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

In the Matter of the First Amended Accusation Against: Norman Peter Woods, M.D. Physician's & Surgeon's Certificate No. G 34166 Respondent.	Case No. 800-2017-036282

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 December 4, 2020.

IT IS SO ORDERED November 5, 2020.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
MARTIN W. HAGAN
Deputy Attorney General
State Bar No. 155553
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9405
Facsimile: (619) 645-2061

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: **NORMAN PETER WOODS, M.D.** **15425 Los Gatos Blvd., Suite 120** **Los Gatos, CA 95032-2553** **Physician's and Surgeon's Certificate No. G 34166** Respondent.	Case No. 800-2017-036282 OAH No. 2020040452 **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), acting solely in his official capacity. This action was brought by the former Interim Executive Director of the Board, Christine J. Lally, acting solely in her official capacity. The Complainant is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

2. Respondent Norman Peter Woods, M.D. (Respondent) is represented in this proceeding by Thomas E. Still, Esq., of Hinshaw, Marsh, Still & Hinshaw, LLP, whose address is 12901 Saratoga Avenue, Saratoga, CA 95070-4110.

3. On or about June 6, 1977, the Board issued Physician's and Surgeon's Certificate No. G 34166 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2017-036282 and will expire on January 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-036282 and all other statutorily required documents were properly served on Respondent on August 19, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A First Amended Accusation was filed on or about December 13, 2019, and is currently pending against Respondent. A true and correct copy of First Amended Accusation No. 800-2017-036282 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2017-036282. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended 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.

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. 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 First Amended Accusation No. 800-2017-036282 and that his Physician's and Surgeon's Certificate No. G 34166 is therefore subject to discipline.

9. Respondent further agrees that if an accusation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2017-036282 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

RESERVATIONS

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

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or 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.

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

////

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

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 34166 issued to Respondent Norman Peter Woods, M.D., shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, issued in connection with the allegations and causes of discipline set forth in First Amended Accusation No. 800-2017-036282, is as follows:

> You are hereby publicly reprimanded for the unprofessional conduct, repeated negligent acts and/or failure to maintain adequate or accurate records concerning Patients A and B, as set forth more fully in First Amended Accusation No. 800-2017-036282, a true and correct copy of which is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein..

B. 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 First Amended 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. Failure to participate in and successfully complete the prescribing practices course requirements as outlined above shall constitute unprofessional conduct and be grounds for further disciplinary action.

C. **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 First Amended 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. Failure to participate in and successfully complete the medical record course requirements as outlined above shall constitute unprofessional conduct and be grounds for further disciplinary action.

////

////

////

////

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Thomas E. Still. 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: 9/16/20

NORMAN PETER WOODS, M.D.
Respondent

I have read and fully discussed with Respondent Norman Peter Woods, 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: September 16, 2020

THOMAS E. STILL
Attorney for Respondent

ENDORSEMENT

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

DATED: September 17, 2020

Respectfully submitted,

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

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

SF2019201359
82519981.docx

Exhibit A

First Amended Accusation No. 800-2017-036282

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
EMILY L. BRINKMAN
Deputy Attorney General
State Bar No. 219400
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3374
Facsimile: (415) 703-5480
E-mail: Emily.Brinkman@doj.ca.gov
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 13, 2019
BY: Anna Logan ANALYST

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

In the Matter of the First Amended Accusation Against: **Norman Peter Woods, M.D.** 15425 Los Gatos Blvd. Suite 120 Los Gatos, CA 95032-2553 **Physician's and Surgeon's Certificate No. G 34166,** Respondent.	Case No. 800-2017-036282 **FIRST AMENDED ACCUSATION**

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 June 6, 1977, the Medical Board issued Physician's and Surgeon's Certificate Number G 34166 to Norman Peter Woods, 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 January 31, 2022, 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 Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states, in relevant 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:
>
> ". . . ."
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> ". . . ."

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

\\\

\\\

\\\

\\\

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct [repeated negligent acts] and inadequate medical record keeping based on the care provided to Patient A)[1]

7. Respondent Norman Peter Woods, M.D. is subject to disciplinary action under Code sections 2234 [unprofessional conduct], and/or 2234 (c) [repeated negligent acts], and/or 2266 [inadequate medical records] based on the care he provided to Patient A. The circumstances are as follows:

8. Respondent treated Patient A, a then 60-year-old female for long-term chronic conditions, including back pain and sciatica. Patient A also had a documented history of depression and anxiety. Respondent produced medical records to the Medical Board for the period from November 14, 2014 through November 2017.

9. On or about November 14, 2014, Respondent first met with Patient A. He noted the patient's chronic medical conditions and that she was currently taking diazepam[2] and Norco[3]. The medication note indicates that Patient A was taking one pill of 5/500 mg (milligrams) of Norco every day; however, the Controlled Substance Utilization Review and Evaluation System (CURES)[4] report indicates Patient A was actually prescribed seven pills of 5/325 mg of Norco every day.

10. At that first appointment, Respondent prescribed 240 pills of Norco, but increased the dosage from 5/325 mg to 7.5/325 mg (amounting to approximately eight pills per day) and 60

---

[1] Patients will be identified alphabetically to protect their privacy. Respondent will learn the names of the patients during discovery.

[2] Diazepam, also known by the trade name Valium, is a benzodiazepine. It is a psychotropic drug used 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 Health and Safety Code section 11057.

[3] Norco is the trade name for acetaminophen and hydrocodone. Norco tablets contain five to 10 milligrams (mg) of hydrocodone bitartrate and 350 to 550 mg of acetaminophen. Acetaminophen is a non-opiate, non-salicylate analgesic and antipyretic. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022. Norco is a schedule II controlled substance as defined by Health and Safety Code section 11055. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence

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

pills[5] of 10 mg diazepam (amounting to approximately two pills per day). Respondent's medical records do no document the reason why he increased the Norco dosage or prescribed diazepam. Respondent failed to review and document the patient's pain levels or pain history (i.e. the source of the pain, how long she's been in pain, how the pain impacts her life, whether she has suffered any impairment by the use of the controlled substances, and whether she had ever tried to reduce her pain medications). Additionally, Respondent did not conduct an evaluation of Patient A's alcohol use, which would be particularly important in a patient taking both opioids and benzodiazepines. Respondent also failed to take and document the medical justification for Patient A's dose of diazepam. Respondent also failed to consider the risks of a 60-year-old female taking such high doses of controlled substances and failed to document whether he discussed these risks with Patient A.

11. Through the end of 2014 and into 2015, Respondent continued to see Patient A on several occasions. At none of the appointments did Respondent take or document that he discussed the risks of the high doses of controlled substances with Patient A, assessed her use of alcohol, monitored her level of possible impairment while taking such high doses of controlled substances, or re-evaluated Patient A's need for these medications. Respondent continued to refill both the Norco and diazepam at high doses and quantities.

12. On or about October 12, 2015, Respondent wrote in Patient A's progress note "high dose Norco/diazepam" without any further explanation as to whether he expressed these concerns with Patient A or what he actually meant by this statement.

13. Throughout 2016, Patient A's medical records show Respondent approving medication refill requests for Norco and diazepam without any physician documentation. It is unclear from Patient A's medical record if Respondent was re-assessing Patient A's need for these medications or assessing any concerns for possible abuse. While the dosages remained stable during 2016, there were nine occasions when another physician prescribed Norco or

[5] According to the medical record, Respondent prescribed Patient A 60 pills of diazepam; however, according to CURES only 50 pills of diazepam were actually filled.

oxycodone[6] to Patient A in small quantities.[7] Respondent did not document whether he was aware of these additional prescriptions when refilling Patient A's controlled substance medications.

14. On or about September 23, 2016, Respondent saw Patient A after a hospitalization for a drug overdose, but Respondent failed to review or document any information about the hospital admission and whether he had any concerns about Patient A overdosing on medications he prescribed. According to Respondent's progress notes, Patient A was "positive for substance abuse" but "negative for depression and suicidal ideas. The patient is nervous/anxious." Under the Assessment/Plan portion of the progress note, Respondent documented that he assessed her anxiety, including reviewing prescriptions and "counseling." He also noted that she had fractured ribs. There was no additional documentation or assessment about the fractured ribs. Respondent also documented that Patient A had a severe episode of recurrent major depressive disorder without psychotic features and he wrote "Psch [sic], counseling, rx." There was no documentation about whether this meant Respondent referred the patient for counseling or reviewed counseling records, and what he did in relation to the medications prescribed. At the end of the appointment, Respondent refilled 10 mg of diazepam (60 pills, with two refills) but refused to refill the Norco.

15. During Respondent's interview with Board investigators, he stated he was aware that Patient A drank excessively and took her medications leading to the overdose. Respondent never addressed nor documented that he discussed Patient A's alcohol use with her either before or after her overdose.

---

[6] Oxycodone is also known by the trade name Endocet, a combination of oxycodone and Acetaminophen. Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It 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. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

[7] On a tenth occasion, another physician prescribed 240 pills of 7.5/325 mg of Norco to Patient A.

16. Respondent continued to refill Patient A's controlled substance prescriptions without documenting that he re-assessed Patient A's need for these medications or any concerns for possible abuse.

17. Respondent departed from the standard of care based on the following:

a) Failed to take and document the patient's pain history and need for controlled substances, including documenting any medical indication for the drugs and dosages prescribed to Patient A;

b) Failed to take or document the patient's alcohol use history, especially when he continued to prescribe controlled substances after her overdose;

c) Failed to recognize the risks of these medications in a patient over 60 and failed to discuss those risks with Patient A.

d) Failed to document the specifics regarding Patient A's hospital admission following her overdose;

e) Failed to document whether it was appropriate to continue prescribing diazepam to Patient A after her overdose;

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct [repeated negligent acts] and inadequate medical records based on the care provided to Patient B)

18. Respondent Norman Peter Woods, M.D. is subject to disciplinary action under Code sections 2234 [unprofessional conduct] and/or 2234 (c) [repeated negligent acts], and/or 2266 [inadequate medical records] based on the care he provided to Patient B. The circumstances are as follows:

19. Patient B was a then 36-year-old male when he established care with Respondent. Patient B underwent a below-the-knee amputation in 2007 and suffered from phantom limb pain and chronic pain. According to the CURES reports, multiple physicians prescribed Patient B

varying doses of fentanyl transdermal,[8] methadone,[9] Lyrica,[10] and diazepam going back to at least 2014. Respondent treated Patient B from October 27, 2016 through December 21, 2018.

20. On or about October 27, 2016, Patient B went to Respondent for treatment of his phantom limb pain. The progress note stated that Patient B was unable to see a pain management specialist without any further explanation in the record. Prior to this visit, Patient B was taking the following medications: 300 mcg (micrograms) fentanyl (every 48 to 72 hours), 10 mg methadone (one to two pills per day), and 300 mg of Lyrica (three pills per day). Respondent increased the methadone to three pills per day, but he did not document in the medical record the reason for the increase in the methadone.

21. Over the course of the next two years, Patient B and Respondent's medical staff communicated extensively through email for medication refills and Respondent saw Patient B almost every three months. Patient B's requests were often related to needing early refills due to his work travel schedule, patches falling off early due to physical activity, requests for larger quantities of fentanyl patches so his out of pocket costs would not be as large, or that the pharmacy did not have the medication in stock. Only once did Patient B report that he lost his medications. There is no documentation in the medical record that Respondent discussed misuse/abuse issues with Patient B.

---

[8] Fentanyl transdermal system is the generic name for Duragesic and comes in the form of a patch. Fentanyl is an opioid pain reliever used for the treatment of chronic pain that cannot be managed by lesser means. It is a dangerous drug as defined by section 4022 and is a schedule II controlled substances as defined by Health and Safety Code section 11055. Patients taking fentanyl are at increased risk for respiratory depression and care should be used when prescribing other central nervous system depressants (CNS) at the same time. Fentanyl can produce drug dependence similar to morphine and has the potential for abuse. Psychic and physical dependence, as well as tolerance may develop upon repeated use.

[9] Methadone hydrochloride is a synthetic narcotic pain reliever with similar properties as morphine. It is a dangerous drug as defined by section 4022 and is a schedule II controlled substances as defined by Health and Safety Code section 11055. Methadone can produce drug dependence similar to morphine and has the potential for abuse. Psychic and physical dependence, as well as tolerance may develop upon repeated use. It should be used cautiously in patients who are receiving other narcotic pain relievers.

[10] Lyrica is the tradename for pregabalin, an antiepileptic medication. It is a dangerous drug as defined by section 4022 and a schedule V controlled substance as defined by Health and Safety Code section 11058. Lyrica is used for the management of neuropathic pain.

22. Additionally, during this time, other physicians provided small quantities of medication refills to Patient B while providing coverage for Respondent while he was out of the office. Respondent did not document whether he was aware of or reviewed these additional refills made by other providers.

23. On or about August 25, 2017, Patient B returned to Respondent's office for a visit. According to the progress note, Respondent documented that he discussed a trial reduction of fentanyl, but that he would prescribe "extra Dilaudid for a short period."[11] Respondent refilled the fentanyl, methadone, and Lyrica without any changes. According to the CURES report, Patient never filled a prescription for Dilaudid from Respondent and never reduced his fentanyl prescription.

24. Over the course of treatment, Respondent moderately increased the dosages of Patient B's medications. Respondent did not clearly document the reasons for the increase in these doses. For example, Respondent initially prescribed 90 pills of 10 mg methadone to last for 30 days (three pills per day) but increased the prescription to 90 pills of 10 mg of methadone every 15 days.

25. It is almost impossible to determine exactly what doses of medications Patient B was taking at any point in time given the frequent refill requests. Patient B's medications were not reconciled in the chart to update doses or instructions to ensure the chart accurately reflected what medications and doses Patient B was actually prescribed. Respondent and other physicians prescribed the fentanyl patches in varying doses and quantities throughout the month. For example, in November 2016, Patient B filled two prescriptions for 100 mcg patches but for different quantities. One was for 20 patches for 20 days and the other prescription was for 10

[11] Dilaudid is the trade name for hydromorphone hydrochloride. It is a dangerous drug as defined by section 4022 and is a schedule II controlled substances as defined by Health and Safety Code section 11055. Dilaudid is a powerful pain reliever that can result in drowsiness, mental clouding, respiratory depression, and vomiting. Patients receiving Dilaudid should be monitored more carefully if they are also taking other CNS depressant medications because this medication increases CNS depression. Dilaudid can produce drug dependence similar to morphine and has the potential for abuse. Psychic and physical dependence, as well as tolerance may develop upon repeated use.

patches for 10 days. Then in October 2017, Patient A filled seven different fentanyl patch prescriptions, prescribed by Respondent, at varying doses and quantities:

a) October 2, 2017: 100 mcg 20 patches for 15 days;

b) October 9, 2017: 50 mcg five patches for three days;[12]

c) October 11, 2017: 75 mcg 10 patches for 10 days;[13]

d) October 16, 2017: 100 mcg five patches for five days;[14]

e) October 19, 2017: 100 mcg 30 patches for 20 days;

f) October 27, 2017: 50 mcg five patches for three days;

g) October 31, 2017: 50 mcg 10 patches for seven days.

This practice of varying quantities and doses of fentanyl patches continued through the end of Respondent's care of Patient B. Respondent did not document the rationale for the dosage changes, nor did he create a record that would allow for tracking of the medications and amounts over time.

26. Respondent departed from the standard of care based on his failure to document the actual doses of controlled substance medications he prescribed to Patient B along with the rationale for any changes to the prescriptions.

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 34166, issued to Norman Peter Woods, M.D.;

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

3. Ordering Norman Peter Woods, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

---

[12] Another physician wrote this prescription.
[13] Another physician wrote this prescription.
[14] Another physician wrote this prescription.

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

DATED: December 13, 2019

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

SF2019201359
21539136.docx