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

In the Matter of the Accusation Against: Kimberly Hicks, M.D. Physician's and Surgeon's Certificate No. G 79714 Respondent.	Case No. 800-2019-053765

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct a clerical error that does not affect the factual or legal basis of the Proposed Decision. The Proposed Decision is amended as follows:

1. Page 2, paragraph 1, line 1: the Physician's and Surgeon's Certificate is corrected to read "August 24, 1994".

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

This Decision shall become effective at 5:00 p.m. on November 20, 2020.

IT IS SO ORDERED October 21, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:

KIMBERLY HICKS, M.D.,

Physician's and Surgeon's Certificate No. G 79714

Respondent.

Agency Case Nos. 800-2019-053765

OAH No. 2020040758

PROPOSED DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on August 24 and 25, 2020, by telephone and videoconference.

Deputy Attorneys General Greg W. Chambers and Ana Gonzalez represented William Prasifka, Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California.

Attorney at Law Stephanie Bolden represented respondent Kimberly Hicks, M.D., who was present.

The record closed and the matter was submitted for decision on August 25, 2020.

FACTUAL FINDINGS

Procedural Background

1. On July 28, 1994, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate (certificate) No. G 79714 to respondent Kimberly Hicks, M.D.

Because of her history of alcohol abuse, which manifested during medical school and postgraduate training, respondent's certificate was issued as a probationary certificate for a period of five years, with conditions including participation in the Board's Diversion Program and biological fluid testing. Respondent successfully completed probation on July 28, 1999.

Respondent's certificate was active during the events described below. The certificate expired on July 31, 2020, and is in delinquent status.

2. On March 23, 2020, respondent's certificate was suspended pursuant to an Interim Suspension Order that was issued after hearing, pursuant to Government Code section 11529, subdivision (g).

3. On April 28, 2020, acting in her official capacity as Interim Executive Director of the Board, Christine J. Lally filed the First Amended Accusation against respondent. Complainant William Prasifka subsequently replaced Lally as the Board's Executive Director.

Complainant seeks revocation of respondent's certificate for mental impairment due to alcohol use disorder and for dozens of extreme departures from the standard of care in connection to 11 patients, primarily involving overprescribing of controlled substances and failure to maintain accurate medical records.

4. Respondent filed a Notice of Defense, and this hearing ensued.

Consumer Complaints

5. This matter initially arose from the following four consumer complaints:

a. In August 2017, an individual filed an online complaint regarding respondent's treatment of the individual's father, Patient 3. The individual claimed that respondent was prescribing controlled substances to Patient 3, her father, even though he is an addict and had been "blacklisted" from being prescribed narcotics. The individual further alleged that respondent was "dealing illegal pain killer prescriptions to local drug dealers who are using elderly and mentally ill patients to trade crack cocaine for the Norco pills and sell them on the streets."

b. In November 2017, Patient 10 submitted an online complaint. She wrote that she had made an appointment to see respondent as a new patient for follow up treatment for pneumonia. She complained that the office was dirty and she was made to wait an excessive amount of time. After she had her mother call the receptionist to complain about the wait, respondent banged on the wall of the room and yelled and cursed at her. Respondent came into the room and yelled at her. Respondent left the room without examining her. Respondent left the door wide open and the topless patient exposed.

c. In June 2018, Patient 11 submitted an online complaint. She wrote that she made an appointment as a new patient for a physical examination and bloodwork. The office was in disarray. Respondent was eating in the examination room, kept falling asleep, and appeared impaired. She performed only a chest auscultation. The patient had to assist respondent in filling out a lab form.

d. In August 2018, Patient 9 submitted a written complaint. She complained that respondent canceled appointments the same day, treated her in a rude and unprofessional manner, discussed her private medical information in front of others, refused to refill a prescription after saying she would, and refused to provide the patient's medical records upon request so that she could transfer care to another provider. Patient 9 identified herself as mentally unstable.

Investigation

6. The Board opened an investigation of respondent in light of these complaints. Alisa Summers was the primary investigator.

CURES Reports

7. Summers performed a search of respondent's neighbors, relatives, and associates, and ran their names through CURES[1]. She discovered that respondent had prescribed controlled substances to her mother (Patient 1) and her brother (Patient 2).

Summers consulted with Medical Consultant Sandra Karpenko, M.D. Dr. Karpenko reviewed respondent's prescribing history on CURES, and observed suspicious prescribing practices involving a number of patients. Summers obtained

[1] CURES is California's prescription drug monitoring program.

patient releases for five patients who appeared to have been overprescribed controlled substances, Patients 4 through 8. She also obtained releases from the four patients involved in the complaints submitted to the Board.

Summers sent these patient releases to respondent and directed her to produce patient records. Respondent did not respond to these requests in a timely manner. As discussed further below, she was ultimately only able to produce more or less complete records for one patient, and was unable to produce any records for most of the patients.

UNANNOUNCED VISIT, JANUARY 2019

8. Summers made an unannounced visit to respondent's clinic on January 31, 2019, early in the process of seeking patient records. She observed stacks of boxes and patient charts piled on the floor. Respondent blamed staffing issues and a broken fax machine for her inability to comply with the Board's requests for patient records. Respondent provided 115 pages of medical records for Patient 9, in random order.

INTERVIEW, MAY 2019

9. Summers and Dr. Karpenko scheduled an interview with respondent at the Concord Field Office for May 22, 2019. Respondent had promised to bring patient records with her to the interview. Respondent was 50 minutes late. She arrived with a large plastic tub with disorganized patient records.

Respondent explained that she had been short staffed since the prior August and had not kept records since that time, that she was experiencing financial difficulties, that she was not billing her patients or paying her bills, that she was

drinking two vodkas on the days that she did not see patients, and that she had two recent alcohol-related driving incidents.

Respondent provided records, albeit disorganized, for Patient 7. Some documents had no dates of service on them. After first claiming that they were complete, she acknowledged that they were not complete.

Respondent provided documents, also disorganized, for Patient 8. Summers spent an entire day organizing these records.

Respondent had brought records for Patient 4 with her. Summers observed her writing on the documents and asked her to stop. Respondent took the records back with her and promised to provide a complete set of records for Patient 4, 5, 6 and 7 in two days. Respondent did not do so and never did.

SECOND UNANNOUNCED VISIT, JUNE 10, 2019

10. Summers made an unannounced visit to respondent's clinic on June 10, 2019. The clinic was extremely disorganized and cluttered with paperwork and furniture. There was a patient in the waiting room. Respondent was in the parking lot behind the clinic, rummaging through bags and boxes in her vehicle.

SECOND INTERVIEW, JULY 2019

11. An interview was scheduled for July 10, 2019. Respondent called an hour after the scheduled time and explained that she was running late; the interview was rescheduled for July 17, at 10:00 am. Respondent arrived 40 minutes late and Summers informed her that she could not do the interview that day. Respondent sat on the floor with patient records and appeared to be sorting through them. She promised to return with them in one week. She did not do so.

An interview finally took place on July 31. Summers and Dr. Karpenko were again present.

Respondent reiterated that she had been understaffed and unable to adequately keep up with medical records and billing records for some patients. Respondent was asked to show identification; her driver's license had expired earlier that month because respondent forgot to renew it. Respondent admitted having two drinks of vodka with ice on her four days off. She denied being an alcoholic.

Respondent acknowledged that she was not registered in CURES, even though by this time registration and use of CURES was mandatory for all physicians who prescribe controlled substances. Respondent commented that she did not even know she could register for CURES until recently. She thought only pharmacists were responsible for monitoring controlled substance prescriptions.

Respondent acknowledged that she needed to spend more time on her charting. She again promised to produce additional patient records, but never did.

12. Based on her observations of respondent during the interview, Dr. Karpenko was concerned that respondent might be cognitively impaired and unable to practice medicine by reason of a mental illness. She recommended that respondent be evaluated by a psychiatrist.

13. On September 11, 2019, respondent contacted Summers and told her she would be taking a break from her practice in order to participate in an outpatient rehabilitation program. Respondent did not enroll in a program and had not enrolled in any rehabilitation program by the time of the hearing, almost one year later.

Mental Health Evaluation

14. In January 2020, respondent was ordered to submit to a mental health examination by a Board-designated expert. Respondent was directed to schedule an examination with psychiatrist Laura Davies, M.D.

Dr. Davies conducted a psychiatric evaluation of respondent to determine if respondent's ability to safely practice medicine was impaired. Dr. Davies interviewed respondent on February 6, 2020. In addition, Dr. Davies reviewed a variety of records, including transcripts from respondent's interviews, respondent's CURES reports, an expert report from Robert Franklin, M.D., medical records for a number of respondent's patients, and treatment records from respondent's therapist. She also spoke with Summers and Dr. Karpenko.

15. Dr. Davies issued two reports, dated February 9 and 19, 2020, setting forth her findings and conclusions, and testified at hearing. Dr. Davies's opinions were unrebutted and persuasive.

Dr. Davies diagnosed respondent with Alcohol Use Disorder, based upon respondent's years of excessive drinking, with negative consequences to her work and finances, as well as two recent alcohol-related driving incidents reported by respondent. The fact that respondent began drinking after previously suffering negative consequences related to her drinking reflects the severity of her illness. Dr. Davies noted that respondent lacked insight into her illness and had been unable to maintain basic standards of professionalism in her medical practice.

Dr. Davies described respondent's reported drinking habit of "2 vodkas four days a week," plus "cocktails with friends" on the weekend as significant and in excess of the threshold for problem drinking.

Dr. Davies also observed that respondent spontaneously disclosed information that was against her interests, including that she drove to the appointment despite the fact that she still did not have a valid driver's license, that she was unlawfully living in a Section 8 property that she owns, and that she drove luxury cars while paying her therapist a reduced fee.

16. Dr. Davies concluded that respondent's Alcohol Use Disorder is a condition that impairs respondent's ability to practice medicine safely, and that respondent's continued practice of medicine poses a threat to the public health, safety and welfare. She recommends that respondent attend an inpatient treatment program, but is not sure whether respondent could eventually practice medicine safely.

17. The facts underlying Dr. Davies' determination included: patients observed that respondent is unable to function at work; respondent admitted to falling asleep during encounters with patients and had been unable to maintain appropriate boundaries; respondent treated patients for chronic pain, yet she had not registered for CURES; respondent's documentation was an extreme departure from the standard of care; respondent was unable to comply with Board requests to produce patient records; respondent resumed consuming alcohol after a period of intensive treatment and sobriety; respondent did not believe that she has a problem with alcohol; and although respondent indicated that she would seek treatment for alcohol abuse in September 2019, she did not follow through.

Expert Opinion

18. The Board retained Robert Franklin, M.D., to perform an expert review of respondent's care of the 11 patients in this case. Dr. Franklin is board certified in Family Medicine and practices at a clinic in the Bayview Hunters Point area of San

Francisco, an underserved community. He has performed reviews for the Board since 2003. Dr. Franklin reviewed all patient records provided to the Board by respondent as of January 2020, as well as the transcripts of the Board's interviews of respondent. Dr. Franklin wrote several reports and testified at hearing regarding the causes for discipline premised on respondent's treatment of Patients 1 through 11. Dr. Franklin's report and testimony were unrebutted and persuasive. Dr. Franklin established all allegations set forth in the First Amended Accusation pertaining to Patients 1 through 11, as set forth below:

PATIENT 1

a. Respondent prescribed Tylenol No. 3[2] to Patient 1 (her mother) on two occasions, November 27, 2015 (30 quantity) and January 6, 2018 (60 quantity). Respondent did not maintain medical records documenting care of this patient. When treating a family member, the same standard of care that applies to the treatment of any patient applies, as due the requirements for maintaining accurate and adequate records. At hearing, respondent acknowledged that she did not maintain patient records for Patient 1.

[2] Tylenol No. 3 (acetaminophen with codeine 300mg/30mg) is a tradename for a combination of acetaminophen and codeine phosphate. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule III controlled substance and narcotic as defined by Health and Safety Code section 11056, subdivision (e).

Dr. Franklin concluded that respondent's two acts of prescribing Tylenol No. 3 to her mother were simple departures from the standard of care in light of the lack of medical documentation.

Respondent's failure to conduct or document that a patient history, physical examination, and rational assessment to support the prescription of controlled substances for this patient constituted an extreme departure. Her treatment of Patient 1 also reflected unprofessional conduct.

PATIENT 2

b. Respondent prescribed testosterone to Patient 2 (her brother) over a three-year period. Respondent failed to provide medical records for her treatment of Patient 2.

Dr. Franklin concluded that respondent's prescribing of testosterone for three years without documentation and without taking and documenting a thorough medical history and examination, without measuring testosterone and prostate specific antigen levels, without documenting that the risks and benefits of treatment had been explained to the patient, and without documenting the ongoing safety and effectiveness of the treatment all constituted extreme departures from the standard of care. Her treatment of Patient 2 also reflected unprofessional conduct.

PATIENT 3

c. Between August 7, 2017 and May 11, 2018, respondent prescribed Norco[3] to Patient 3 on 10 occasions and prescribed Tylenol No. 3 (acetaminophen with codeine 300mg/30mg)[4] on one occasion. Respondent failed to provide any medical records for her treatment of Patient 3.

Dr. Franklin concluded that respondent's prescribing of these controlled substances to Patient 3 while failing to document informed consent, any indication or rationale for prescribing them, specific objective goals for treatment or possible alternative modalities, as well as her failure to document or perform a physical examination prior to prescribing controlled substances, failure to consult CURES, and failure to review and document the treatment for safety and efficacy all constituted extreme departures from the standard of care. Her failure to maintain adequate and accurate medical records constituted an extreme departure from the standard of care. Her treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

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[3] Norco is a tradename for hydrocodone bitartrate with acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and is a dangerous drug as defined by Business and Professions Code section 4022. Norco is a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055, subdivision (e).

[4] The accusation incorrectly states that respondent prescribed Vicodin 30 mg/300mg instead of Tylenol No. 3, as the CURES data establishes.

PATIENT 4

d. Dr. Franklin reviewed the CURES data for Patient 4, which revealed that between February 2, 2016 and January 21, 2019, respondent prescribed Duragesic[5] (37 times), Methadone[6] (four times), Oxycodone IR[7](35 times), Phenergan[8] with codeine (three times) and zolpidem[9] (10 times). No records were ever produced for this patient,

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[5] Duragesic is a tradename for fentanyl transdermal system. It is an opioid analgesic and a dangerous drug pursuant to Business and Professions Code section 4022. It is a Schedule II controlled substance as defined by Health and Safety Code section 11055.

[6] Methadone hydrochloride is a synthetic narcotic analgesic. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055, subdivision (c).

[7] Oxycodone hydrochloride is a pure agonist opioid known by the tradename Oxycontin. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055, subdivision (b)(1).

[8] Phenergan is a tradename for promethazine. It is a dangerous drug as defined by Business and Professions Code section 4022.

[9] Zolpidem is known by the tradename Ambien. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule IV controlled substance as defined by Health and Safety Code section 11057.

although during her Board interview, respondent stated that she had 890 pages of records for this patient and promised to produce them. Respondent stated that she was treating the patient for chronic abdominal pain, and that the patient had tested positive for cocaine during a hospital stay.

Dr. Franklin noted that the combination of controlled substances prescribed to this patient is extremely dangerous and potentially fatal. The substances are commonly abused by addicts and are also diverted into the community in exchange for money or other substances.

Dr. Franklin explained that assuming that respondent had 890 pages of records for this patient, the fact that she was unable to produce them in usable form to the Board violated the standard of care. Physicians are required to maintain readily accessible records for all patients for a variety of important purposes. Respondent's explanations did not excuse her failure to produce records. If the records cannot be produced, it is the same as if they do not exist.

Dr. Franklin identified the following extreme departures from the standard of care regarding respondent's treatment of Patient 4: simultaneously prescribing an extremely dangerous combination of controlled substances without indication or rationale; failing to order toxicology screens despite a positive test for cocaine; failing to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities; failing to perform or document an adequate physical examination prior to prescribing controlled substances, failing to consult CURES, and failing to review and document the treatment for safety and efficacy on a regular basis. Her failure to maintain adequate and accurate medical records constituted an extreme

departure from the standard of care. Her treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

PATIENT 5

e. Respondent produced no records for Patient 5. Respondent told the Board's investigators that she had treated the patient for back pain for about a decade, and had referred the patient for pain management. Between February 4, 2016, and January 7, 2019, respondent prescribed to Patient 5 the following: SOMA[10] (39 times), Valium[11](24 times), Norco (36 times) and zolpidem (31 times). Respondent prescribed 150 tablets of SOMA during a 37-day period in 2017.

Dr. Franklin concluded that respondent's prescribing of a dangerous mixture of controlled substances, including a dangerous amount of SOMA, constituted extreme departures from the standard of care. In addition, respondent committed additional extreme departures by: failing to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities; failing to perform or document an adequate physical examination prior to prescribing controlled substances, failing to

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[10] SOMA is a tradename for carisoprodol. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule IV controlled substance as defined by Health and Safety Code section 11057.

[11] Valium is a tradename for diazepam. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule IV controlled substance as defined by Health and Safety Code section 11057.

consult CURES, and failing to review and document the treatment for safety and efficacy on a regular basis. Her failure to maintain adequate and accurate medical records constituted an extreme departure from the standard of care. Her treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

PATIENT 6

f. Respondent provided no records for Patient 6. She told the investigators that she had referred the patient for pain management. Respondent prescribed the following to Patient 6, between May 3, 2016, and January 23, 2019, a period during which other practitioners also issued prescriptions to this patient: methadone (15 times), Norco (2 times), Percocet[12](1 time), and zolpidem (33 times).

Dr. Franklin concluded that respondent's treatment of Patient 6 constituted multiple extreme departures from the standard of care, in that she failed to document any rationale for prescribing short-acting opiates to a patient being treated with methadone and zolpidem, failing to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities; failing to perform or document an adequate physical examination prior to prescribing controlled substances, failing to consult CURES, and failing to review and document the treatment for safety and efficacy on a regular basis. Her failure to maintain adequate and accurate medical

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[12] Percocet is a tradename for a combination of oxycodone and acetaminophen. It is a dangerous drug as defined by Business and Professions Code section 4022. It is a Schedule II controlled substance as defined by Health and Safety Code section 11055.

records constituted an extreme departure from the standard of care. Her treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

PATIENT 7

g. Respondent produced incomplete records for Patient 7 which did not contain her progress notes. The CURES data established that respondent prescribed the following to Patient 7, between February 15, 2016, and January 10, 2019: Norco (31 times), Valium (45 times) and methadone (37 times).

Dr. Franklin noted that respondent was aware that Patient 7 was abusing controlled substances and other drugs, as reflected by statements she made in her interview and multiple items in his records referencing abuse of cocaine and alcohol.

Dr. Franklin concluded that respondent committed extreme departures from the standard of care in her treatment of Patient 7 by: simultaneously prescribing Norco, Valium, and Methadone when she knew the patient abused cocaine and alcohol; failing to articulate a rationale for prescribing these substances; failing to order toxicology screens for this patient; failing to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities; failing to perform or document an adequate physical examination prior to prescribing controlled substances, failing to consult CURES, and failing to review and document the treatment for safety and efficacy on a regular basis. Respondent also inaccurately documented Patient 7's extremities and mobility as "normal" on the same day she submitted a pre-operative report for a knee replacement surgery. Her failure to maintain adequate and accurate medical records constituted an extreme departure

from the standard of care. Her treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

PATIENT 8

h. Patient 8 was the only patient for whom respondent produced a more or less complete set of medical records.

CURES data established that between February 1, 2016, and January 30, 2019, respondent prescribed to Patient 8: SOMA (20 times), Norco (37 times), Valium (4 times), methadone (1 time), and zolpidem (1 time). Other practitioners were regularly prescribing zolpidem and Temazepam[13] to Patient 8 during this time.

Dr. Franklin concluded that respondent committed extreme departures from the standard of care in her treatment of Patient 8 by: failing to document an accurate medication list; failing to document the nature and extent of respondent's treatment for the patient's obesity, bipolar disorder, hypertension, and lupus, and failing to document a complete discussion of smoking cessation for this patient who had chronic obstructive pulmonary disease (COPD); simultaneously prescribing Norco, Soma, and Valium without indication or rationale; prescribing methadone with no documented or rational reason; failing to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities; failing to perform or document an adequate physical examination prior to prescribing controlled substances, failing to consult CURES, and failing to review and document the treatment for safety and efficacy on a regular basis. Her failure to maintain adequate

[13] Temazepam is a benzodiazepine used a sleep aid.

and accurate medical records constituted an extreme departure from the standard of care. Her treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

PATIENT 9

i. As discussed in Finding 5.d., Patient 9 complained to the Board about rude and unprofessional treatment by respondent and difficulty obtaining her medical records. Although respondent had treated this patient since October 2005, she was unable to produce any records for treatment prior to August 2016 and was unable to produce progress notes for treatment prior to April 2016. CURES data reflected that between 2016 and 2018, respondent regularly prescribed Norco to Patient 9. She was also being prescribed Valium by other providers at the same time. Respondent also prescribed Phenergan and Flexeril[14] to Patient 9. This patient was known to abuse cocaine. The medical records were insufficient to support the care provided.

At the Board interview, respondent acknowledged that there had been a conflict between her and Patient 9, and that respondent terminated the physician/patient relationship as a result. Respondent's discussion of the incident was confusing. Respondent did not document the incident in the patient's records and did not document terminating the patient's care. Respondent acknowledged that the patient asked for her records, but this request was likewise not documented.

Dr. Franklin concluded that respondent committed extreme departures from the standard of care in her treatment of Patient 9, by failing to document: an accurate and

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[14] Flexeril is a tradename for cyclobenzaprine, a muscle relaxant. It is a dangerous drug as defined by Business and Professions Code section 4022.

complete physical examination; a thorough assessment of the patient, including patient's hypertension, chronic pain, substance use disorder, cough, severe degenerative joint disease, obesity, or mental health problems that included psychiatric hospitalizations for homicidal and suicidal ideation. Further extreme departures from the standard of care included: simultaneously prescribing dangerous substances, prescribing controlled substances without informed consent; continuing to prescribe controlled substances after the patient was hospitalized on a psychiatric hold and tested positive for benzodiazepines, cocaine, and Ecstasy; failing to document suspected substance abuse; failing to timely provide records to the patient's new treatment provider upon request; failing to document the incidents and rationale for terminating the physician-patient relationship; failing to consult CURES; and failing to review and document the treatment for safety and efficacy on a regular basis. Her failure to maintain adequate and accurate medical records constituted an extreme departure from the standard of care. Respondent's treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

PATIENT 10

j. As discussed in Finding 5.b., Patient 10 filed an online complaint regarding the treatment she received when visiting respondent's clinic as a new patient needing follow up care and antibiotics for pneumonia. Respondent was unable to provide records for this patient's one visit.

Patient 10 reported that she was made to wait in an examination room, undressed, for a long period. Patient 10 called her mother, who called the receptionist. Respondent then knocked on the wall and yelled and berated her. Respondent entered the room, yelled some more, and then left with the door open and the undressed patient exposed. The patient left without being assessed by respondent.

Dr. Franklin concluded that respondent's failure to maintain accurate and adequate records and failure to assess the patient who reported a recent pneumonia diagnosis constituted extreme departures from the standard of care. Respondent's treatment of this patient also reflected unprofessional conduct.

PATIENT 11

k. As discussed in Finding 5.c., Patient 11 also filed an online complaint after her first and only visit to respondent's clinic. The patient reported that respondent was eating during the visit, fell asleep repeatedly, and appeared impaired. Respondent provided incomplete records of this visit, which she acknowledged did not contain the history and physical examination portions. The only physical examination performed was a chest auscultation. Respondent acknowledged falling asleep during the visit at her Board interview.

Dr. Franklin concluded that respondent committed extreme departures from the standard of care in her treatment of Patient 11 by: failing to maintain accurate and adequate medical records, including documenting the history and physical examination and failing to measure the blood pressure, height, and weight of the patient, who was pre-diabetic. Respondent's treatment of this patient also reflected unprofessional conduct and a lack of knowledge.

Respondent's Evidence

BACKGROUND, EDUCATION, AND EXPERIENCE

19. Respondent is 60 years old. She received her medical degree from the University of California, Irvine, in 1988, and completed an internal medicine residency at Highland Hospital in Oakland, in 1994.

Respondent is a native of Oakland and is proud to have served primarily indigent patients in the East Bay throughout her career. She opened her own practice in 1999. Many of her patients suffer from chronic conditions such as diabetes, COPD, hypertension, and asthma. Respondent also practices bariatrics. A small percent of her practice, approximately 4%, involves pain management. Respondent was previously board certified in internal medicine, but her certification is no longer current.

RESPONDENT'S TESTIMONY REGARDING HER FITNESS TO PRACTICE

20. Respondent acknowledged that she has a drinking problem, which started during her residency in the aftermath of her father's death. She maintained sobriety for 10 years. After she completed five years in the Board's Diversion Program, she attended a 30-day inpatient program and participated in an aftercare program through the New Bridge Foundation for five years. She attended Alcoholics Anonymous meetings three times a week, had a sponsor, and worked the 12 steps. She stopped participating and relapsed in 2004. Her drinking problem intensified upon the death of her spouse in 2011.

Respondent denied any recent driving under the influence offenses and stated that the most recent of any incident of that nature was 15 years ago. She was unaware that her driver's license had expired at the time she went to her Board interview, and has now rectified this.

After her evaluation session with Dr. Davies, respondent decided that she should return to Alcoholics Anonymous. Because of the pandemic, she has been attending meetings online. She has reduced her drinking but is not sober. Respondent stated that she is determined to quit drinking and plans to enter an inpatient treatment program. She is confident that she "can do it again."

Respondent has seen a therapist intermittently for 20 years, but has not been able to "get it together" to resume therapy which must take place by Skype because of the pandemic.

RESPONDENT'S TESTIMONY REGARDING THE PATIENT CARE ALLEGATIONS

21. Respondent denied that her care of patients fell below the standard of care, but acknowledged that her recordkeeping was inadequate and did not reflect the care actually provided to patients. She also asserted that she sent additional patient records to the Board in April 2020 which would substantiate her care; counsel for complainant asserted that no such records were received.

Respondent described her typical patient care procedures. She explained that she takes a patient history and performs a review of systems of all new patients. When treating patients with chronic pain, respondent claimed that she always followed prescribing guidelines, used a pain management contract, required monthly visits for patients taking controlled substances, explained the benefits and risks of medications, and prescribed the lowest effective dose. She tried to refer patients to pain management specialists. She added that as soon as she learned that SOMA was "bad," she started weaning her patients off of it.

Respondent explained that her long-time front office manager left in 2018, not long after her back office employee left. Respondent tried without success to hire new employees. Around this time, she realized that there were issues with her patient files. Her staff had not been keeping up with putting respondent's notes into patient files. Charts were piled up and stacks of notes were awaiting filing. When patients came in, respondent noticed that her notes from prior visits were missing from the files.

Respondent candidly admitted that by 2019, her office was in disarray. In addition to piles of notes that needed to be placed into patient files, there were files of inactive patients that needed to be culled and placed into storage. She cut down the number of days she saw patients in order to spend time trying to put things in order. She purchased an electronic recordkeeping program but still had trouble keeping her files up to date, and she felt overwhelmed. She reported that at the time of the hearing, her office was still not adequately organized.

Respondent does not intend to reopen her practice. If allowed to keep her certificate, she would seek to work in a prison or skilled nursing home. She is willing to be monitored and is willing to comply with any probation terms and conditions.

LEGAL CONCLUSIONS

1. The standard of proof in an administrative hearing to discipline a physician's and surgeon's certificate is clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Complainant has the burden of proof as to each fact the existence or nonexistence of which is essential to establishing cause for discipline. (Evid. Code, § 500.)

First Cause for Discipline (Mental Impairment)

2. Business and Professions Code sections 822, 2227, and 2239 provide that the Board may suspend or revoke the certificate of an individual who is mentally impaired. Respondent's ability to practice medicine safely is impaired because she suffers from Alcohol Use Disorder. Cause for discipline was established in light of the matters set forth in Findings 14 through 17.

Second Cause for Discipline (Patients 1 and 2)

3. Clear and convincing evidence established that respondent prescribed controlled substances to her mother and her brother without documentation and failed to maintain adequate and accurate records. Cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence); 2234, subdivision (c) (repeated simple negligent acts), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records) was established in light of the matters set forth in Findings 18.a and 18.b.

Third Cause for Discipline (Patient 3)

4. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 3. (Finding 18.c.)

Fourth Cause for Discipline (Patient 4)

5. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct) 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 4. (Finding 18.d.)

Fifth Cause for Discipline (Patient 5)

6. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct) 2234,

subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, 2266 (inadequate medical records), and 725 (excessive prescribing), in relation to respondent's treatment of Patient 5. (Finding 18.e.)

Sixth Cause for Discipline (Patient 6)

7. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct) 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 6. (Finding 18.f.)

Seventh Cause for Discipline (Patient 7)

8. Clear and convincing evidence established cause for discipline under Business and Professions sections 2234 (unprofessional conduct) 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 7. (Finding 18.g.)

Eighth Cause for Discipline (Patient 8)

9. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct) 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 8. (Finding 18.h.)

Ninth Cause for Discipline (Patient 9)

10. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct) 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), 2242 (furnishing dangerous drugs without examination, and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 9. (Finding 18.i.)

Tenth Cause for Discipline (Patient 10)

11. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct), 2234 subdivision (b) (gross negligence) and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 10. (Finding 18.j.)

Eleventh Cause for Discipline (Patient 11)

12. Clear and convincing evidence established cause for discipline under Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), 2234, subdivision (d) (lack of knowledge), and 2266 (inadequate medical records), in relation to respondent's treatment of Patient 11. (Finding 18.k.)

Discussion

13. The evidence established that respondent suffers from Alcohol Use Disorder and has engaged in numerous extreme departures from the standard of care in her treatment of multiple patients. Respondent has failed to seek treatment for her illness, despite serious adverse consequences, including issuance of a suspension order against her certificate. As a result of her condition, respondent was unable to

maintain the standard of care in the operation of her medical practice and in her treatment of patients. Respondent's prescribing practices reflected a lack of medical knowledge and created a serious risk of lethal consequences to her patients and a serious risk of diversion of controlled substances into the community. Respondent's unprofessional conduct with patients included yelling at a patient and falling asleep while conducting an examination. Respondent does not accept responsibility for her misconduct, blaming her lack of office staff and never acknowledging the risk of patient harm her actions have caused.

The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016; Cal. Code Regs., tit. 16, § 1361) provide that either revocation or a period of probation may be an appropriate penalty for respondent's violations.

In exercising its disciplinary functions, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board is also required to take disciplinary action that is calculated to aid the rehabilitation of the physician whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

In this case, given the number and severity of the departures from the standard of care, and respondent's impairment due to untreated severe Alcohol Use Disorder, probation is simply not an option. Revocation of respondent's certificate is necessary for protection of the public.

ORDER

Physician's and Surgeon's Certificate No. G 79714, issued to Kimberly Hicks, M.D., is revoked.

DATE: September 24, 2020

DocuSigned by:
Karen Reichmann
213262228BA640F...

KAREN REICHMANN
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
GREG W. CHAMBERS
Deputy Attorney General
State Bar No. 237509
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3382
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Kimberly Hicks, M.D.** **3317 Elm Street Suite 102** **Oakland, CA 94609** **Physician's and Surgeon's Certificate No. G 79714,** Respondent.	Case No. 800-2019-053765 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 24, 1994, the Medical Board issued Physician's and Surgeon's Certificate Number G 79714 to Kimberly Hicks, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2020, unless renewed.

JURISDICTION

3. This First Amended 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 Business and Professions Code authorizes the Board to take action against a licensee by revoking, suspending for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action taken as the Board deems proper.

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

6. Section 2239 of the Code states in pertinent part:

"(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct."

7. Section 2242(a) of the Code provides that prescribing, dispensing or furnishing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

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

9. Section 725 of the Code provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the community of licensee is unprofessional conduct.

10. Section 820 of the Code provides that whenever it appears that a licensee may be unable to practice his or her profession safely as a result of mental illness or physical illness affecting competency, the licensing agency may order an examination of licensee.

11. Section 822 of the Code provides that, if a licensing agency determines that a licensee's ability to practice his or her profession safely is impaired because of mental or physical illness affecting competency, the licensing agency may take action by revoking the licensee's

certificate or license, suspending the licensee's right to practice, placing the licensee on probation, or taking such other action in relation to the licensee as the licensing agency in its discretion deems proper.

PERTINENT DRUGS

12. **Ambien**, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is indicated for the short-term treatment of insomnia. It is a central nervous system depressant and should be used cautiously in combination with other central nervous system depressants. Any central nervous system depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien. The recommended dosage for adults is 10 mg. immediately before bedtime.

13. **Carisoprodol**, also known by the trade name SOMA, is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022 of the Business and Professions Code, and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

14. **Cocaine** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(2)(6) and dangerous drug pursuant to Business and Professions Code section 4022.

15. **Diazepam**, also known by its trade name Valium, is a psychotropic drug for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals

(such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. Valium is available in 5 mg. and 10 mg. tablets. The recommended dosage is 2 to 10 mg. 2 to 4 times daily.

16. **Duragesic** is a trade name for a fentanyl transdermal system. Fentanyl is an opioid analgesic. Fentanyl is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code. Duragesic is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and requires continuous opioid administration. Duragesic presents a risk of serious or life-threatening hypoventilation.

17. **Ecstasy** is the street name for MDMA (*3,4-methylenedioxy-methamphetamine).* Ecstasy is a Schedule I controlled substance as defined by section 11054 of the Health and Safety Code, and a dangerous drug as defined by section 4022 of the Health and Safety Code. Ecstasy is an illegal synthetic drug that alters mood and perception (awareness of surrounding objects and conditions). It is chemically similar to both stimulants and hallucinogens, producing feelings of increased energy, pleasure, emotional warmth, and distorted sensory and time perception.

18. **Flexeril** is a trade name for cyclobenzaprine HCl, a muscle-relaxant. It is a dangerous drug as defined in section 4022. Flexeril may enhance the effects of alcohol, barbiturates, and other CNS depressants. Cyclobenzaprine is closely related to tricyclic antidepressants such as amitriptyline and imipramine and may, like the tricyclic antidepressants, produce arrhythmias, sinus tachycardia, and prolongation of the conduction time leading to myocardial infarction and stroke.

19. **Methadone hydrochloride** is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It also goes by the trade names Methadose and Dolophine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the

same degree of caution appropriate to the use of morphine. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics. The usual adult dosage is 2.5 mg. to 10 mg. every three to four hours as necessary for severe acute pain.

20. **Norco** is a trade name for hydrocodone bitartrate with acetaminophen. Norco tablets contain 10 mg of hydrocodone bitartrate and 350 mg of acetaminophen. Acetaminophen is a non-opiate, non-salicylate analgesic and antipyretic. Hydrocodone bitartrate is semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 of the Business and Professions Code. Norco is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (e) of the Health and Safety Code. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence.

21. **Oxycodone hydrochloride** is known by the trade name Oxycontin. Oxycodone is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycontin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. Interactive effects resulting in a respiratory depression, hypotension, profound sedation or coma may result if these drugs are taken in combination with the usual doses of Oxycontin. Oxycontin is a mu-antagonist opioid with an abuse liability similar to morphine.

22. **Phenergan** is a trade name for promethazine HCL. It is a dangerous drug as defined in section 4022 which has antihistaminic, sedative, anti-motion sickness, antiemetic, and anticholinergic effects. It may be used as a preoperative sedative. The concomitant use of alcohol, sedative hypnotics (including barbiturates), general anesthetics, narcotics, narcotic analgesics, tranquilizers or other central nervous system depressants may have additive sedative

effects and patients should be warned accordingly. Phenergan may significantly affect the actions of other drugs. It may increase, prolong, or intensify the sedative action of central-nervous-system depressants.

23. **Tylenol No. 3,** or Tylenol with Codeine, is a trade name for a combination of acetaminophen and codeine phosphate. It is a dangerous drug as defined in section 4022 and a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code. Codeine can produce drug dependence of the morphine type, and therefore has the potential for being abused. Tylenol No. 3 [4] contains 30 [60] mg. of codeine phosphate; the maximum 24 hour dosage of codeine phosphate should not exceed 360 mg.

24. **Vicodin** is the trade names for a combination of hydrocodone bitartrate and acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022, a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety Code.

FIRST CAUSE FOR DISCIPLINE

(Mental Impairment)

25. Respondent's certificate is subject to Board action pursuant to sections 822, 2227, and 2239 of the Code, in that due to a mental illness and her alcohol use, her ability to practice medicine safely is impaired.

26. On November 16, 2018, the Board entered an Order Compelling Psychiatric Evaluation of Licensee, ordering Respondent to submit to an examination to be conducted by a physician and surgeon specializing in psychiatry, to be selected by the Board or its designee, to determine if Respondent were mentally ill to such an extent as to affect her ability to practice medicine.

27. On February 6, 2020, Respondent underwent a full evaluation by a Board appointed psychiatrist, who ultimately issued two reports that stated that Respondent "has a chronic severe illness." The psychiatrist diagnosed Respondent with Alcohol Use Disorder and opined that Respondent is not able to safely practice medicine at this time because of a mental illness or

condition. Additionally, the examiner opined that Respondent's continued practice of medicine poses a present danger or threat to the public health, welfare and safety.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; Prescribing Without Conducting Thorough Examination; Failure to Maintain Accurate and Adequate Records – Patients 1 and 2)

28. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patients 1 and 2 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

29. Respondent was asked to produce medical records for two family members that Respondent treated (Patients 1 and 2).[1] Respondent was unable to produce records for those patients.

30. Respondent prescribed Tylenol III with codeine to Patient 1 without the documentation necessary to support the prescriptions; and failed to conduct or document patient history, physical examination, and rational assessment sufficient to support treatment prior to prescribing controlled substances.

31. Additionally, over a three-year period, Respondent prescribed testosterone to Patient 2, who was between the ages of 57 and 61 years of age, without taking and documenting a thorough history and physical examination, without measuring testosterone and prostate specific antigen levels, without documenting that the risks and benefits of that treatment had been considered and explained to the patient, and without documenting the ongoing safety and efficacy of the treatment.

[1] Numbers are used to protect patient privacy. Respondent may learn the names of the patients through the discovery process.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 3)

32. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 3 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

33. Even though authorization for release of records was provided, Respondent failed to provide records for Patient 3.

34. According to CURES, Respondent treated Patient 3 from at least September 12, 2017, through May 11, 2018. During that ten month period, Respondent prescribed Patient 3 Norco 7.5mg./325mg; Norco 10mg./325mg.; and Vicodin 30mg/300mg., while failing to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities. Additionally, Respondent failed to perform and document an adequate physical examination of Patient 3 prior to prescribing controlled substances, failed to consult CURES, and Respondent failed to review and document the treatment for safety and efficacy on a regular basis.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 4)

35. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 4 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or

lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

36. Even though authorization for release of records was provided, Respondent failed to provide records for Patient 4.

37. According to CURES, Respondent treated Patient 4 from at least February 2, 2016, through January 1, 2019. During the course of treatment, Respondent prescribed Patient 4, Valium, Duragesic, Methadone, zolpidem, oxycodone HCL, and Phenergan with codeine.

38. Between February 2, 2016, and February 4, 2016, Respondent simultaneously prescribed the following without indication or rationale:

- February 2, 2016 – Diazepam 10mg. #60 (30 days)
- February 2, 2016 – Duragesic 1hr/75mcg. #10 (30 days)
- February 2, 2016 – Methadone 10mg #120 (30 days)
- February 4, 2016 – Oxycodone HCL 15mg. #25 (5 days)

39. Between July 19, 2017, and July 26, 2017, Respondent simultaneously prescribed the following without indication or rationale:

- July 19, 2017 – Ambien 10mg #30 (30 days)
- July 20, 2017 – Oxycodone HCL 30mg. #90 (30 days)
- July 26, 2017 – Duragesic 1hr/50mcg. #10 (30 days)

40. On October 26, 2018, Respondent simultaneously prescribed the following without indication or rationale:

- October 26, 2018 – Duragesic 1hr/50mcg. #10 (30 days)
- October 26, 2018 – Ambien 10mg #30 (30 days)
- October 26, 2018 – Oxycodone HCL 30mg. #120 (30 days)

41. A review of CURES does not show a tapering of the controlled substances.

42. At the subject interview, Respondent claims that Patient 4 tested positive for cocaine during a hospitalization. Yet, Respondent never ordered toxicology screens for this patient while continuing to prescribe controlled substances.

43. During the course of treatment, Respondent failed to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities. Additionally, Respondent failed to perform and document an adequate physical examination of Patient 4 prior to prescribing controlled substances, failed to consult CURES, Respondent failed to review and document the treatment for safety and efficacy on a regular basis, and failed to order toxicology screens for a patient known to have tested positive for an illicit substance.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 5)

44. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination], 725 [excessive prescribing] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 5 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

45. Even though authorization for release of records was provided, Respondent failed to provide records for Patient 5, whom Respondent claims she treated for a decade.

46. According to CURES, Respondent treated Patient 5 with a cocktail consisting of opioids, benzodiazepines, and SOMA throughout the course of treatment from February 2016 through at least January 2019. For example, Respondent prescribed the following to Patient 5 over a 37-day period (May 2 – June 7, 2017), which included a 74-day supply of SOMA:

- May 2, 2017 – SOMA 350 mg. #22 (22 days)
- May 2, 2017 – Diazepam 10 mg. #45 (22 days)
- May 2, 2017 – Zolpidem tartrate 10mg. #30 (30 days)
- May 9, 2017 – Norco 350mg. #45 (22 days)

- May 9, 2017 – SOMA 350mg. #45 (22 days)
- May 26, 2017 – SOMA 350mg. #60 (30 days)
- May 26, 2017 – Diazepam 10mg. #45 (22 days)
- June 8, 2017 – SOMA 350mg. #45 (22 days)

47. Respondent failed to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities. Additionally, Respondent failed to perform and document an adequate physical examination of Patient 5 prior to prescribing controlled substances, failed to consult CURES, and Respondent failed to review and document the treatment for safety and efficacy on a regular basis.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 6)

48. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 6 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

49. Even though authorization for release of records was provided, Respondent failed to provide records for Patient 6.

50. According to CURES, Respondent treated Patient 6 from at least February 2016 through at least January 2019. During this period, Respondent predominately prescribed the patient methadone and zolpidem tartrate. However, Respondent prescribed Norco on two occasions and Percocet on one occasion. Respondent failed to document any rationale for prescribing short acting opioids to a patient being treated with methadone and zolpidem. Further, Respondent failed to document the rationale for prescribing any of these controlled substances.

51. Respondent failed to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities. Additionally, Respondent failed to perform and document an adequate physical examination of Patient 6 prior to prescribing controlled substances, failed to consult CURES, and Respondent failed to review and document the treatment for safety and efficacy on a regular basis.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 7)

52. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 7 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

53. Even though authorization for release of records was provided, Respondent failed to provide complete and accurate records for Patient 7. For example, on August 26, 2014, Respondent submitted a pre-operative clearance for Patient 7 to undergo a total knee arthroplasty (knee replacement surgery). On that same date, Respondent inaccurately wrote in the records that the patient's "extremities & mobility" were normal.

54. From the limited records provided, Respondent treated Patient 7 from December 13, 2013 until at least January 10, 2019, for asthma and COPD, among other issues. From 2016 through 2018, Respondent continuously provided Patient 7 simultaneous prescriptions for Methadone, Norco, and Valium, even though Respondent knew or should have known that Patient 7 abused other drugs, including cocaine and alcohol.

55. Respondent was unable to explain the rationale for prescribing the Valium to the patient, even though she was provided three written warnings (September 2017; October 2017; and April 2018) regarding the dangers of the controlled substances that she was prescribing.

56. Respondent never ordered toxicology screens for this patient while continuing to prescribe controlled substances.

57. Respondent failed to have in place and document informed consent, any indication or rationale for prescribing controlled substances, specific objective goals for treatment, or possible alternative modalities. Additionally, Respondent failed to perform and document an adequate physical examination of Patient 7 prior to prescribing controlled substances, failed to consult CURES, failed to review and document the treatment for safety and efficacy on a regular basis, and failed to order toxicology screens for a patient known to have used illicit substances.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 8)

58. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 8 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

59. Respondent commenced treating Patient 8 from at least March 7, 2015, and continued through to at least January 2019.

60. Respondent did provide medical records for Patient 8; however, those records failed to contain an accurate medication list, failed to document the nature and extent of Respondent's treatment of the patient's obesity, bipolar disorder, hypertension, and lupus, and failed to document a complete discussion of smoking cessation for a patient with COPD.

61. Other providers diagnosed Patient 8 with polysubstance abuse in 2011, yet from July 17, 2018, through January 30, 2019, Respondent simultaneously prescribed Norco, Soma and Valium to Patient 8. There are no progress notes that explain the indication or rationale for combining these three controlled substances.

62. On August 28, 2018, Respondent prescribed Patient 8 methadone 10mg. #10, for no documented or rational reason.

63. Respondent failed to have in place and timely document informed consent.[2] Additionally, Respondent failed to have in place and document specific objective goals for treatment, or possible alternative modalities. Further, Respondent failed to perform and document an adequate physical examination of Patient 8 prior to prescribing controlled substances, failed to consult CURES, and Respondent failed to review and document the treatment for safety and efficacy on a regular basis.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Excessive Prescribing Without an Appropriate Medical Examination/Medical Indication; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 9)

64. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2242 [furnishing dangerous drugs without examination] for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment of Patient 9 included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

65. Respondent treated Patient 9 from October 2005 through at least June 26, 2018. Respondent was unable to provide any medical records for this patient regarding treatment that Respondent rendered prior to August 17, 2016. Additionally, Respondent was unable to provide any progress notes for Patient 9 for treatments rendered prior to April 6, 2017.

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[2] Respondent failed to obtain informed consent for Patient 8 until February 22, 2019, three years after commencing the prescribing of Norco to the patient.

66. Respondent did provide eleven progress notes for treatment provided between April 6, 2017, and June 26, 2018, for Patient 9. However, none of those records contained an accurate and complete physical examination; thorough assessment of the patient, including patient's hypertension, chronic pain, substance use disorder, cough, severe degenerative joint disease that required at least two joint replacements, obesity, or her mental health problems that included psychiatric admission for homicidal and suicidal ideation. Further, none of the records provided a safe and effective plan for the patient, who was known to abuse cocaine.

67. Respondent prescribed Norco and Phenergan elixir to Patient 9, who was simultaneously prescribed Valium by other providers. Additionally, Respondent prescribed Flexeril to Patient 9 at the same time the patient was prescribed Norco and Valium.

68. Respondent prescribed Norco to Patient 9 on August 12, 2016; September 25, 2016; November 11, 2016; and December 12, 2016, but did not have Patient 9 sign an informed consent document regarding the use of controlled substances until January 7, 2017.

69. Records provided by Respondent show that on February 17, 2018, Patient 9 was admitted to the hospital under a psychiatric hold after making homicidal and suicidal threats. A urine toxicology screen taken during the hospitalization was positive for benzodiazepines, cocaine, and ecstasy. Still, Respondent continued to prescribe Norco to the patient on February 26, 2018; March 26, 2018; April 23, 2018; May 21, 2018; and June 26, 2018, all the while failing to note Patient 9's issues with substance abuse.

70. Respondent failed to timely provide medical records to Patient 9's new treatment provider, as requested; failed to document in detail the events and rationale that led Respondent to terminate the physician-patient relationship with Patient 9, failed to consult CURES, and Respondent failed to review and document the treatment for safety and efficacy on a regular basis to a patient who was prescribed Norco, taking Valium and known to abuse cocaine.

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TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts; and Failure to Maintain Accurate and Adequate Records – Patient 10)

71. Respondent has subjected her license to disciplinary action under section 2234 [unprofessional conduct], 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and 2266 [inadequate medical records], in that the care and treatment of Patient 10 included departures from the standard of unprofessional conduct and failure to maintain accurate and adequate medical records. The circumstances are as follows:

72. On or about November 21, 2017, Patient 10 visited Respondent's office for possible pneumonia. Patient 10 was escorted to an examination room, had her vital signs taken by an unknown staff member, and asked to remove her shirt and put on a paper gown with the front open, which she did. Patient 10 described the examination room as dirty, with white construction dust about the room.

73. After waiting alone for 30 minutes, and feverish, Patient 10 called her mother to discuss the wait. The mother then called Respondent's office and spoke with a receptionist regarding the waiting time. When Respondent was informed of the mother's call to the office, Respondent banged on the wall between she and Patient 10 and cursed at the patient through the wall before charging into the examination room and telling Patient 10 to either go to an emergency room or wait. Respondent then left the room, leaving the door open, and exposing Patient 10, whose upper body was unclothed, visible to others. At that point, Patient 10, who had been waiting at the doctor's office for an hour and a half, left without being examined by Respondent.

74. Respondent was asked to provide records of Patient 10's visit. Respondent provided a Certificate of No Records, even though she remembers the patient.

ELEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence; Repeated Negligent Acts; and/or Lack of Knowledge; Failure to Maintain Accurate and Adequate Records – Patient 11)

75. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], for unprofessional conduct, and 2266 [inadequate medical records], in that the care and treatment

of Patient 11 included departures from the standard of care constituting gross negligence, and/or repeated negligent acts, and/or lack of knowledge, in conjunction with the other departures alleged herein, and failure to maintain accurate and adequate medical records. The circumstances are as follows:

76. On June 15, 2018, Patient 11 presented to Respondent for an initial visit, requesting a physical examination and blood work, and found the office in disarray. Patient 11 alleges that Respondent appeared to nod off during the examination and had to be awakened by Patient 11.

77. The only physical examination procedure that Respondent performed was a chest auscultation. Respondent failed to take the blood pressure, height and weight of Patient 11, who was known to be pre-diabetic.

78. In response to the Medical Board's request for Patient 11's records , Respondent provided incomplete records, with: the history and physical (H&P) portions of the record missing.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 79714, issued to Kimberly Hicks, M.D.;

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

3. Ordering Kimberly Hicks, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: APR 28 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant