicit drugs and was possibly withdrawing from his Xanax and oxycodone. Patient 1 also reported that he had lost his medications. Patient 1 stated that his anxiety was only controlled with Xanax 2 mg three times a day. Physician Assistant B documented that Patient 1 was a long haul truck driver. Physician Assistant B documented that he discussed the patient with Respondent and that no more benzodiazepines or pain medication would be prescribed to Patient 1. Physician Assistant B documented that Patient 1 became angry, kicked a chair, and stormed out of the office. Physician Assistant B documented that there was a concern that the patient would become violent so Patient 1 was allowed to leave. On or about November 28, 2016, Respondent signed a letter that was addressed to Patient 1 notifying him that the clinic was withdrawing from providing him further and cited a breach of Patient 1's pain contract as the basis.

44. Between August 16, 2014, and November 23, 2016, as noted above, Respondent failed to provide adequate supervision over the mid-level medical providers that were providing care to Patient 1, in particular Physician Assistant A and Physician Assistant E. As noted above, on July 22, 2016, Physician Assistant E began prescribing 90 mg of oxycodone a day to Patient 1 which resulted in a morphine equivalent dose (MED[12]) of 135 and he provided multiple post-dated hard copy prescriptions which allowed for repeated medication filling without close monitoring and follow-up. Furthermore, between July 22, 2016, and October 12, 2016, Physician Assistant E prescribed 6 mg of alprazolam and 30 mg of diazepam on a daily basis in combination with Patient 1's 90 mg oxycodone prescription. Between August 16, 2014, and November 22, 2016, there is no documentation that Respondent or the mid-level providers working under him performed a detailed alcohol use assessment on Patient 1 despite evidence that Patient 1 may have been misusing alcohol. Between August 16, 2014, and November 22,

[12] Morphine Equivalent Dose ("MED"), An MED is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day. http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17.

2016, there was repeated mention that urine drug screening was being performed in the progress notes, but there is no documentation of any urine drug screening test results in Patient 1's medical records to support those assertions. Finally, between August 16, 2014, and November 22, 2016, the medical records kept by Respondent and the mid-level providers working under him fail to document why pain medications were being prescribed to Patient 1 and fail to show clear, objective proof of the nature of the pain being treated. The clinic records kept for Patient 1 between August 16, 2014, and November 22, 2016, are lacking in x-rays, specialist's notes, documentation of careful and detailed functional examinations of the musculoskeletal system, documentation of careful reasoning on why certain medications were being prescribed, and documentation of detailed discussions of trying to utilize other non-pharmacologic modalities which would have supported the continued prescribing of controlled substances.

Patient 2

45. Respondent began caring for Patient 2 in July 2012. On or about February 20, 2015, Respondent saw Patient 2 for a follow-up labs and three-month follow-up. Respondent documented that Patient 2 suffered from chronic pain, was obese, had hypertension, had heart disease, had hyperlipidemia, suffered from migraines, had hypogonadism, suffered from depression, had anxiety, suffered from insomnia, had diabetes, had fibromyalgia, and had a past history of stroke with partial left hemiparesis. Under social history, Respondent documented that Patient 2 was self-employed, married, a former smoker, that Patient 2 denied alcohol, tobacco, and illicit drug use. Under alcohol intake, Respondent documented "none." Respondent did not document a pain score but did document a complete review of systems and physical examination, noting a wide based gait. Respondent documented that Patient 2's medications were refilled which included 60 tablets of 1 mg alprazolam BID with two refills, 8 patches of 20 mcg/hr. Butrans Transdermal Patches to be taken one patch weekly with three refills, 180 tablets of 10/325 mg Norco Q4H, testosterone, atorvastatin, beta-blockers, Cialis, sumatriptan nasally, lisinopril, metformin, Flexeril, 100 mg of trazodone nightly, and 10 mg of zolpidem to be taken nightly. At that time, Respondent was prescribing opioids in combination with a benzodiazepine and a hypnotic.

46. On or about April 15, 2015, Respondent saw Patient 2 in clinic for a complaint of six-week follow-up. Respondent increased Patient 2's Butrans Transdermal Patch prescription to one patch every 72 hours with no refills and prescribed 8 patches. Respondent did not document why he was increasing the Butrans Transdermal Patch prescription. All other prescriptions remained the same. On or about July 15, 2015, Respondent saw Patient 2 in clinic for a chief complaint of three-month follow-up. Respondent increased Patient 2's alprazolam prescription to 3 mg per day and increased Patient 2's Butrans Transdermal Patch to two patches every 72 hours with 3 refills.[13][14] Respondent did not document why he was increasing the alprazolam and the Butrans Transdermal Patch prescriptions. Respondent also continued Patient 2 on 180 tablets of 10/325 mg hydrocodone with acetaminophen per month. Respondent also provided the patient with hard-copy prescriptions of the opioids with post-dating to be filled at later dates which allowed the patient to fill prescriptions without additional oversight. At the July 15, 2015 visit, Respondent documented and incorporated a pain contract signed by Patient 2 into the medical records. The Respondent did not document what Patient 2 was required to do with the wastage from the Butrans patches as the patches were seven day patches and he was ordering that Patient 2 apply two patches every 72 hours rather than for one week as recommended by the manufacturer.

47. On or about October 11, 2015, Respondent documented that he saw Patient 2 in clinic and entered a pain score of 7 out of ten. Respondent ordered a urine drug screen that showed consistent results. On or about December 4, 2015, Respondent documented that he saw Patient 2 in clinic. Patient 2 was still being prescribed a daily dose of 3 mg of alprazolam, 40 mcg/hr. Butrans transdermal patch, 60 mg of hydrocodone, 10 mg of zolpidem, 100 mg of trazodone, and

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[13] The MED of two 20 mcg./hr. patches (40 mcg./hr.) multiplied times 24 hours is 960 mcg/day and when converted to milligrams with one mg of buprenorphine equal to a 75 mg morphine equivalent dose. As such, Patient 2 was receiving an MED of 135 each day (the Butrans and the Norco as they were prescribed on July 15, 2015.) https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-Aug-2017.pdf

[14] There is risk of prolonged QTc interval when a patient is dosed over a level of 20 mcg/hour. https://www.drugs.com/dosage/butrans-patch.html

30 mg of cyclobenzaprine. Respondent documented that Patient 2 reported he had continued pain, that he was having TIA's[15] on a daily basis, got stupors of thought, and had trouble concentrating. Respondent ordered labs (which were generally normal), had Patient 2 sign another pain contract, and referred Patient 2 for a neurological consult.

48. A neurologist saw Patient 2 in office on or about February 1, 2016. The neurologist noted a past history of illicit drug and alcohol use, and determined based on his exam and all the CT and MRI studies that Patient 1's symptoms did not have organic causes and the neurologist suggested a possible somatization or conversion disorder. The neurologist also thought a dissociative disorder may be present. The neurologist's report became part of Respondent's medical records for Patient 2 on or about February 15, 2016. A psychologist saw Patient 2 on or about February 26, 2016. The psychologist noted that Patient 2 reported that he used cocaine in high school and college. The psychologist also noted that Patient 2 drank excessive amounts of alcohol 4-5 times a week prior to suffering a stroke in 2009-2010.. The psychologist made recommendations regarding work abilities and deferred treatment of depression, anxiety, confusion, and memory issues to Respondent. The psychologist's report was scanned into Respondent's medical records for Patient 2 on or about March 21, 2016.

49. On or about March 3, 2016, Respondent saw Patient 2 for a chief complaint of lab review and prescription refill. Respondent noted that Patient 2 reported he had fallen off a ladder, hit his thumb with a hammer and hit a guard rail while driving his vehicle. A medication review was performed and Respondent documented that Patient 2's pain was a seven out of ten. Respondent refilled Patient 2's medications, including providing multiple hard copy prescriptions that were postdated to be filled on later dates which limited additional patient oversight in the form of monthly office visits. Respondent failed to incorporate the neurologist's findings, that Patient 2 had a prior history of illicit drug use and alcohol use, into Patient 2's treatment plan for chronic pain management.

[15] While not defined in Respondent's records, he may be referring to transient ischemic attack with the abbreviation of "TIA".

50. On or about August 31, 2016, Respondent saw Patient 2 in clinic for a chief complaint of follow-up on labs and annual physical examination. Respondent documented that he modified the order for the Butrans Transdermal Patch to two 20 mcg/hr. patches per week as opposed to two 20 mcg/hr. patches every three days and prescribed eight boxes of four patches with three refills. Respondent also continued to prescribe opioids to Patient 2 by filling out multiple hard copy prescriptions that were post-dated for future dates to be filled. Respondent did not incorporate the psychologist's report from February 26, 2016, that Patient 2 had a history of cocaine use and excessive alcohol use, into Patient 2's substance abuse history. On or about November 9, 2016, Respondent saw Patient 2 in clinic and document that Patient 2 reported that he fell down some stairs. Respondent documented Patient 2's chronic pain as 4 out of 10 on Norco and Butrans. On or about January 25, 2017, Respondent saw Patient 2 in clinic and ordered a urine drug screen. Respondent documented that Patient 2 reported he had two episodes of dizziness and fell down. Patient 2's January 25, 2017, urine drug screen was generally consistent with Respondent's prescriptions, but the urine drug screen also showed an inconsistent result for butalbital, a Schedule III controlled barbiturate. Respondent next saw Patient 2 in clinic on or about April 26, 2017. Respondent documented that Patient 2 reported having many falls since his January 25, 2017, visit and that he had nerve pain and numbness which was causing him to drop things. Respondent did not document whether he discussed the January 25, 2017, inconsistent drug screen result with Patient 2, but Respondent continued Patient 2 on two 20 mcg/hour Butrans transdermal patches, 10 mg of zolpidem, 3 mg of alprazolam and 60 mg of Norco per day despite the potential presence of butalbital which can increase risk of sedation and respiratory depression when combined with the medications Respondent was prescribing.

51. On or about May 20, 2017, Patient 2 suffered a chain saw accident to his leg. On or about May 23, 2017, Patient 2 was seen in clinic by Physician Assistant E for a check of his leg wound. Respondent did not counter-sign the May 23, 2017, progress note. Physician Assistant E documented that Patient 2 was reporting that he was suffering from musculoskeletal pain, documented a complete ROS and a complete physical examination. Physician Assistant E did not document any further details regarding how or why Patient 2 suffered a chain saw accident to his

leg in the progress note. Physician Assistant E next saw Patient 2 on May 30, 2017, for suture removal. Patient 2 remained on 2 patches of 20 mcg/hr Butrans transdermal patch, 60 mg of Norco, 10 mg of zolpidem, and 3 mg of alprazolam as previously prescribed. Patient 2 also continued to take cyclobenzaprine and trazodone.

52. On or about July 24, 2017, Respondent saw Patient 2 in clinic for a three-month follow-up. Under social history Respondent continued to document that Patient 2 had no alcohol intake despite a prior documented history of alcohol abuse and documented that Patient 2 denied illicit drug use despite a documented history of illicit drug use. Respondent documented that Patient 2 was suffering from frequent falls, averaging 1.5 falls in the last three months and documented that the chainsaw injury was healing well. Respondent documented that Patient 2's pain level was 4 out of 10 and that Patient 2 had "(n)o negative side effects." Respondent documented in the progress note that he discussed Patient 2's memory loss problems due to benzodiazepines and zolpidem despite documenting "no negative side effect." Respondent documented that Patient 2 was not interested in stopping either medications. Respondent continued Patient 2 on 2 patches of 20 mcg/hr Butrans transdermal patch, 60 mg of Norco, and 10 mg of zolpidem per day. Respondent prescribed 90 tablets of 1 mg clonazepam to be taken TID to Patient 2 with three refills. Respondent did not document whether he was having Patient 2 stop taking alprazolam or why he was starting a prescription for clonazepam. A urine drug screen performed on July 24, 2017, was consistent.

53. Respondent next saw Patient 2 on or about October 23, 2017 in clinic. Respondent documented that Patient 2 reported he was now falling 2 to 3 times a week. Respondent documented that Patient 2 reported he was using ankle supports due to the multiple falls. Respondent documented that Patient 2 reported clonazepam was helping with headache related pain and he documented that Patient 2 reported alprazolam was helping with anxiety. It is not clear from the record if Patient 2 was now taking both clonazepam and alprazolam and whether or not that was Respondent's intended treatment plan. Respondent noted that Patient 2 was having trouble using the Butrans patches but continued to prescribe a daily dosage of 40 mcg/hr. Butrans, 60 mg Norco, 10 mg of zolpidem, and 3 mg of clonazepam. Respondent also continued to

provide hard copy prescriptions for the opiates that were postdated to be filled by Patient 2 at later dates.

54. On or about January 25, 2018, Respondent saw Patient 2 in clinic for an unknown chief complaint. Respondent documented that Patient 2 continued to fall, but noted that falls were not related to opiate use. Respondent did not explain how he concluded that falls were not caused by Patient 2's medications. Respondent continued to document an alcohol intake of "none" and that Patient 2 denied both alcohol use, and illicit drug use, despite a documented past history of both illicit drug and alcohol abuse. Respondent noted in the records that Patient 2 should not self-medicate. Respondent lowered Patient 2's Norco prescription to 50 mg a day, but continued prescriptions of Butrans, clonazepam, and zolpidem at previous levels.

55. On or about April 23, 2018, Respondent saw Patient 2 in clinic for med refills and "DISCUSS CCM ENROLLMENT." Respondent was prescribing 2 20 mcg/hr patches of Butrans, 50 mg of hydrocodone, 3 mg of alprazolam, and 10 mg of zolpidem per day. Respondent had Patient 2 provide a urine drug screen. On or about April 25, 2018, the urine drug screen result was consistent for opioids and benzodizapines but also showed the presence of alcohol metabolites. The alcohol metabolites[16] were greater than 100000 ng/ml for ETG and 97500 ng/ml for ETS. The cut off range for this particular urine drug screen was 500 ng/ml for ETG and 100 ng/ml for ETS. On or about June 2, 2018, Doctor F saw Patient 2 in clinic. Doctor F did not modify Patient 2's social history in the medical record and did not document whether the April 25, 2018, urine drug screen that showed the presence of alcohol impacted Patient 2's treatment plan. On or about June 14, 2018, Respondent saw Patient 2 in clinic. Respondent did not modify Patient 2's social history, continued to document that Patient 2 denied alcohol use and did not document whether or not the April 25, 2018, urine drug screen that was positive for alcohol metabolites had any impact on Respondent's continued treatment plan for chronic pain care for Patient 2. Respondent continued Patient 2 on 3 mg of clonazepam, 2 20 mcg/hr Butrans

[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711108/ As noted in this 2010 article, ETG and ETS are minor metabolites of ethanol. Peak levels of 100,000 ng/ml may indicate heavy drinking as noted in the article.

Transdermal patches, 50 mg of hydrocodone, and 10 mg of Ambien per day. On or about February 26, 2019, during an interview with the Board, Respondent stated the following that,

> We meet on a monthly basis to – uh – review our protocols and what we're doing and the last concern actually is when --- these alcohol metabolites are positive and to understand them better as far as their numbers and – and what that means, does that mean they had one drink, you know, two hours ago or last night, I – I don't know that answer.

Respondent went on to say at the interview that if Patient 2 was telling him that he was alcohol free and had a positive urine drug result that Respondent would discuss that result at the next visit despite the fact that Respondent failed to discuss the positive alcohol result on June 14, 2018, with Patient 2.

56. Between February 20, 2015, and June 14, 2018, Respondent, and the mid-level providers under his supervision, failed to properly monitor and treat Patient 2 as a high risk patient and failed to modify his chronic pain management treatment accordingly. Patient 2 was on high dose opiates, combined with multiple sedatives, and had a prior history of illicit drug and alcohol use that was ignored by Respondent. In addition, Patient 2 had multiple psychiatric diagnoses. Between February 20, 2015, and June 14, 2018, Respondent ignored multiple warning signs that Patient 2 may be experiencing medication related side effects including Patient 2 reporting multiple falls, Patient 2 having memory issues, Patient 2 driving his vehicle into a guardrail, and Patient 2 suffering a chain saw accident. Respondent ignored the findings of the neurology report from February 2016, which did not find an organic basis for Patient 2's symptoms based on a normal MRI and the suggestion of the neurologist that indicated that Patient 2's issues may be caused by psychiatric causes. Respondent did not take into account Patient 2's abnormal urine drug screen from January 25, 2017, which showed the presence of a barbiturate. On or about July 24, 2017, Respondent allowed Patient 2 the choice of continuing to take a benzodiazepine and hypnotic despite his own documented concerns regarding Patient 2's continued memory loss. Finally, Respondent ignored the urine drug screen from April 25, 2018, which showed a markedly high metabolite for alcohol use and continued prescribing Patient 2 controlled substances.

57. Between February 20, 2015, and June 14, 2018, Respondent, and the mid-level providers under his supervision, kept Patient 2 on a chronic pain management regimen where the MED was above 125. At his subject interview on February 26, 2019, Respondent incorrectly stated that Patient 2, "started out at about 120 morphine equivalent doses and is now down to 50 with the Butrans and I don't know – I don't remember the conversion of Butrans right now." Between February 20, 2015, and June 14, 2018, Respondent failed to closely follow the patient, as evidenced by missing multiple red flags as noted in paragraph 53 of the Accusation, failed to refer patient to a pain management specialist for a chronic pain management consultation, failed to document any side effects from medications, failed to adequately taper the patient's medications, prescribed twice the recommended dosage of Butrans, and failed to make modifications to Patient 2's chronic pain treatment plan as issues arose during treatment.

58. Between February 20, 2015, and June 14, 2018, Respondent, and the mid-level providers under his supervision, prescribed multiple drugs that in combination can lead to severe respiratory depression and death. These dangerous combinations included, but are not limited to, prescribing trazodone with Flexeril, hydrocodone with Butrans, hydrocodone with Flexeril, opioids with benzodiazepines, and opioids with hypnotics. Respondent continued to mix and combine medications throughout Patient 2's treatment history despite multiple red flags as listed in paragraphs 53 and 54 of the Accusation.

Patient 3

59. The Medical Board of California reviewed medical records for Patient 3 from on or about January 15, 2015, and through on or about May 22, 2018. Patient 3 was a complex patient with a number of medical issues. For example, on or about January 26, 2015, Patient 3 was seen in clinic by Physician Assistant E for a chief complaint of medication refill, headaches, and for a urine drug screen. Patient 3's various medical conditions and problems included, depression, ADHD, chronic pain from her shoulder, knee, lower back, and muscle spasms, migraines, hypertension, insomnia, fibromyalgia, and hypothyroidism. As of January 25, 2016, Patient 3 was taking a 20 mg tablet of Adderall BID,[17] a 350 mg tablet of Soma QID, a tablet of 10 mg of

[17] BID means twice a day, TID means three times a day, QID means four times a day.

diazepam BID, a tablet of 10/325 mg of Norco QID, a tablet of 15 mg immediate release morphine sulfate QID, a tablet of 60 mg extended release morphine sulfate (TID). Patient 3 was also prescribed Remeron, venlafaxine, insulin, and thyroid medication. Her daily morphine equivalent dose was 280 MED while she was also receiving a sedative and muscle relaxer. Physician Assistant E administered a 100 mg Demerol injection and a 50 mg Phenergan injection during the office visit which added an additional 10 MED. According to Respondent, during his February 26, 2019, subject interview with the Medical Board, the clinic knew that Patient 3 used marijuana, but that was not documented in her medical records as part of her treatment plan or social history. Patient 3's social history as documented in the medical records showed that she denied alcohol and illicit drug use, she was a pack a day cigarette smoker for the last 40 years, and she was in a wheelchair due to severe knee arthritis and pain. Patient 3 was documented with a BMI of 29.5, had a moderately elevated blood pressure of 161/86, and an oxygen saturation of 95% on room air which indicated she was mildly hypoxic. Physician Assistant E did not document a pain score but did document that Patient 3 reported she had no significant side effects from her medication and that the current regimen of medications was effective for the management of her chronic pain. Physician Assistant E documented a thorough ROS and physical examination. Physician Assistant E had Patient 3 provide a urine drug screen and Patient 3 signed a pain contract.

60. Between January 15, 2015, and through May 22, 2018, Patient 3 was seen in clinic by Respondent, Doctor F, and a combination of mid-level practitioners who were supervised by Respondent and Doctor F. Patient 3 was seen in clinic every one to three months on average. Patient 3's surgical history between January 15, 2015, and through May 22, 2018, included having a left rotator cuff surgery on March 3, 2015, a total right knee replacement surgery in November 2015, and a total left knee replacement surgery on May 28, 2017. Between January 15, 2015, and through May 22, 2018, Patient 3 had a number of oxygen saturation results which indicated mild hypoxia which included the following examples: On April 5, 2015, with Physician Assistant D, Patient 3 had a 91% oxygen saturation; On July 9, 2015, with Respondent, Patient 3 had a 94% oxygen saturation; On July 12, 2016, with Physician Assistant D, Patient 3 had a 94%

oxygen saturation; On April 5, 2017, with Physician Assistant C, Patient 3 had a 94% oxygen saturation; On August 17, 2017, with Physician Assistant E, Patient 3 had a 94% oxygen saturation; and On May 22, 2018, with Respondent, Patient 3 had a 93% oxygen saturation. Between January 15, 2015, and through May 22, 2018, Patent 3 had a number of blood pressure results which indicated possible hypertension which included the following examples: On May 12, 2016, with Physician Assistant G, Patient 3 had a blood pressure of 181/111; On July 5, 2016, with Respondent, Patient 3 had a blood pressure of 183/115; On July 12, 2016, with Physician Assistant D, Patient 3 had a blood pressure of 164/114; and On December 1, 2017, with Respondent, Patient 3 had a blood pressure of 193/95.

61. Between January 15, 2015, and through May 22, 2018, a review of the medical records showed the following events: On or about October 22, 2015, Vistaril 50 mg QID was added for nausea, Patient 3 provided a consistent urine screen, and Patient 3 was prescribed temazepam for sleep. On or about February 4, 2016, Respondent was noted as personally seeing Patient 3 and he documented a pain score of 7 out of 10 and reviewed Patient 3's pain contract with her. On or about May 12, 2016, during a pre-operative EKG,[18] the test showed the presence of a new inferior-lateral myocardial infarction of an unknown date and Patient 3 was referred to a cardiologist for pre-operative clearance. On or about July 9, 2016, a nuclear study showed that there was evidence of an old, fixed infarction but no ongoing ischemia and Patient 3 was cleared for surgery. It is noteworthy that Patient 3 had evidence of transient atrial fibrillation after her right knee replacement in November 2015. The May 12, 2016, visit with Physician Assistant G, which also revealed Patient 3's blood pressure to be 181/111, was co-signed by Respondent. This was the only mid-level provider note that was co-signed by Respondent for Patient 3 between January 15, 2015, through May 22, 2018.

62. On or about May 16, 2016, Respondent saw Patient 3 in clinic and lowered her prescription of a 60 mg tablet of morphine sulfate extended release TID prescription to a prescription of 60 mg tablet of morphine sulfate extended release BID. Respondent added a

[18] Electrocardiography is the process of producing an electrocardiogram (EKG), a recording of the electrical activity of the heart using electrodes placed on the skin.

prescription for 2 mg tablet alprazolam TID to be taken concurrently with a prescription for 10 mg diazepam BID. Patient 3 remained on carisoprodol, amphetamine salts, and morphine sulfate immediate release. Patient 3 returned to a 60 mg tablet of morphine sulfate TID prescription on July 5, 2016. Patient 3 continued to fill alprazolam through August 9, 2016. In addition, morphine sulfate immediate release was stopped on July 5, 2016, and restarted on April 15, 2017. Also, Norco was stopped on or around April 11, 2016, and restarted on September 27, 2016. On September 27, 2016, a urine drug screen was performed which was consistent with her prescriptions and Patient 3 signed a new pain contract with the clinic.

63. On or about April 5, 2017, Patient 3 was seen by Nurse Practitioner C for a medication refill. At that time, Patient 3 was receiving a daily dose of 6 mg of alprazolam, 40 mg of amphetamine salts, 1400 mg of carisoprodol, 20 mg of diazepam, 40 mg of hydrocodone, 45 mg of morphine sulfate immediate release, and 180 mg of morphine sulfate extended release. The morphine equivalent dosage was 265 MED in combination with two benzodiazepines, one muscle relaxer, and one stimulant. Patient 3's September 27, 2016, pain contract specifically stated that she specifically agreed to not get pain medication from any other doctor, dentist, or healthcare provider. Nurse Practitioner C documented Patient 3's pain level as 0 at the April 5, 2017, visit. On or about May 1, 2017, Patient 3, filled a 15-day prescription for 160 tablets of 10 mg oxycodone for post-operative pain from a Physician Assistant affiliated with the orthopedist who would be performing her knee surgery scheduled for May 28, 2017. Assuming Patient 3 took the oxycodone as prescribed, her morphine equivalent dose when combined with her existing opioid prescriptions in June 2017 would have been 445 MED while still being prescribed a combination of two benzodiazepines, one muscle relaxer, and one stimulant.

64. On or about July 7, 2017, Physician Assistant D saw Patient 3 in clinic for a medication refill and ordering labs. Physician Assistant D documented that Patient 3 was requesting Norco. Physician Assistant D documented that Patient 3 was told that due to the high amount of opiate medication she was taking, that she would need to see a physician on the next visit. At the next visit to the clinic, on or about August 17, 2017, Physician Assistant E saw Patient 3 for a chief complaint of migraine. Respondent did not see Patient 3 on August 17, 2017,

and did not counter-sign the note despite Physician Assistant D's notation on July 7, 2017, that Patient 3 see a physician on her next visit. Physician Assistant E gave Patient 3, a 100 mg/ml. shot of Demerol for Patient 3's migraine despite the fact that in 2017 Demerol had a black box warning that the medication could cause cardiac toxicity. On August 17, 2017, Patient 3 filled a prescription for 90 tablets of 15 mg morphine sulfate immediate release, and on August 18, 2017, Patient 3 filled a prescription for 90 tablets of 60 mg morphine sulfate extended release, 120 tablets of 10/325 mg hydrocodone with acetaminophen, and, 60 tablets of 20 mg amphetamine salts. Patient 3 was still filling prescriptions for carisoprodol and diazepam at that time.

65. On or about September 12, 2017, Respondent saw Patient 3 in clinic for a medication refill and consultation. Respondent documented that Patient 3 was prepared to begin tapering her medications. Respondent ordered that Patient 3 taper from 60 mg of morphine sulfate extended release TID to 50 mg of morphine sulfate extended release TID. Respondent also ordered that Patient 3 take one less 10/325 mg Norco per day. Respondent documented a "(g)oal of getting off morphine but 1st goal is down to 120 MED's". Respondent continued to prescribe morphine sulfate immediate release, carisoprodol, alprazolam and diazepam to Patient 3. Respondent did not refer Patient 3 to a pain management specialist.

66. On or about September 29, 2017, Patient 3's medical insurance company sent Respondent a letter that Patient 3's MED was above 120 and also that Respondent's medical practice was prescribing opiates in combination with benzodiazepines and carisoprodol to Patient 3. The insurance company cited to existing medical research and CDC guidelines that opiate prescriptions were recommended to be below 120 MED, that medical research recommended use of non-controlled substance therapies and the document specifically stated that medical prescribers should not co-prescribe opiates with benzodiazepines, sedatives-hypnotics, muscle relaxants, or barbiturates. This letter was incorporated into Patient 3's medical record on or about October 26, 2017.

67. On or about May 22, 2018, Respondent saw Patient 3 in clinic for a medication refill. Respondent documented that Patient 3 was prescribed a daily dose of 60 mg tablet of morphine sulfate extended release BID, a 15 mg tablet of morphine sulfate immediate release BID, a 10/325

mg hydrocodone with acetaminophen TID, a 10 mg tablet of diazepam BID, a 350 mg tablet of carisoprodol QID, and 40 mg of amphetamine salts.[19] A drug screen performed on May 22, 2018, was consistent with these prescriptions, but also showed the presence of marijuana and the presence of oxycodone. According to pharmacy records, oxycodone was last prescribed on May 1, 2017, which could potentially show that the patient was hoarding medication or receiving medication from a different source. Test results obtained on or around May 22, 2018, revealed in two eye exams, that Patient 3 had hypertensive retinopathy. Also, test results obtained on or around May 22, 2018, revealed that Patient 3's labs showed an A1C of 8.3% and a high hemoglobin of 19.4.

68. Between January 15, 2015, and through May 22, 2018, Respondent repeatedly failed to properly monitor Patient 3 as he prescribed controlled medications, in particular high-dose opioids, to Patient 3. Patient 3's morphine equivalent dosing was often above 200 and sometimes was much higher. Respondent failed to detail the presence of specific side effects, failed to perform more frequent urine drug testing, and failed to refer Patient 3 to a pain specialist for chronic pain management. In addition, Patient 3 received a high amount of oxycodone from a different medical provider in violation of her pain contract without any documented analysis in the clinic's medical records on whether that impacted Patient 3's chronic pain treatment plan. Respondent's mid-level provider also gave Patient 3 Demerol on two occasions, including on one occasion in 2017 which was after Demerol contained a black box warning in regards to cardiac toxicity. Finally, Patient 3 repeatedly presented at visits with potential evidence of hypoxia and Respondent failed to monitor whether that hypoxia was related to the controlled substances that he or the mid-level providers under his supervision were prescribing.

69. Between January 15, 2015, and through May 22, 2018, Respondent, and the mid-level providers under his supervision, prescribed multiple drugs that in combination could lead to severe respiratory depression and death. For example, Patient 3 was prescribed two short-acting opioids at the same time in the form of hydrocodone with acetaminophen and morphine sulfate

[19] Patient 3 was still receiving a MED of 180 in combination with a benzodiazepine and a muscle relaxant.

immediate release, prescribed hydrocodone in combination with Demerol, prescribed opioids in combination with benzodiazepines, and prescribed opioids in combination with carisoprodol. Of particular concern, in or around May 2017, Patient 3 was taking four different opiate/opioid medications, in combination with a benzodiazepine and a muscle relaxer which greatly increased her risk of respiratory depression and death. Between January 15, 2015, and through May 22, 2018, Respondent, and the mid-level providers under his supervision, prescribed other dangerous combinations of drugs including but not limited to venlafaxine in combination with Demerol, and, venlafaxine in combination with Phenergan.

70. Between January 15, 2015, and through May 22, 2018, Respondent, and the mid-level providers under his supervision, failed to properly manage Patient 3's multiple and serious medical problems that were in addition to her chronic pain. By way of example, Respondent and the mid-level providers under his supervision, failed to address Patient 3's blood pressure readings that evidenced hypertension despite Patient 3 being a diabetic. Also, by way of example, Respondent and the mid-level providers under his supervision ignored hypertensive retinopathy results on two eye exams. Respondent and the mid-level providers under his supervision failed to treat Patient 3's hyperlipidemia, despite Patient 3 being diabetic, nor did they offer her the prescription of an ace-inhibitor to protect her kidneys. Respondent and the mid-level providers under his supervision failed to address Patient 3's cardiac issues despite evidence that Patient 3 had suffered a myocardial infarction between November 2015 and May 2016 and which was confirmed by a nuclear study in July 2016. Furthermore, Respondent and the mid-level providers under his supervision never referred Patient 3 to a diabetologist for management of her diabetes, never referred her for a sleep study despite repeated evidence of hypoxia and obesity, and never performed an in depth analysis of her elevated hemoglobin of 19.4 to determine its cause.

Patient 4

71. On or between February 3, 2015, and through June 19, 2018, Respondent, Doctor F, Physician Assistants B, D, and E, saw Patient 4 in clinic. A review of the progress notes showed a very thorough review of systems and physical examinations, even when visits were for

relatively minor complaints like a pre-operation EKG or a wound-care follow-up. A review of the progress notes showed that the notes were very similar, that the pain score was usually documented as a seven out of ten, that Patient 4 chewed tobacco and that Patient 4 consumed three alcoholic beverages on a weekly basis.

72. A review of the records between February 3, 2015, and through June 19, 2018, revealed that Patient 4 had chronic pain arising from a work injury to his back that occurred in 2005. Patient 4 also had a previous surgical history that included neck surgery in 2000, and back surgery in 2007. Patient 4's chronic neck and back pain required chronic pain management treatment. Patient 4 was also followed for severe knee arthritis which eventually led to a knee replacement in 2017, suffered from hypertension, hepatitis C, depression, insomnia, muscle spasms, neuropathy, and gastroesophageal reflux. A review of the records between February 3, 2015, and through June 19, 2018, Respondent rarely counter-signed the progress notes of the mid-level providers working under his supervision.

73. By way of example, on or about February 13, 2015, Physician Assistant E saw Patient 4 in clinic for a 3-month follow-up. At the time, Patient E was receiving monthly prescriptions of 90 pills of 10/325 mg hydrocodone with acetaminophen, 60 tablets of carisoprodol, and 30 pills of 12.5 mg Ambien. In essence, Patient 4 was receiving a MED of 30 in combination with a hypnotic and muscle relaxant. It is noteworthy that on this occasion, and on other occasions between February 3, 2015, and June 19, 2018, Patient 4 received two hard copy prescriptions for opiates that were post-dated to be filled at later dates in addition to his prescription that was to be filled on the day of the treatment visit.[20] Respondent did not counter-sign the progress note on February 13, 2015. A urine screen was performed on or about March 10, 2015. The urine drug screen result was completely negative despite the fact that Patient 4 was being prescribed hydrocodone, carisoprodol, and Ambien.

74. On or about April 7, 2015, Physician Assistant E saw Patient 4 in clinic for a workmen's compensation follow-up. Physician Assistant E started Patient 4 on a daily

[20] For example, it appears post-dated scripts were also issued on August 31, 2015, for hydrocodone and morphine sulfate.

prescription of 30 mg tablet of morphine sulfate extended release, 2 tablets of 10/325 mg hydrocodone, 3 tablets of 350 mg carisoprodol, and 1 tablet of 2 mg lorazepam. Physician Assistant E discontinued Ambien and replaced it with lorazepam. In essence, Physician Assistant E increased Patient 4's MED to 50 in combination with a muscle relaxer and a benzodiazepine. Physician Assistant E failed to document in the progress note that Patient 4 had provided a negative urine drug screen, nor did he incorporate that negative urine drug screen into Patient 4's chronic pain treatment plan. Respondent did not counter-sign the April 7, 2015, progress note.

75. On or about November 30, 2015, Patient 4 signed a pain contract. The pain contract did not state whether or not Patient 4 could take illicit drugs, marijuana, or consume alcohol while on chronic pain management. On or about January 22, 2016, Patient 4 provided a urine drug screen which showed the presence of marijuana, opiates, and benzodiazepines. At the subject interview with the Medical Board on February 26, 2019, Respondent stated that he was aware that Patient 4 was consuming marijuana. However, on or about March 29, 2016, at his next visit to the clinic, Patient 4 saw Respondent in clinic for a chief complaint of "w/c" and Respondent failed to document that Patient 4 was consuming marijuana in addition to receiving chronic pain therapy. By March 29, 2016, Respondent was prescribing Patient 4 a daily chronic pain regimen of 90 mg of morphine sulfate extended release, 30 mg of hydrocodone with acetaminophen, 4 mg of lorazepam, and 1050 mg of carisoprodol. In essence, Respondent had Patient 4 on a MED of 120 in combination with a muscle relaxant and a benzodiazepine and evidence of on-going marijuana use. A review of the medical records between March 29, 2016, and June 19, 2018, reveal no other urine drug screens despite Patient 4's November 30, 2015, pain contract clearly stating that urine drug screens would be performed every three months.

76. On or about January 12, 2018, Respondent saw Patient 4 in clinic for a chief complaint of follow-up. At the time, Respondent was prescribing a daily prescription of 90 mg of morphine sulfate extended release, 30 mg of Norco, 1050 mg of Soma, and 6 mg of lorazepam. In essence, Respondent was continuing to prescribe Patient 4 a MED of 120 in combination with a muscle relaxant and a benzodiazepine and evidence of on-going marijuana use. The January 12,

2018, prescriptions represented a significant increase in medication over the prescriptions that Patient 4 had received in February 2015.

77. Between February 3, 2015, and through June 19, 2018, Respondent and the mid-level providers he was supervising, failed to properly monitor Patient 4, as he was prescribed controlled substances, in particular, high dose opiates and opioids. For example, the medical records only revealed the documented results of two urine drug screens, one of which was negative for drugs despite on-going prescriptions and the other drug screen showed the presence of marijuana which was not incorporated into Patient 4's documented on-going chronic treatment plan. Respondent and the mid-level providers he was supervising failed to document whether they referred Patient 4 to pain management specialists, psychiatrists, or neurosurgeons. Respondent and the mid-level providers he was supervising failed to perform formal evaluations such as a CAGE questionnaire or Beck Depression Inventory on Patient 4. In addition, Respondent failed to more regularly review and counter-sign the progress notes of the mid-level providers that he was supervising as they provided medical care to Patient 4, despite his complex issues with chronic pain. Respondent, at the subject interview with the Medical Board, stated that he enlisted the help of Patient 4's wife to tell Respondent if Patient 4 was having problems with his chronic pain treatment without using more objective means to test Patient 4's compliance on chronic pain therapy. Finally, Respondent repeatedly received letters in 2016 and 2017 as part of Patient 4's worker's compensation case that indicated independent expert medical reviewers had raised concerns with Patient 4's on-going high dose opiate and opioid prescriptions, Patient 4's on-going benzodiazepine prescriptions, and Patient 4's on-going carisoprodol prescriptions, without modifying Patient 4's chronic pain treatment plan.

78. Between February 3, 2015, and through June 19, 2018, Respondent, and the mid-level medical providers that he was supervising, continued to prescribe multiple combinations of medications to Patient 4 that placed him at greater risk of respiratory depression and death. For example, Respondent prescribed opiates in combination with benzodiazepines and carisoprodol on multiple occasions. Opiates and benzodiazepines in combination are known to cause severe sedation. Opiates and carisoprodol in combination are known to cause severe sedation. In

addition, Respondent and the mid-levels providers he was supervising, prescribed Naprosyn and benazepril in combination, which can cause serious renal compromise, and he prescribed Lyrica and benazepril in combination which can cause respiratory compromise. Respondent also failed to adequately examine and/or document whether Patient 4's marijuana use and alcohol use in combination with opiates, benzodiazepines, and carisoprodol could also lead to additional risk of sedation and/or death. Finally, Respondent, and the mid-level providers he was supervising failed to show any significant efforts at tapering the multiple combinations of drugs that Patient 4 was taking between February 3, 2015, and June 19, 2018.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

79. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, and Title 16, California Code of Regulations section 1399.541, in that he committed gross negligence during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

80. Complainant realleges paragraphs 24 through 70, and those paragraphs are incorporated by reference as if fully set forth herein.

81. Respondent's license is subject to disciplinary action because he, and the mid-level providers he was supervising, committed gross negligence during the care and treatment of Patients 1, 2, and 3 in the following distinct and separate ways:

a. By failing to properly provide supervision and oversight to mid-level practitioners who prescribed high quantities of controlled substances to Patient 1 in such a way to place Patient 1 at risk of overdose and death;

b. By failing to properly evaluate and manage Patient 2 while Patient 2 received controlled substances as a high risk patient who was at risk of suffering from serious side effects due to a past history of illicit drug use and alcohol use; and

c. By failing to manage Patient 3's complex, multiple, and serious medical problems that were in addition to her chronic pain issues.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

82. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, and Title 16, California Code of Regulations section 1399.541 in that he, and the mid-level providers he was supervisiong, committed repeated negligent acts during the care and treatment of Patients 1, 2, 3, and 4. The circumstances are as follows:

83. Complainant realleges paragraphs 24 through 78, and those paragraphs are incorporated by reference as if fully set forth herein.

84. Respondent committed the following negligent acts during the care and treatment of Patients 1, 2, 3, and 4:

a) By failing to properly provide supervision and oversight to mid-level practitioners who prescribed high quantities of controlled substances to Patient 1 in such a way to place Patient 1 at risk of overdose and death;

b) By failing to closely monitor the dangerous amounts of controlled substances, specifically multiple prescriptions of 90 mg of oxycodone per day, that were prescribed to Patient 1 in the form of multiple hard copy prescriptions which allowed for refills without office visits;

c) By prescribing opiate medications in combination with sedatives, specifically a daily dosing of 90 mg of oxycodone with 6 mg of alprazolam and 30 mg of diazepam, to Patient 1 which may increases the risk of respiratory depression and death;

d) By failing to evaluate and manage Patient 1 as a high-risk chronic pain patient to ensure that Patient 1 was not at risk of improperly using controlled medications, specifically failing to do an assessment of Patient 1's alcohol use and failing to perform drug screening;

e) By failing to properly document accurate and complete medical records during the treatment of Patient 1;

f) By failing to properly evaluate and manage Patient 2 while Patient 2 received controlled substances as a high risk patient who was at risk of suffering from serious side effects due to a past history of illicit drug use and alcohol use;

g) By prescribing dangerous levels of opiates to Patient 2 without properly managing Patient 2's plan of treatment;

h) By prescribing multiple combinations of medications, including but not limited to multiple opioids with multiple sedatives, to Patient 2 which may have increased the risk of respiratory depression and death;

i) By failing to manage Patient 3's complex, multiple, and serious medical problems that were in addition to her chronic pain issues;

j) By failing to properly monitor dangerous amounts of controlled substances, specifically opiates, to Patient 3 in such a way to place Patient 3 at risk of addiction and serious side effects;

k) By prescribing opiate medications in combination with sedatives to Patient 3 which may increase the risk of respiratory depression and death;

l) By failing to properly monitor dangerous amounts of controlled substances, specifically opiates, to Patient 4 in such a way to place Patient 4 at risk of addiction and serious side effects; and

m) By prescribing opiate medications in combination with sedatives to Patient 4 which may increase the risk of respiratory depression and death.

THIRD CAUSE FOR DISCIPLINE

(Inaccurate and Inadequate Medical Records)

85. Respondent's license is subject to disciplinary action under section 2266 of Code, and Title 16, California Code of Regulations section 1399.541, in that he, and the mid-level providers he was supervising, kept inaccurate and incomplete medical records. The circumstances are as follows:

86. Complainant realleges paragraphs 24 through 78, and those paragraphs are incorporated by reference 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. A 87909, issued to Daniel S. Sewell, M.D.;

2. Revoking, suspending or denying approval of Daniel S. Sewell, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Daniel S. Sewell, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Ordering Daniel S. Sewell, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and

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

DATED: October 4, 2019

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

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