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

In the Matter of the Accusation Against:

CARLOS RAMIREZ, M.D.

Physician's and Surgeon's Certificate No. A 98670,

Respondent.

Agency Case No. 800-2017-034878

OAH No. 2019111046

DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on June 8 through 12, 2020. This hearing was conducted by videoconference. The participants appeared from various locations near Oakland, California.

Mary Cain-Simon, Supervising Deputy Attorney General, represented complainant William Prasifka, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Robert W. Hodges, Attorney at Law, McNamara, Ney, Beatty, Slattery, Borges & Ambacher LLP, represented respondent Carlos Ramirez, M.D.

The record was held open until September 4, 2020, to allow the parties to submit written closing arguments and rebuttal. Complainant timely filed a closing argument and a rebuttal, which were marked for identification as Exhibits 19 and 20, respectively. Respondent timely filed a closing argument, which was marked for identification as Exhibit S.

The record closed and the matter was submitted for decision on September 4, 2020.

FACTUAL FINDINGS

Procedural History

1. Complainant Kimberly Kirchmeyer brought the Accusation in her official capacity as Executive Director[1] of the Medical Board of California, Department of Consumer Affairs (Board).

2. On January 19, 2007, the Board issued Physician's and Surgeon's Certificate (Certificate) No. A 98670 to respondent Carlos Ramirez, M.D. Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on January 31, 2021, unless renewed.

Summary of Case

3. This case came to the Board's attention in July 2017, after a doctor filed a complaint expressing concerns regarding respondent's prescribing practices with respect to one of her patients. Following an investigation, the complainant filed an Accusation against respondent. The Accusation alleges that between 2012 and 2018, respondent committed unprofessional conduct (repeated acts of negligence, gross negligence, and failure to maintain adequate

[1] William Prasifka is currently the Board's Executive Director.

and accurate medical records) in his treatment of three chronic pain patients, identified herein as patients A, B, and C.[2] The Accusation alleges that respondent prescribed hundreds, and in the case of Patient C, thousands, of opioid pills, in combination with other controlled substances[3] and dangerous drugs[4], without a proper evaluation of medical necessity; without assessing the risks involved in prescribing such medications; without developing a treatment plan and objectives; without sufficient informed consent; without compliance monitoring and ongoing assessments of the treatment; and without maintaining adequate and accurate medical records.

4. Respondent disputes the allegations. He asserts, among other things, that he prescribed opioids after a proper evaluation of the patients; he advised them of the risks involved; and, he moderated their treatment appropriately. Respondent believes that the care and treatment he provided to patients A, B and C, and his medical record keeping, were within the standard of care.

5. The evidence presented at hearing was voluminous. The pertinent facts follow.

Respondent's Education, Training and Medical Practice

6. Respondent was born in Colima, Mexico. In 1986, he graduated from medical school in Mexico, where he also completed a residency in family practice. Respondent relocated to the United States in the 1990s, where he held a series of positions in health education, managed care, and as a research assistant. In 2002 he began an internal medicine residency program at Alameda County

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[2] The patients are referred to by initials to protect their privacy.

[3] See Health and Safety Code sections 11055 and 11057.

[4] See Business and Professions Code section 4022.

Medical Center, Highland Hospital. After respondent's father became ill in 2005, he returned to Mexico and did not complete his residency program in internal medicine at Highland Hospital. Respondent subsequently returned to California and has been licensed to practice medicine in California since 2007. Between 2007 and 2010, respondent worked in a staff position at QuickHealth Medical Corporation.

7. Respondent opened his current family practice, Terra Nova Medical Group, in 2010. Respondent sees between 20 and 25 patients each day, 6 or 7[5] days each week, on a first-come, first-served basis. Respondent's patients wait in long lines to see him and pay for services in cash.[6] Respondent also takes calls on urgent matters after hours. Respondent is the only licensed medical professional in his clinic. He is assisted by medical assistants and the clinic's business director, who is his wife. Respondent describes his patients as largely Latino, "primarily uninsured, the disenfranchised, socially economically-challenged population." Respondent does not advertise or accept insurance. Respondent has continued to see patients during the pandemic.

Expert Testimony

8. The experts who testified at hearing were familiar with the standard of care applicable to family practice, primary care physicians such as respondent, who prescribe opioids and other controlled substances on a long-term basis to treat chronic pain. Each expert reviewed pertinent medical records and documents, including the transcript from the Board's interview with respondent on August 28, 2018. They each offered an opinion as to whether respondent committed unprofessional conduct in connection with his

[5] Respondent works one Sunday each month.

[6] During his interview with the Board on August 28, 2018, respondent stated that he charged his patients $75 per visit.

treatment of patients A, B, and C.

9. The experts provided different opinions regarding the sufficiency of the care provided by respondent to Patients A, B, and C, as well as the adequacy of his record keeping. Dr. Korenstein opined that respondent committed multiple acts of gross negligence in connection with his treatment of Patients A, B, and C, and that his medical records were extremely deficient. Dr. Nickles opined otherwise, with the exception of what he regarded as minor deficiencies in respondent's record keeping.

EXPERTS' TRAINING AND EXPERIENCE

10. Board expert Steven J, Korenstein, M.D., is board-certified in family medicine. He graduated from Ross University School of Medicine in 2009 and completed his residency in family medicine at Mercy Health Systems Family Medicine in Wisconsin in 2012. Dr. Korenstein has practiced family medicine in Eureka since 2012. He first worked at Eureka Family Practice, and for the past three years, he has practiced family medicine at St Joseph's Heritage in Eureka. Dr. Korenstein began performing expert reviews for the Board in 2017. He evaluated respondent's conduct in a 28-page report dated November 11, 2019.

11. Respondent's expert Dean J. Nickles, M.D., is board-certified in internal medicine. He graduated from West Virginia University Medical School in 1975. He completed an internship at Madigan Army Medical Center in Tacoma, Washington, in 1976, and he completed his residency in internal medicine at Tripler Army Medical Center in Honolulu in 1979. Dr. Nickles has practiced internal medicine in California for almost 40 years. Dr. Nickles practices internal medicine at Stanford Medical Partners in Emeryville. In addition to his clinical practice, he performs medical-legal evaluations. Dr. Nickles evaluated respondent's conduct in

a four-page report dated March 1, 2020.

STANDARD OF CARE FOR PRESCRIBING CONTROLLED SUBSTANCES

12. The experts largely agreed that the standard of care refers to the level of skill, knowledge and care that would be exercised by a reasonably prudent physician in similar circumstances.[7]

13. The experts agreed that the standard of care for treating patients and prescribing opioids and other controlled substances includes: taking a history and performing a physical examination of the patient; developing a treatment plan that includes objectives by which the treatment can be evaluated; obtaining informed consent from the patient; periodically reviewing the effectiveness of the treatment; and, keeping proper medical records. They also agreed that a departure from the standard of care may be simple or extreme, and that an extreme departure from the standard of care is defined as the want of even scant care and involves behavior that places a patient at risk.

14. There was disagreement in a few areas as to what the standard of care requires when prescribing opioids and other controlled substances to patients on a long-term basis.[8]

15. Dr. Korenstein opined that the standard of care for prescribing

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[7] At hearing, Dr. Nickles testified that the standard of care is "that care rendered to a patient by a prudent physician of similar knowledge, *training and experience*." (Emphasis added.) In his written report, Dr. Nickles wrote: "There are certain mitigating factors which must be considered in evaluating the care of Dr. Ramirez. He is a foreign medical graduate. He did not participate in a residency training program nor is he board certified as both Dr. Korenstein and myself. Yet, he is providing necessary medical care to an underserved and disenfranchised population." Dr. Korenstein's testimony established that all patients are entitled to the same level of care, and contrary to Dr. Nickles's statements, the standard of care does not differ based upon a particular doctor's training and experience or upon a patient's economic status, race or ethnic origin.

[8] Long-term use is defined as greater than 90 days.

long-term use of opioids for chronic, non-cancer pain, includes[9]:

- Evaluating the patient to establish a diagnosis of medical necessity for the long-term use of controlled substances;
- Assessing the risk of misuse, abuse, and/or diversion to determine the safety of treating the patient with controlled substances (also referred to as risk stratification);
- Developing a treatment plan and objectives, including measurable goals and a strategy to discontinue narcotic treatment;
- Obtaining the patient's informed consent, including informing the patient of the dangers involved in using opioids, alone and in combination with other controlled substances;
- Performing compliance monitoring, such as reviewing CURES[10] reports, conducting pill-counting or obtaining urine drug screens;
- Performing ongoing assessments to determine whether use of opioids is advancing the patient's treatment goals, and to determine whether the patient is abusing, diverting or misusing the medication; and

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[9] The standards apply equally to prescribing controlled substances generally.

[10] CURES refers to the Controlled Substance Utilization Review and Evaluation System. It is a database maintained by the State of California that allows providers to see what controlled substances were provided to their patients, including the name of the prescriber and the location where the prescription was filled. According to Dr. Korenstein, review of the CURES database prior to prescribing controlled substances has been the standard of care since 2012.

- Having a controlled substance contract[11] between the provider and the patient, which expresses the patient/provider responsibilities.

16. Dr. Korenstein opined that respondent failed to comply with the above-described responsibilities in his treatment of Patients A, B, and C; and, except for the failure to have a controlled substance contract, these transgressions were an extreme departure[12] from the standard of care.

17. Dr. Nickles claimed otherwise: in his words, Dr. Korenstein "has an inflated definition of the standard of care." Dr. Nickles believes that the requirements outlined by Dr. Korenstein are "components that a prescribing physician might elect to address as they're treating a patient with a controlled substance."

18. While Dr. Nickles's analysis of respondent's treatment of Patients A, B, and C is discussed in detail later, he did offer general comments about the standard of care that highlights some of the differences between himself and Dr. Korenstein. Dr. Nickles opined that review of CURES was not the standard of care until October 2018, when it became legally required. Therefore, in his view, checking CURES reports was not the standard of care during the period of time that respondent treated Patients A, B, and C. He also opined that other forms of compliance monitoring such as pill counting or urine tests were not required by the standard of care, unless there are "red flags." Additionally, Dr. Nickles disagreed with Dr. Korenstein that the standard of care requires that a contract for the long-

[11] Among other things, controlled substance contracts (also referred to as opioid contracts) require the patient to obtain controlled substances only from the provider and to fill prescriptions at only one pharmacy. According to Dr. Korenstein, as of 2014, the standard of care requires written controlled substance contracts for the long-term use of controlled substances.

[12] The term "extreme departure from the standard of care" is synonymous with gross negligence.

term use of controlled substances needs be in writing. Dr. Nickles also opined that respondent cannot be criticized for failing to counsel his patients about the proper way to store and dispose of medications; in Dr. Nickles's view, this is the responsibility of the pharmacist. Dr. Nickles agreed that the standard of care requires a doctor to inform a patient about the risks and side effects associated with combining different controlled substances, but unlike Dr. Korenstein, he opined that the failure to provide such advisements constitutes simple and not gross negligence. And, unlike Dr. Korenstein, Dr. Nickles opined that the standard of care does not require the provider to document such discussion.

19. While Dr. Nickles testified at hearing that respondent's treatment of Patients A, B, and C met the standard of care, his written impressions[13] of the case in general, obtained by complainant via subpoena[14] and quoted below, suggest otherwise:

ISSUES:

- IT APPEARS THAT DR. RAMIREZ WROTE 11,172 CONTROLLED SUBSTANCES RXS DURING THE 2.5 YEAR PERIOD
- HE WAS NOT USING CURES DATABASE
- RXS WERE OFTEN PRESCRIBED EARLY
- DRUG DOSES WERE NOT AT LOWEST DOSES DAILY
- COMBINATION OF OPIATES, BENZOS AND BARBITUATES IS CONCERNING AND INCREASES RISK

[13] These impressions were written by Dr. Nickles in the course of his assessment of respondent's conduct and, at times, are in conflict with his report dated March 1, 2020.

[14] All further references to Dr. Nickles's written impressions refer to the documents obtained by complainant via subpoena.

- USING 812 INJECTIONS FOR SCIATICA IS PROBLEMATIC AND WELL BELOW SOC
- HE DID NOT ORDER CCP ANTIBODY TO DIAGNOSE RHEUMATOID ARTHRITIS
- HIS USE OF METHOTREXATE IS A PROBLEM WITH NO LABS OR FOLLOW UP LABS
- HE DID NOT DO NEURO EXAMS ON PATIENTS WITH RADICULAR SXS
- HE SHOULD HAVE BEEN COORDINATING CARE WITH KAISER FOR [PATIENT C]
- LACK OF DIAGNOSTICS
- TOO EASILY WENT TO NARCOTICS AS INITIAL TREATMENT
- PLUSES
    - HIS NOTES WERE THOROUGH AND LENGTHY
    - OPIOID CONTRACT NOT STANDARD OF CARE
    - THESE CHRONIC PAIN PATIENTS ARE DIFFICULT
    - MANY OF HIS PATIENTS LACK HEALTH INSURANCE. I DON'T KNOW [THE] SPECIFICS ABOUT THE THREE PATIENTS CITED IN THE INVESTIGATION
    - HE DID HAVE OPIOID CONTRACTS
    - CURES INQUIRY NOT THE STANDARD OF CARE UNTIL A FEW YEARS AGO

STANDARD OF CARE FOR MEDICAL RECORD KEEPING

20. Insofar as medical records provide the basis for planning and maintaining the quality of care, the standard of care requires providers to maintain

sufficient documentation of the care and treatment provided to their patients. Additionally, adequate and accurate documentation is necessary in order to provide other providers with sufficient information so that they can adequately treat the patient.

21. The experts' opinions diverged as to the extent of detail necessary to meet the standard of care, Dr. Nickles believes that the standard of care does not require the doctor's records to include the amount of detail that Dr. Korenstein found necessary. In Dr. Nickles's view, the standard of care requires a provider to document a patient's history, chief complaint and a focused examination. In his written report, Dr. Nickles states: "There is some inconsistency in some of the entries in the medical record and some lack of explanation as to why certain medications were prescribed, these documentation failures suggest simple departures from the standard of care."

His testimony reflected a more positive view of respondent's records: he stated that "in a perfect world" respondent should have documented the interaction between various medications, but the fact that he did not do so does not amount to a breach of the standard of care.

22. At hearing, Dr. Nickles disagreed with Dr. Korenstein that the standard of care requires providers to document discussions regarding the risks associated with combining prescriptions for controlled substances.

Respondent's Testimony Regarding His General Prescribing Practices

23. Respondent testified that he believes that he complied with the standard of care when he treated Patients A, B, and C with controlled substances between 2012 and 2018. Respondent did not consult CURES data during the time that he prescribed controlled substances to Patients A, B, and C. Respondent testified he had ongoing problems accessing CURES: he registered in January

2016, but had difficulties obtaining access to the data through 2017. Respondent does not believe that the standard of care required him to consult CURES when prescribing controlled substances to his patients until it became mandatory in 2018. He currently has access to CURES and uses it when prescribing to patients.

24. Respondent testified to the following procedures with respect to his treatment of patients with controlled substances during the time he treated Patients A, B, and C: He talks to the patient to determine his or her history and complaints and performs a physical examination. The examination includes use of the pain scale, consideration of the patient's functionality, and whether the patient's pain level is consistent with his physical examination. Respondent assesses the patient's medical issues and evaluates the medical necessity of treatment with controlled substances. In doing so, he considers alternatives to using controlled substances, such as physical therapy and chiropractic, yoga, meditation and over-the-counter medications.

25. Once respondent determines that controlled substances are appropriate, he decides what class or classes of medications to prescribe and formulates a plan. Respondent stated that when he prescribes pain medications, he discusses the risks and benefits of the medications, in either Spanish or English, according to the patient's language. He includes warnings regarding combining different types of pain medications, such as opioids, benzodiazepines and muscle relaxers.

26. Respondent used verbal and written opioid agreements (entitled "Agreement for Opioid Therapy") with his patients. The written and oral agreements included information regarding the risks and benefits of the medication and required the patient to agree to safely store the medications and not to obtain opioids from another provider.

27. During the patient's follow-up visit, respondent assesses whether the medication is helping manage the patient's pain and whether to modify the treatment plan. Respondent did not order his patients to undergo urine testing to confirm that they were not abusing or misusing the controlled substances because his patients could not afford that testing. He did not count pills or use CURES.

28. Respondent used electronic medical records at the time he treated Patients A, B, and C. He stated that the electronic medical record does not give him the ability to cut and paste information from one appointment to the next and that he customized the patient's information at each visit.

Patient A

29. Patient A, a man in his 40's, sought treatment from respondent for a variety of ailments, including gout, chronic back pain, insomnia, obesity, and hypertension. Respondent treated Patient A between May 2012 and March 2018. During this time, respondent prescribed a variety of controlled substances to treat Patient A's musculoskeletal pain, including opioids, benzodiazepines, sedative-hypnotics and muscle relaxers. Respondent had contracts for the use of pain medications with Patient A on June 23, 2016,[15] and August 30, 2017.

30. Respondent testified that he performed the proper examination, assessments, advisements and monitoring in connection with his treatment of Patient A, consistent with his prescribing practices described in Factual Findings 23 through 28.

31. Respondent tried to obtain Patient A's prior medical records but was unable to do so because Patient A's doctor had retired. He did advise Patient A not to drive or use alcohol with the drugs that were prescribed.

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[15] Respondent testified that there was also a written pain contract dated January 22, 2016, but the contract itself was not produced at hearing.

BOARD'S EXPERT

32. Dr. Korenstein opined that with respect to Patient A, respondent failed to comply with the standard of care requirements applicable to prescribing controlled substances which are described in detail in Factual Finding 15. Dr. Korenstein concluded that respondent's transgressions, set forth below in Factual Findings 33 through 37, and 39, constituted extreme departures from the standard of care.

33. In reviewing Patient A's medical records, Dr. Korenstein found that there was "little evidence" of medical necessity to support the initiation and use of long-term opioid therapy. Dr. Korenstein did not conduct a complete back exam or a neurological exam on Patient A's first visit. Additionally, Dr. Korenstein found that respondent did not assess the risks involved in treating Patient A with opiates and other controlled substances. For example, respondent did not inquire about Patient A's prior use of drugs and his family history, either through the use of a formal screening tool[16] or by way of informal questions, to enable respondent to "make an educated judgment whether opioids or other controlled substances are appropriate for that patient, and if they are, how to - well, how tightly to keep that in control." Dr. Korenstein explained that obtaining information regarding a patient's history of drug use, mental health issues, or for female patients, sexual abuse, helps a provider understand whether a patient is low- or high-risk for misusing or abusing the medications. This information also helps the provider determine the extent to which a patient needs to be followed.

34. Dr. Korenstein also noted that respondent failed to assess the risks involved in prescribing controlled substances to Patient A. In Dr. Korenstein's view,

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[16] One tool referenced was the Sheehan Disability Scale.

Patient A presented risks of misuse, abuse and/or diversion in that he suffered from depression and anxiety, he had received controlled substances from another provider, and he had filled prescriptions at three different pharmacies.

35. Dr. Korenstein also found that respondent did not develop a treatment plan or objectives, which typically involves assessing improvement in pain and function, and improvement of symptoms associated with pain, such as sleep disturbance, depression, anxiety, and lack of engagement with family, friends, and/or work. Dr. Korenstein noted that Patient A "never demonstrated any improvement during the five years that he was under [respondent's] care."

36. Dr. Korenstein also found that respondent did not adequately obtain Patient A's informed consent for the long-term use of opioids and other controlled substances. For example, respondent did not document that he discussed the potential risks of long-term opioid use, such as cognitive impairment, as well as the potential risks involved in combining opioids with benzodiazepines, sedatives and muscle relaxers. Dr. Korenstein explained that the risks of combining controlled substances include cognitive and motor impairment, respiratory depression, dizziness, an increased risk of falls, and death. Dr. Korenstein expressed concern that respondent failed to reassess Patient A's medication regimen after he reported dizziness on a number of occasions and, in 2016, fell from a ladder.

37. Dr. Korenstein also found that respondent did not perform any compliance monitoring of Patient A, such as checking CURES reports, conducting "pill counts" or obtaining any drug testing, during Patient A's treatment period. In his report, Dr. Korenstein notes that CURES reports show that Patient A received prescriptions for controlled substances from another provider in July 2015 and March 2017.

38. Dr. Korenstein noted that the two written controlled substance contracts in Patient A's file, from 2016 and 2017, were "very typical and appropriate." However, there are no such contracts in Patient A's records prior to 2016, and such contracts were required by the standard of care in 2014. According to Dr. Korenstein, respondent's failure to have a controlled substance contract constituted a simple departure from the standard of care.

39. Dr. Korenstein also found that respondent's medical records for Patient A were inadequate and inaccurate because he failed to document a history of present illness for Patient A, and his review of systems and physical exam findings are largely the same for each visit, raising concerns that the notes were pasted from prior entries. And, respondent failed to include details regarding the necessity for the long-term use of controlled substances, a risk assessment or a treatment plan and objectives. In Dr. Korenstein's view the deficiencies in respondent's medical records amounted to an extreme departure from the standard of care.

RESPONDENT'S EXPERT

40. Dr. Nickles believes that respondent's evaluation of Patient A established a medical necessity for the use of controlled substances based upon Patient A's "pain syndrome." He opined that there is "plenty of documentation in the medical record historically and also by examination of his chronic pain." Dr. Nickles also opined that respondent "address[ed] emotional issues such as anxiety and depression and treated them." While Dr. Nickles opined that respondent's records indicated a clear purpose for using analgesics to relieve Patient A's back pain, he noted, however, that when respondent diagnosed him with "sciatic complaint," there was a "lack of back and neurologic examinations" for Patient A.

41. Dr. Nickles also expressed no concerns about respondent's risk stratification for Patient A. The only concern Dr. Nickles addressed was the lack of documentation regarding the risks involved in combining benzodiazepines with opiates.

42. Dr. Nickles opined that the treatment plan was sufficiently developed: it was to relieve pain, anxiety and depression. Additionally, he found that respondent had measurable goals and objectives throughout the treatment plan, as reflected by periodic assessments of Patient A's pain and anxiety. Dr. Nickles did not believe an "exit strategy" was necessary because Patient A's pain problem was not "under control in the first place."

43. With respect to informed consent, Dr. Nickles found that respondent sufficiently documented the risks and benefits of using controlled substances. For example, respondent documented the potential for sedation and not to drive or combine controlled substances with alcohol.

44. With respect to compliance monitoring, Dr. Nickles opined that pill counting and urine screens are not required by the standard of care. Urine screens are only used when a provider has concerns regarding misuse of the controlled substance, and in the case of Patient A, there were no "red flags" that would suggest the need for a urine drug screen. Dr. Nickles believes that respondent's failure to check CURES reports was not problematic because it was not the standard of care when respondent treated Patient A.

45. Dr. Nickles also disagreed that a written controlled substance contract between the provider and patient, outlining provider and patient responsibilities, is required by the standard of care. Therefore, the fact that respondent did not have a written controlled substance contract with Patient A in 2014 and 2015 is not a breach of the standard of care.

Additionally, in Dr. Nickles's view, the fact that respondent had a written controlled substance contract in 2016 and 2017 demonstrates that he exceeded what is required by the standard of care.

46. Dr. Nickles's written impressions of the case outline the following concerns regarding respondent's treatment of Patient A that were not discussed in his written report: "NO BACK EXAM, NO DIETARY REFERRAL, NO DIET RECOMMENDATIONS, NO URIC ACID DETERMINATION, NO ANTI-INFLAMMATORY AGENTS FOR GOUT, GIVEN NARCOTICS TOO EARLY IN THIS DISORDER, NO PT REFERRAL, NO RECORDS REQUEST, NO LABS ORDERED."

Elsewhere in his written impressions, Dr. Nickles notes that on January 14, 2013, respondent should have started Patient A with 5 mg of Zolpidem, a sedative-hypnotic, instead of 10 mg.

47. As to respondent's advisements regarding the dangers of controlled substances, and in particular, mixing them, Dr. Nickles observed that a chart note from September 17, 2012, reflects that he cautioned Patient A not to mix medication with alcohol or drive after taking his narcotic medication.

48. In Dr. Nickles's opinion, respondent's documentation with respect to Patient A was thorough and more than adequate.

ULTIMATE FINDINGS RE PATIENT A

49. Dr. Korenstein's opinions are well-reasoned and supported by the evidence. In contrast, Dr. Nickles's impressions and conclusions regarding respondent's treatment of Patient A are, at times, internally inconsistent and unsupported by the evidence; and his written evaluation of respondent's conduct was less comprehensive than Dr. Korenstein's. For these reasons, it is found that Dr. Korenstein's conclusions are more persuasive than the conclusions of Dr. Nickles.

50. Accordingly, respondent committed multiple and extreme departures from the standard of care in his prescribing of opioids, benzodiazepines, muscle relaxers and sedatives to Patient A; as such, respondent's conduct was grossly negligent. (Factual Finding 32.)

51. Based on Dr. Korenstein's analysis, it is also found that respondent's failure to have a written controlled substance contract for Patient A between 2014 and 2016, constituted a simple departure from the standard of care. Respondent's conduct in this regard constituted simple negligence. (Factual Finding 38.)

52. Dr. Korenstein's conclusion that respondent failed to maintain adequate medical records for Patient A, and that the deficiencies in his medical records constituted an extreme departure from the standard of care, is also supported by the evidence and found more persuasive than the opinions offered by Dr. Nickles. As such, it is found that respondent's record keeping with respect to Patient A was grossly negligent. (Factual Finding 39.)

Patient B

53. Patient B, a woman in her 40's, sought treatment from respondent for wrist, neck and back pain; and she was also treated for a respiratory tract problem and a thumb infection, which caused her pain. Patient B also suffered from severe migraines, decreased strength in her arms, and severe pain in her lower extremities. Respondent treated Patient B on 21 occasions between 2015 and 2018, and during this time, prescribed a variety of controlled substances to her, including hydrocodone, oxycodone, tramadol, benzodiazepines, muscle relaxers and sedatives.

54. Respondent testified that he performed the proper examination, assessments, advisements and monitoring in connection with his treatment of Patient B, consistent with his prescribing practices described in Factual Findings 23

through 28.

55. Patient B signed a controlled substance contract in March 2018 but did not return to respondent's clinic thereafter.

BOARD'S EXPERT

56. Dr. Korenstein opined that with respect to Patient B, respondent failed to comply with the standard of care requirements applicable to prescribing controlled substances, which are described in detail in Factual Finding 15, Dr. Korenstein concluded that respondent's transgressions, set forth below in Factual Findings 57 through 63, constituted extreme departures from the standard of care.

57. Dr. Korenstein found "little evidence" in Patient B's medical records to support a diagnosis of medical necessity for the long-term use of opioids. Respondent failed to gather information, by way of a formal screening tool or by informal questions, to assess the potential risks involved in the long-term use of opioids.

58. With respect to informed consent, while respondent did advise Patient B not to drive or consume alcohol while on pain medication and to store medications in a safe place, he did not explain the risks involved in combining the medications that he had prescribed. Dr. Korenstein was particularly concerned with respondent's failure to evaluate the risks of combining opiates with other controlled substances and muscle relaxers and sedatives, which presented risks of respiratory depression, cognitive and motor impairment, and death.

59. Dr. Korenstein also found that Patient B's medical records did not contain a treatment plan or objectives. For example, there were no measurable goals, no strategy for discontinuing the medications, and no

evidence of improvement.

60. Respondent did not perform any compliance monitoring, such as pill-counting, drug screens or reviewing CURES reports. Dr. Korenstein notes that CURES reports show that Patient B received prescriptions for controlled substances from other providers in February and March 2016.

61. Dr. Korenstein was concerned that respondent failed to perform ongoing assessments of Patient B's pain to determine the necessity of continued treatment with pain medication or explore whether Patient B was misusing the medication, since Patient B was on a mix of medications that contained a variety of risk; she had a history of mental illness; she complained of dizziness; and, she had a fall in her bathtub. Dr. Korenstein noted that Patient B's pain levels remained largely constant, which lead him to question whether the medications were improving her pain.

62. Dr. Korenstein also found that respondent did not have a written controlled substance contract with Patient B for the entire time that she was treated by respondent. Although she signed a contract on March 5, 2018, she did not return to him thereafter. He found that this was an extreme departure from the standard of care.

63. Dr. Korenstein also found that respondent's medical records for Patient B were inadequate and inaccurate. In drawing his conclusion, he noted a lack of a detailed and consistent history of present illness for Patient B's complaints. He cited to several examples: Respondent notes that Patient B was sleeping better while on triazolam, but later in the note, states that her insomnia was worsening; respondent treated Patient B for laryngitis, or inflammation of the throat, yet he found the throat exam to be completely normal; and, respondent diagnosed Patient B with a urinary tract infection, but no treatment for this condition is evident

in the chart. In Dr. Korenstein's view, the deficiencies in respondent's medical records amounted to an extreme departure from the standard of care.

RESPONDENT'S EXPERT

64. Dr. Nickles opined that respondent's notes reflect a medical necessity for prescribing controlled substances because Patient B was not obtaining relief from non-opioid medications. Dr. Nickles opined that there was a sufficient treatment plan and an exit strategy, reflected in respondent's plan to taper her off of Percocet.

65. Dr. Nickles found that respondent's advisements regarding the risks associated with the medications were sufficient to meet the standard of care. He noted that respondent advised Patient B not to drive after taking anti-anxiety medication or hydrocodone. Because, in his opinion, documentation regarding discussions as to the dangers of combined controlled substances is not required by the standard of care, respondent's failure to do so was not below the standard of care.

66. Dr. Nickles also found that respondent engaged in sufficient compliance monitoring because he saw Patient B often and the prescriptions lasted for short periods of time. The fact that respondent did not check CURES or engage in other compliance monitoring is not problematic since these actions were not required by the standard of care.

67. Dr. Nickles also found that respondent was thorough in documenting Patient B's progress, pain status and side effects. In Dr. Nickles's view, the fact that Patient B slipped in the bathtub was not a sign or symptom of a side effect of the medications.

68. Dr. Nickles opined that respondent's failure to have a written pain contract with Patient B until 2018 did not deviate from the standard of care

because oral contracts were sufficient.

69. Dr. Nickles opined that respondent's records were "very thorough and complete" and complied with the standard of care. He acknowledged a couple of inconsistencies in the records but added that "no records are perfect."

70. The written impressions of Dr. Nickles suggest concerns regarding respondent's treatment of Patient B that were not discussed in his written report: Dr. Nickles noted that respondent started Patient B on a high dose of Norco; he started Percocet at 10 mg; and did not perform a neurological exam on Patient B. Dr. Nickles also noted that respondent's prescription of methotrexate was "not appropriate in this setting."

ULTIMATE FINDINGS RE PATIENT B

71. Dr. Korenstein's opinions are well-reasoned and supported by the evidence. In contrast, Dr. Nickles's impressions and conclusions regarding respondent's treatment of Patient Bare, at times, internally inconsistent and unsupported by the evidence; and, his written evaluation of respondent's conduct was less comprehensive than Dr. Korenstein's. For these reasons, it is found that Dr. Korenstein's conclusions are more persuasive than the conclusions of Dr. Nickles. Accordingly, respondent committed multiple and extreme departures from the standard of care in his prescribing controlled substances to Patient B; as such, respondent's conduct was grossly negligent. (Factual Finding 56.)

72. Dr. Korenstein's conclusion that respondent failed to maintain adequate medical records for Patient B, and that the deficiencies in his medical records constituted an extreme departure from the standard of care, is also supported by the evidence and found more persuasive than the opinions offered by Dr. Nickles. As such, it is found that respondent's record

keeping with respect to Patient B was grossly negligent. (Factual Finding 63.)

Patient C

73. Patient C, a woman from Silicon Valley in her 50's, sought treatment from respondent for depression, anxiety, insomnia, abdominal pain, gastritis and muscle-skeletal pain, post-surgery abdominal abscess, dysfunctional uterine bleeding, and migraine headaches. Patient C also suffered from morbid obesity.

74. Respondent treated Patient C between 2012 and 2018 on 51 occasions, and during this time, prescribed a variety of controlled substances to Patient C, including Norco, Percocet, alprazolam, lorazepam, and clonazepam. During the years that respondent treated Patient C, he prescribed approximately 2,160 hydrocodone tablets, 120 oxycodone tablets, 2,080 clonazepam tablets, 890 alprazolam tablets, and 100 lorazepam tablets.

75. Respondent testified that he performed the proper examination, assessments, advisements and monitoring in connection with his treatment of Patient C, consistent with his prescribing practices described in Factual Finding 23 through 28.

76. Patient C falsely reported to respondent that she was being treated at Kaiser and Stanford Hospital for uterine cancer and that she had been receiving chemotherapy. Patient C also reported that she had been hospitalized for cancer at Kaiser for one week. She also claimed that she had cervical cancer, a lung biopsy and a uterine ablation with her other providers.

77. At the time she was treated by respondent, Patient C had doctors at Kaiser in the Silicon Valley area; and CURES reports showed that her doctors at Kaiser were prescribing opiates to her between July 2015 and March 2018.

78. Respondent did not obtain Patient C's medical records from her other providers, obtain any imaging studies or labs to confirm her reported diagnoses; and he did not consult with any of Patient C's doctors regarding her conditions and treatment. Respondent claimed that he attempted on numerous occasions to obtain Patient C's medical records, without success, until 2018.

79. Patient C reported a number of falls or accidents, including car accidents, while she was being treated by respondent.[17] She also reported that her pain medications were lost or stolen on three occasions.[18] With respect to the alleged theft of her medications, respondent stated that because he trusted Patient C, he did not ask her to provide a police report.

80. Patient C signed two written controlled substance contracts with respondent, in June 2016 and October 2017.

BOARD'S EXPERT

81. Dr. Korenstein opined that with respect to Patient C, respondent failed to comply with the standard of care requirements applicable to prescribing controlled substances which *are* described in detail in Factual Finding 15. Dr. Korenstein concluded that respondent's transgressions, set forth below in Factual Findings 82 through 87 and 89, constituted extreme departures from the standard of care.

82. Dr. Korenstein found that there was little evidence to support the

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[17] For example, on December 28, 2012, Patient C reported severe shoulder pain after a fall; on December 6, 2013, she reported a large burn on her right shoulder, back and chest; on September 6, 2014, she reported back pain from a motor vehicle accident; on April 3, 2017, she reported a severe fall on the left side of her body; on August 30, 2017, she reported taking a bad fall; and on January 20, 2018, she reported back pain after a motor vehicle accident.

[18] On December 28, 2012, she reported that her purse was stolen, which contained her medications; on September 25, 2014, she reported that she lost her handbag containing her medications; and on July 25, 2017, she reported losing her clonazepam pills.

use of chronic opioid therapy to treat Patient C's chronic pain. Dr. Korenstein expressed concern that respondent failed to properly obtain records from her other providers to establish a medical necessity for her treatment and that he failed to gather information; by way of a formal screening tool or by informal questions, to assess the potential risks involved in the long-term use of opioids,

83. Dr. Korenstein also found that respondent failed to assess the potential risks involved in the long-term use of controlled substances. Dr. Korenstein was particularly concerned with respondent's failure to evaluate the risks of combining opiates with other controlled substances, which presented risks of respiratory depression, cognitive and motor impairment, and death.

84. Dr. Korenstein also found that respondent failed to develop a comprehensive treatment plan for Patient C. Respondent did not obtain her medical records to assist him with formulating goals and objectives of treatment; and he failed to include a strategy for discontinuing opioid therapy in the event that tapering or discontinuation of therapy became necessary.

85. With respect to informed consent, respondent did not sufficiently discuss the risks of long-term opioid use or the risks involved in combining opiates with other controlled substances, which include cognitive and motor impairment, respiratory depression, and death.

86. Dr. Korenstein was particularly concerned that respondent did not take any steps to monitor Patient C's compliance with controlled substances treatment. During the time that Patient C was under respondent's care, she exhibited numerous risk factors for long-term controlled substance treatment: Patient C had numerous falls and accidents; she had several car accidents; she requested an early refill; and she reported lost or stolen medication on multiple occasions. Yet, respondent did not perform any compliance monitoring, such as

pill-counting, drug screens or reviewing CURES reports. And, he failed to consult with Patient C's doctors at Kaiser regarding her diagnoses and treatment there. As noted previously, CURES reports showed that Patient C received prescriptions for controlled substances from other providers during the time that she was treated by respondent.

87. Dr. Korenstein also found that respondent failed to perform ongoing assessments of Patient C's pain to determine the continued necessity of treatment. For example, he did not document whether Patient C was making progress toward the treatment objectives or assess whether her level of functioning had improved. Additionally, there was no indication that respondent assessed any side effects from the medication or followed up on potential abuse or diversion issues. Dr. Korenstein opined that Patient C was harmed during the time that she was treated by respondent due to the "numerous falls, accidents, car accidents she had, which can be attributed to her medication and the combinations of medication she was on."

88. Although respondent had controlled substance contracts for Patient C in June 2016 and October 2017, he did not have contracts prior to that time. Insofar as written controlled substance contracts became the standard of care in 2014, Dr. Korenstein found that respondent's failure to do so constituted a simple departure from the standard of care.

89. Dr. Korenstein found that respondent's medical records for Patient C were inadequate and inaccurate. In drawing his conclusion, he noted a lack of documentation in a number of areas: a lack of a detailed history of present illness for Patient C's complaints, a failure to document the rationale for treatment, and an absence of an ongoing assessment of the risks, benefits, and side effects of treatment.

RESPONDENT'S EXPERT

90. Dr. Nickles opined that with two exceptions noted below, respondent's care and treatment of Patient C complied with the standard of care.

91. Dr. Nickles opined that respondent's notes revealed sufficient medical necessity for prescribing Patient C controlled substances, based upon her abdominal pain and body aches. Dr. Nickles found that respondent adequately discussed the risks and benefits of the prescribed medicines.

92. In Dr. Nickles's view, Patient C deceived respondent regarding her identity and possibly other matters. For this reason, Dr. Nickles believes that if respondent had checked CURES reports for Patient C under the name she used at respondent's clinic, such reports would not have revealed that Kaiser providers were also prescribing controlled medications. Dr. Nickles noted that after respondent learned that Patient C was receiving prescriptions for controlled substances from Kaiser doctors, he terminated the doctor-patient relationship.

93. Later in his testimony, however, Dr. Nickles agreed that once Patient C told him that she was being treated at Kaiser, respondent should have asked her for the name of her Kaiser doctor, which would have enabled him to contact Patient C's doctor. Dr. Nickles stated that respondent's failure to ascertain the name of, and contact, Patient C's Kaiser provider, constituted a simple departure from the standard of care. Dr. Nickles added, however, that if respondent "had been given the correct name of the patient, if [respondent] had received the Kaiser records and if he still treated the patient the same way, in my opinion that would have been an extreme departure from the standard of care.[19]

[19] As complainant points out, respondent was aware that Patient C used a hyphenated last name as early as June 16, 2016, when she used that name when signing her controlled substance agreement. For this reason, it is not clear why Dr. Nickles concludes that respondent was unaware of both last

94. Dr. Nickles was concerned that respondent did not take action to monitor Patient C's compliance after she reported that her prescription medications were lost or stolen. Dr. Nickles viewed this as a "red flag" and opined that respondent should have performed a random drug test to monitor her compliance. In Dr. Nickles's view, respondent's failure to do so amounted to simple negligence.

95. Dr. Nickles noted that respondent had a written contract with Patient C in connection with his prescription of opiates and anxiety medications.

96. Dr. Nickles also opined that respondent's chart notes were "thorough and complete."

97. In his written impressions of the case, Dr. Nickles expressed the following concerns regarding respondent's treatment of Patient C that were not addressed in his written report:

> DID NOT ADDRESS TACHYCARDIA, SHOULD NOT HAVE STARTED NORCO AT 10 AND AMBIEN AT 10, NO TREATMENT OTHER THAN CONTROLLED SUBSTANCES, NO AMYLASE/LIPASE ORDERED.

Elsewhere in his written impressions, he commented: "Finally using non-narcotics," "Just shooting from the hip with no coordination with Kaiser treating physicians," and "no attempt to contact Kaiser treating doctors or to get medical records." Dr. Nickles also wrote that respondent's prescription of fioricet was a "problem for patient alread[y] on Norco and Benzos." Dr. Nickles also noted that Patient C's request for refills for alprazolam, Norco and Ambien because her medications had been stolen because she had been mugged, was a "red flag."

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names used by Patient C.

ULTIMATE FINDINGS RE PATIENT C

98. Dr. Korenstein's opinions are well-reasoned and supported by the evidence. In contrast, Dr. Nickles's impressions and conclusions regarding respondent's treatment of Patient C are, at times, internally inconsistent and unsupported by the evidence; and, his written evaluation of respondent's conduct was less comprehensive than Dr. Korenstein's. For these reasons, it is found that Dr. Korenstein's conclusions are more persuasive than the conclusions of Dr. Nickles. Accordingly, respondent committed multiple and extreme departures from the standard of care in his prescribing controlled substances to Patient C; as such, respondent's conduct was grossly negligent. (Factual Findings 81-87.)

99. Based on Dr. Korenstein's analysis, it is also found that respondent's failure to have a controlled substance contract for Patient A between 2014 and 2016, constituted a simple departure from the standard of care; and, respondent's conduct in this regard constituted simple negligence. (Factual Finding 88.)

100. Dr. Korenstein's conclusion that respondent failed to maintain adequate medical records for Patient C, and that the deficiencies in his medical records constituted an extreme departure from the standard of care, is also supported by the evidence and found more persuasive than the opinions offered by Dr. Nickles. As such, it is found that respondent's record keeping with respect to Patient C was grossly negligent. (Factual Finding 89.)

Additional Evidence Pertaining to Rehabilitation and References

COURSES IN PRESCRIBING, MEDICAL RECORD KEEPING AND CONTINUING EDUCATION

101. Respondent completed two courses at the University of California, San Diego, School of Medicine that he believes have helped him improve his practice. The first course, pertaining to physician prescribing, was

completed in October 2018. The second course, pertaining to medical record keeping, was completed in July 2019. Respondent has also completed continuing education courses pertaining to opioid prescribing.

REFERENCE LETTERS AND OTHER MATTERS

102. The following individuals submitted reference letters on behalf of respondent:

a. Tex Allen has been respondent's patient for 10 years. In a letter dated March 6, 2020, Allen expresses his gratitude to respondent for providing him with affordable and high-quality medical care. He believes that respondent's clinic contributes to the well-being of the neighborhood because it enables local residents to obtain health care in a warm, friendly and accessible environment.

b. John Cummings is a marriage and family therapist. He has been respondent's patient for over five years. In a letter dated March 9, 2020, Cummings praises respondent for his ability to handle stressful situations, treat large numbers of clients in his clinic, and spend long hours caring for patients with modest financial resources. Cummings writes that he has referred his clients to respondent and has received positive feedback regarding their experiences with respondent.

c. Jesus de Alva has been respondent's patient for over 10 years. In a letter dated March 2, 2020, de Alva commends respondent for providing "empathy-infused care" to patients who would be otherwise unable to afford medical care. De Alva writes that respondent treats his patients in a manner that "respects and understands their cultural background," and is an outstanding doctor.

d. Maria Theresa Escamilla wrote a letter dated March 9, 2020, on behalf of her family, Escamilla praises respondent for the excellent care that he has provided to several family members. Her family is particularly grateful to respondent for the care that he provided to her younger brother. Escamilla believes that without respondent's help, her brother would not be alive today, Escamilla explains that respondent is a tremendous asset to the Fruitvale community in that he treats patients who are predominantly of Latino descent and who may not qualify for health insurance. She strongly urges the Board to allow respondent to continue serving his patients,

e. In an undated letter, Aida Hernandez writes that she and her partner have been respondent's patients for several years. Hernandez describes respondent as a kind and caring doctor. Hernandez credits respondent for saving the life of her partner, who had been misdiagnosed by another provider and therefore, had lacked proper medical treatment.

f. Bradley Holden, M.D., has been respondent's friend and colleague for over 20 years. In a letter dated March 6, 2020, Dr, Holden praises respondent for the hard work, intelligence, and dedication that he brings to his practice, Dr. Holden admires respondent for providing much needed primary care to a predominantly minority community and describes him as highly respected and loved by his patients.

g. James Liang, D.O, is a family physician who works in respondent's neighborhood. He is familiar with respondent's busy primary care practice. Dr. Liang describes respondent as "caring, responsible and professional." He believes that respondent serves a unique role in that he is bilingual and provides quality care to an underserved patient population, many of whom do not speak English and do not possess health insurance.

h. In an undated letter, Sim A. Middleton writes that she has known respondent for 20 years. Most recently Middleton joined respondent and his wife on a volunteer mission to Tanzania, where she observed respondent teach local women about birthing, breast feeding and hygiene. Middleton describes respondent as someone who is honest, caring, and is dedicated to helping those in need.

i. Esteban Lovato, M.D., has a medical practice located close to respondent's office. In a letter dated March 19, 2020, Dr. Lovato explained that during the last 10 years that respondent has been in practice, they have shared patients. Dr. Lovato has observed respondent's evaluation and treatment of medical conditions, and he describes respondent as an excellent physician. Like other writers, Dr. Lovato notes that respondent is one of a few doctors practicing in East Oakland, where medical care is scarce.

j. Derek Wheat has been respondent's patient for several years. In a letter dated March 1, 2020, he writes that respondent has provided him with excellent care. Wheat has referred friends to respondent; they have been very happy with the care provided by him. Wheat also praised respondent for treating indigent patients, who might otherwise be unable to obtain medical care. Wheat expressed concern that respondent's patients would suffer if respondent was prevented from practicing medicine.

103. Respondent has performed volunteer work overseas with Global Volunteers in Tanzania, where he provided health education on the subjects of pregnancy and nutrition. Respondent has also volunteered for Planned Parenthood and San Francisco Bayview-Hunters Point asthma program outreach.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's Certificate. *(Ettinger v, Board of Medical Quality Assurance* (1982) 135 Cal. App.3d 853, 856.)

2. Unprofessional conduct is grounds for discipline of a physician's Certificate pursuant to Business and Professions Code section 2227,[20] 2234, and 2266. Pursuant to Business and Professions Code section 2234, a licensee may be subject to discipline for committing unprofessional conduct, which includes violating the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), committing gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), committing repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c))[21], and failing to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

First Cause for Discipline (Gross Negligence)

3. By reason of the matters set forth in Factual Findings 49 to 50, 71 and 98, the evidence established that respondent was grossly negligent in connection with his treatment of Patients A, Band C. Cause for license discipline therefore exists pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b).

Second Cause for Discipline (Repeated Negligent Acts)

4. By reason of the matters set forth in Factual Findings 51 and 88, the

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[20] Business and Professions Code section 2227 authorizes the Board to take disciplinary action against licensees who have been found to have committed violations of the Medical Practice Act.

[21] Under the Language of the statute, in order to be repeated there must be two or more separate and distinct negligent acts. (Bus. & Prof. Code, § 2234, subd. (c).)

evidence established that respondent committed repeated negligent acts in connection with his treatment of Patients A and C, based upon his failure to have written controlled substance contracts. Cause for license discipline therefore exists pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

Third Cause for Discipline (Failure to Maintain Adequate and Accurate Records)

5. By reason of the matters set forth in Factual Findings 52, 72 and 100, the evidence established that respondent failed to maintain adequate and accurate medical records for Patients A, Band C. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2266, in conjunction with Business and Professions Code sections 2227 and 2234, subdivision (a).

Fourth Cause for Discipline (Violations of the Medical Practice Act)

6. The matters set forth in Legal Conclusions 3 through 5, establish that respondent committed violations of the Medical Practice Act. As such, cause for license discipline exists to pursuant to Business and Professions Code section 2227 and 2234, subdivision (a).

Disciplinary Determination

7. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (12th ed., 2016)[22], recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's misconduct under Business and Professions Code sections 2234 and 2266. The maximum discipline for each of these violations is revocation of his Certificate.

[22] The Board's Disciplinary Guidelines are incorporated in California Code of Regulations, title 16, section 1361.

In exercising its disciplinary functions, protection of the public is the Board's paramount concern. (§ 2229, subd. (a).) At the same time, the Board is charged with taking disciplinary action that is calculated to aid the rehabilitation of the licensee whenever possible, as long as the Board's action is not inconsistent with public safety. (§ 2229, subds. (b), (c).)

In the instant case, the testimony of Board expert Dr, Korenstein established that between 2012 and 2018 respondent prescribed combinations of opioids, benzodiazepines and other controlled substances to three patients without an adequate evaluation and determination of medical necessity; without a proper assessment of risks; without a treatment plan and objectives; without sufficient informed consent; without compliance monitoring or ongoing assessments of the treatment; and without sufficient controlled substance contracts, And, respondent's record keeping was consistently deficient.

Although respondent's expert disagreed with Dr, Korenstein on the exact requirements of the standard of care, a number of Dr. Nickles's written impressions corroborate Dr, Korenstein's view that respondent failed to comply with the standard of care in his treatment of Patients A, B, and C. As Dr, Nickles noted: Respondent wrote 11,172 controlled substance prescriptions during a two- and one-half-year period, and during this time did not check the CURES database. Prescriptions were often prescribed early, and not at the lowest doses daily; and concern existed due to respondent's prescribing a potentially dangerous combination of opioids, benzodiazepines, and barbiturates.

As Dr, Korenstein explained, while respondent's misconduct placed his patients at risk of harm, Patient C was actually harmed by his misconduct. Respondent's treatment of Patient C was especially concerning because, among

other things, he failed to take steps to contact her doctors at Kaiser regarding her diagnoses and treatment; he failed to obtain her medical records or CURES reports[23]; and he failed to take any steps to monitor Patient C's compliance after "red flags" were raised by her reports of lost and stolen medication and her various falls and car accidents.

Respondent's belief that his treatment of Patients A, B, and C was within the standard of care suggests that he has not come to terms with his misconduct. Although he admits that his medical record keeping was in some respects deficient, he denies the other, more serious charges of gross negligence. While it is plausible that respondent's transgressions in the instant case stemmed from a lack of knowledge regarding the standard of care rather than a conscious disregard of his professional obligations, it is of concern that even after taking recent courses in prescribing practices and record keeping, he continues to deny responsibility for his misconduct.

Although, as the evidence established, the standard of care does not differ based upon a patient's economic status, race or ethnic origin, respondent is commended for his steadfast commitment to treating indigent patients in underserved communities who might not otherwise have access to medical care. In determining the appropriate discipline in this matter, it is also noted that respondent has practiced medicine for 20 years; this is his first disciplinary matter before the Board; and he is highly regarded by the patients and physicians who wrote letters supporting him. Additionally, respondent has completed courses in medical record keeping and prescribing.

Complainant contends that respondent's Certificate should be revoked.

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[23] Respondent claimed that he could not obtain additional information about Patient C because he did not know her other names, but the evidence at hearing suggested otherwise.

Complainant points to the fact that respondent failed to take responsibility for his misconduct; at times, respondent's testimony was inconsistent; at other times, he appeared uninformed about his professional obligations; and, he appeared somewhat ambivalent about some of the probation conditions that might be imposed by the Board. Complainant's points are valid. However, in light of the mitigating factors described above, it was not established that revocation of respondent's Certificate is necessary to protect the public. Absent a valid public protection purpose, revocation may not and should not be imposed. And while respondent did not seem enthusiastic about the prospect of certain probation conditions, he also impresses as someone who is so passionate about his work that he will do whatever is asked of him by the Board, in order to continue practicing medicine.

Complainant also suggests that if respondent's Certificate is not revoked, that he should be placed on probation for seven years. The record, however, does support deviating from the minimum discipline provided by the Guidelines.

Respondent, on the other hand, suggests that a public reprimand would be appropriate in this case. His view also misses the mark. Insofar as respondent has been found to have committed multiple acts of gross negligence in connection with his treatment of three patients over a number of years, a three-year term of probation is necessary and appropriate.

Accordingly, respondent's Certificate will be placed on probation for three years, subject to the terms and conditions set forth below. This Order is consistent with the Board's statutory obligation to fashion disciplinary orders that aid in the rehabilitation of the licensee while also protecting the public. (Bus. & Prof. Code, § 2229.)

ORDER

Physician's and Surgeon's Certificate No. A 98670, issued to respondent Carlos Ramirez, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for three years under the following terms and conditions.

1. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice, The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision, Accusation, and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the

scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction,

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed, If respondent did not successfully complete the clinical competence assessment program, respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of California Code of Regulations, title 16, section 1358, Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial

enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

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

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

3. Education Course

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

course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

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

5. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with

any information and documents that the approved course provider may deem pertinent.

Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

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

6. Monitoring-Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including, but not limited to, any

form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely. It shall be

the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board 01 · its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

7. Solo Practice Prohibition

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

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

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

8. Patient Disclosure

Before a patient's first visit following the effective date of this order and while respondent is on probation, respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on respondent by the Board, the Board's telephone number, and an explanation of how the patient can find further information on respondent's probation on respondent's profile page on the Board's website.

Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not

be required to provide a disclosure if any of the following applies: (1) the patient is unconscious or otherwise unable to comprehend the disclosure and sign a copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) the visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) respondent is not known to the patient until immediately prior to the start of the visit; or (4) respondent does not have a direct treatment relationship with the patient.

9. Notification

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

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

10. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

11. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance

with any court ordered criminal probation, payments, and other orders.

12. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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

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

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

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

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar

days prior to the dates of departure and return.

14. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

15. Non-Practice While on Probation

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

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the

criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

16. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

17. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his certificate. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine, Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. Probation Monitoring Costs

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

JAN 15 2021

This Decision shall become effective at 5:00 pm on _____.

DEC 17 2020

IT IS SO ORDERED _____.

Kristina Lawson

KRISTINA D. LAWSON, J.D., CHAIR
PANEL B

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **CARLOS RAMIREZ, M.D.** 73 Sleepy Hollow Lane Orinda, CA 94563 Physician's and Surgeon's Certificate No. A 98670, Respondent.	Case No. 800-2017-034878 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about January 19, 2007, the Medical Board issued Physician's and Surgeon's Certificate No. A 98670 to Carlos Ramirez, 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, 2021, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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

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

"(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.

"..."

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."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. A 98670 to disciplinary action under section 2227 and 2234, as defined by 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, and C,[1] as more particularly alleged hereinafter:[2]

Patient A

8. From on or about May 2012, through on or about March 2018, Respondent provided care and treatment to Patient A for, among other things, back pain, knee pain, hypertension, insomnia, gout and weight loss.

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

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

9. From on or about May 2012, through on or about March 2018, Respondent prescribed several controlled substances to Patient A, including, but not limited to, Vicodin,[3] Xanax,[4] Ambien,[5] Norco,[6] Soma,[7] and phentermine.[8]

10. From on or about May 2012, through on or about March 2018, Respondent provided care and treatment to Patient A at approximately 20 visits.

11. On or about May 18, 2012, Patient A presented with complaints of anxiety, weight gain, lower back pain and gout. During the visit, Patient A indicated his physician was out of town, which prevented Patient A from obtaining his medications. Respondent prescribed to

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[3] Vicodin is a brand name for the drug combination of 5 mg of hydrocodone and 500 mg of acetaminophen. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain.

[4] Xanax is a brand name for alprazolam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is a short-acting benzodiazepine. When properly prescribed and indicated, it is commonly used to relieve anxiety.

[5] Ambien, brand name for zolpidem, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Ambien is a benzodiazepine analog. When properly prescribed and indicated, it is commonly used to treat insomnia.

[6] Norco is a brand name for the drug combination of hydrocodone (5 mg, 7.5 mg, or 10 mg) and acetaminophen (325 mg). Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The DEA has identified opioids, such as Hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

[7] Soma is a brand name for carisoprodol, a Schedule IV controlled substance pursuant to 21 C.F.R. § 1308.14, and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used as a muscle relaxant. According to the DEA, Office of Diversion Control, published comment on carisoprodol, dated March 2014, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs."

[8] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant.

Patient A 30 tablets of Vicodin and 90 tablets of phentermine. During this visit, Respondent did not perform a complete back examination or neurological examination of Patient A.

12. On or about July 13, 2012, Patient A returned for a follow up visit. During this visit, Patient A informed Respondent that his physician had moved. Patient A discussed his history of back pain and anxiety. Respondent prescribed to Patient A 60 tablets of Xanax (1 mg), 60 tablets of Vicodin, 90 tablets of phentermine, 60 tablets of diclofenac,[9] and 390 tablets of sertraline.[10] Respondent also recommended lab studies, however there is no documentation the recommended lab studies were ordered.

13. On or about September 17, 2012, Patient A returned for a follow up visit. During this visit, Patient A reported experiencing increased pain. Respondent prescribed to Patient A 60 tablets of Vicodin, 60 tablets of Xanax, 60 tablets of phentermine, and 120 tablets of naproxen.[11]

14. On or about January 14, 2013, Patient A returned to refill his medications. During this visit, Patient A reported experiencing sleep issues. Respondent prescribed to Patient A 60 tablets of Vicodin, 60 tablets of Xanax, 90 tablets of phentermine, and 30 tablets of Ambien. Records for this visit do not document any discussion regarding the risks of combining Ambien with Xanax and/or Vicodin.

15. On or about August 24, 2013, Patient A returned for follow up regarding back pain and anxiety. During this visit, Respondent changed Patient A's prescription from Vicodin to 60 tablets of Norco (10/325). Respondent also issued a prescription for 60 tablets of Xanax, 60

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[9] Diclofenac is a nonsteroidal anti-inflammatory drug (NSAID) commonly used to treat pain and inflammatory diseases such as gout. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Sertraline, brand name Zoloft, is a selective serotonin reuptake inhibitor (SSRI) commonly used to treat depression and anxiety. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

[11] Naproxen is an NSAID commonly used to treat pain and reduce swelling. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

tablets of phentermine, and 60 tablets of naproxen. Respondent also began prescribing 120 tablets of Gabapentin[12] to Patient A.

16. On or about July 10, 2014, Patient A returned for a follow up visit regarding obesity, anxiety and pain management. During this visit, Respondent reduced Patient A's Norco prescription to 60 tablets of Norco (5/325). Respondent also issued a prescription for 60 tablets of Xanax, 30 tablets of phentermine, and 30 tablets of Ambien. Respondent also began prescribing 90 tablets of Simvastatin[13] and 90 tablets of Losartan[14] to Patient A.

17. On or about September 3, 2014, Patient A returned to refill his medications. During this visit, Respondent increased Patient A's Norco dosage to 60 tablets of Norco (10/325). Respondent also issued a prescription for 60 tablets of Xanax, 60 tablets of phentermine, and 30 tablets of Ambien. Respondent also issued a prescription for Prednisone[15] to Patient A.

18. On or about May 14, 2015, Patient A returned to refill his medications. During this visit, Respondent refilled Patient A's prescriptions for Norco and phentermine with no documentation of a treatment plan or documentation of the quantity, dosage or instructions regarding the Norco prescription.

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[12] Gabapentin is an anti-epileptic drug commonly used to treat seizures and epilepsy. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

[13] Simvastatin is a HMG CoA reductase inhibitor (statin drug) commonly used to lower cholesteral and triglycerides. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Losartan is an angiotensin II receptor antagonist commonly used to treat high blood pressure. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

[15] Prednisone is a steroid commonly used to treat inflammation and migraine headaches. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

19. On or about July 7, 2015, according to Patient A's patient profile activity report by Controlled Substance Utilization Review and Evaluation System[16] (CURES report), Patient A filled a prescription by another physician for 30 tablets of Norco.

20. On or about July 17, 2015, according to Patient A's CURES report, Patient A filled another prescription by the same physician for 30 tablets of Norco.

21. On or about September 15, 2015, Patient A returned for a follow up visit. During this visit, Respondent issued prescriptions for 60 tablets of Norco, 60 tablets of Xanax, 30 tablets of phentermine, and 30 tablets of Ambien. Respondent also issued a prescription for 20 tablets of Soma. Records for this visit do not document any discussion regarding the risks of Soma.

22. On or about January 22, 2016, Patient A returned to refill his medications. During this visit, Respondent prescribed to Patient A 60 tablets of Xanax, 90 tablets of Norco, 60 tablets of Ambien, 60 tablets of Soma, and 60 tablets of phentermine. Records for this visit indicate Patient A signed an agreement regarding opiate therapy, however the agreement was not maintained in the records.

23. On or about June 23, 2016, Patient A and Respondent signed an agreement for opioid therapy.

24. On or about March 13, 2017, according to Patient A's CURES report, Patient A filled another prescription by another physician for 15 tablets of Ambien and 30 tablets of Norco.

25. On or about April 28, 2017, Patient A returned for a "general check-up." Records for this visit indicate Patient A's hypertension was well controlled with the current prescription for

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[16] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

Losartan/HCTZ[17] (100/25), one per day. However, records for this visit indicate Respondent doubled Patient A's prescription for Losartan/HCTZ (100/25), two per day. Records for this visit do not document any order for lab work.

26. On or about August 30, 2017, Patient A returned for a "general check-up." Records for this visit indicate Respondent refilled Patient A's medications, but stopped prescribing Naproxen, and began prescribing diclofenac and paroxetine.[18] Records for this visit do not document the reasoning for this change in medication. Records for this visit indicate Patient A and Respondent signed an agreement for opioid therapy.

27. According to the CURES report for Patient A, from on or about July 7, 2015, through on or about March 26, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 600 tablets of Ambien (10 mg).

28. According to the CURES report for Patient A, from on or about July 7, 2015, through on or about March 26, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 780 tablets of alprazolam (1 mg).

29. According to the CURES report for Patient A, from on or about July 7, 2015, through on or about March 26, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 940 tablets of Norco (10/325 mg).

30. According to the CURES report for Patient A, from on or about July 7, 2015, through on or about March 26, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 660 tablets of phentermine (37.5 mg).

31. According to the CURES report for Patient A, from on or about July 7, 2015, through on or about March 26, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 220 tablets of carisoprodol (350 mg).

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[17] Losartan/HCTZ (hydrochlorothiazide) is a combination drug commonly used to treat high blood pressure. The maximum dose for Losartan/HCTZ is 100 mg Losartan and 25 mg HCTZ taken orally once a day. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

[18] Paroxetine, brand name Paxil, is an SSRI drug used to treat depression and anxiety. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

32. Respondent committed gross negligence in his care and treatment of Patient A, which included, but is not limited to, the following:

A. Paragraphs 8 through 31, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to perform a proper evaluation of Patient A to establish a diagnosis of medical necessity for chronic opioid therapy, including the failure to use appropriate screening tools and the failure to identify the potential benefits and risks of opioid therapy;

C. Respondent failed to undertake risk stratification of Patient A for chronic opioid use, including the failure to fully evaluate the potential risks of combining opiates with other respiratory depressants (Xanax, Soma, and Ambien);

D. Respondent failed to develop a treatment plan and objectives for Patient A, including the failure to specify measurable goals and objectives and the failure to include an exit strategy for discontinuing narcotic therapy;

E. Respondent failed to provide sufficient information to obtain proper patient consent from Patient A regarding the potential risks of long-term opioid use and combined narcotic, benzodiazepine, muscle relaxant and sedative/hypnotic use, including the failure to discuss potential side effects, risk of impaired motor skills, risk of misuse, dependency, addiction and overdose, or the limited evidence of benefit of long-term opioid therapy;

F. Respondent failed to undertake proper compliance monitoring of Patient A, including the failure to perform random drug testing, review of CURES reports, or conduct pill counting; and

G. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient A, including the failure to provide a detailed plan and rationale for his diagnosis, the failure to document his discussions with Patient A regarding medications chosen or discontinued, the failure to address the

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initiation of statins, and the failure to document the rationale for changes in antidepressant medications.

Patient B

33. From on or about February 2015, through on or about January 2018, Respondent provided care and treatment to Patient B for, among other things, neck pain, back pain, insomnia, anxiety, migraines, wrist and arm pain.

34. From on or about February 2015, through on or about January 2018, Respondent prescribed several controlled substances to Patient B, including, but not limited to, Norco, Soma, Xanax, Percocet (10/325),[19] triazolam,[20] lorazepam,[21] and tramadol.[22]

35. From on or about February 2015, through on or about January 2018, Respondent provided care and treatment to Patient B at approximately 21 visits.

36. On or about February 13, 2015, Patient B presented with complaints of cough with green phlegm, tight chest, and difficulty breathing. During this visit, Respondent assessed Patient B with an upper respiratory tract infection and prescribed to Patient A several prescription drugs, including albuterol, Augmentin, prednisone and promethazine.[23]

37. On or about March 9, 2015, Patient B returned with complaints of an infection in her thumb. Respondent prescribed to Patient B 40 tablets of Norco (10/325).

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[19] Percocet is a brand name for the drug combination of oxycodone (2.5 mg, 5 mg, 7.5 mg, or 10 mg) and acetaminophen (325 mg). Oxycodone is an opioid and is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[20] Triazolam, brand name Halcion, is a benzodiazepine and is classified as a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

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

[22] Tramadol is a Schedule IV controlled substance pursuant to 21 C.F.R. § 1308.14, and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid pain medication.

[23] Albuterol, Augmentin, prednisone and promethazine are classified as dangerous drugs pursuant to Business and Professions Code section 4022.

38. On or about October 15, 2015, Patient B returned with complaints of pain in her arms, legs and back, and difficulty sleeping. Respondent prescribed to Patient B 60 tablets of Naproxen, 15 tablets of baclofen,[24] 60 tablets of Norco (10/325), and 15 tablets of prednisone. According to Patient B's CURES report, Patient B filled a prescription by Respondent for 30 tablets of lorazepam (2 mg) on October 15, 2015, however, the records for this visit do not mention this prescription.

39. On or about February 22, 2016, according to Patient B's CURES report, Patient B filled a prescription by another physician for 30 tablets of Norco (5/325).

40. On or about March 10, 2016, according to Patient B's CURES report, Patient B filled a prescription by another physician for 20 tablets of Tylenol with codeine (300/30).[25]

41. On or about May 10, 2016, Patient B returned with complaints of pain in her neck, shoulders, arms and wrist. Patient B also mentioned difficulty sleeping. Records for this visit indicate Respondent initiated vitamin D treatment. Patient B's CURES report shows Patient B filled a prescription by Respondent for 60 tablets of Norco (10/325), however, records for this visit do not document this prescription.

42. On or about May 13, 2016, Patient B presented for a follow up visit and a request for sleep aid medication. Records for this visit indicate Respondent prescribed 90 tablets of tramadol (50 mg) and 30 tablets of Fioricet (325/50/40)[26] to Patient B.

43. On or about June 3, 2016, Patient B returned with complaints of pain. Records for this visit indicate Respondent noted Patient B's need for a computed tomography scan (CT scan) and magnetic resonance imaging (MRI) of Patient B's neck and spine, but that Patient B did not have sufficient funds to pay for the imaging. Records for this visit further indicate Patient B

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[24] Baclofen is a dangerous drugs pursuant to Business and Professions Code section 4022 commonly used to treat spasms and muscle cramps.

[25] Tylenol with codeine (300/30) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, and a dangerous drug pursuant to Business and Professions Code section 4022.

[26] Fioricet is a combination of acetaminophen, butalbital, and caffeine. Butalbital is a barbiturate commonly used to treat tension headaches. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

reported triazolam was not working. Respondent prescribed 90 tablets of gabapentin, and issued refills for 60 tablets of Naproxen (500 mg) and 90 tablets of Norco (10/325).

44. On or about July 2, 2016, according to Patient B's CURES report, Patient B filled a prescription issued by Respondent for 60 tablets of triazolam.

45. On or about July 15, 2016, Patient B returned with a request for better pain control medications and a request for a referral for an MRI. Respondent prescribed 90 tablets of gabapentin, 60 tablets of Naproxen, 30 tablets of triazolam, and Norco with no indication regarding the number of tablets of Norco prescribed.

46. On or about July 25, 2018, Patient B reported she was unable to sleep with triazolam. Respondent prescribed 10 tablets of lorazepam to Patient B.

47. On or about August 12, 2016, Patient B returned for follow up on her MRI. Records for this visit indicate the MRI results returned normal and Respondent documented the need to continue searching for the etiology of Patient B's pain. Respondent refilled Patient B's medications for Naproxen, Fioricet, Norco, and also issued a prescription for 30 tablets of trazodone.[27]

48. On or about August 31, 2017, Patient B presented early for refills of her medications, claiming she was traveling out of town. Respondent prescribed Percocet (10/325) and Soma to Patient B.

49. On or about October 4, 2017, Patient B presented requesting refills of her medications. Respondent prescribed to Patient B 30 tablets of triazolam, 30 tablets of Soma, 90 tablets of Percocet (10/325), 90 tablets of gabapentin, as well as other medications.

50. On or about November 3, 2017, Patient B presented with complaints of pain due to a fall. Respondent prescribed to Patient B 90 tablets of Percocet (10/325) and 30 tablets of Fioricet.

51. On or about November 27, 2017, Patient B presented with complaints of pain and nausea. Records for this visit indicate Respondent prescribed to Patient B 60 tablets of Soma, 100 tablets of Norco (10/325) and 30 tablets of trazodone.

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[27] Trazodone is a dangerous drug pursuant to Business and Professions Code section 4022 commonly used to treat depression.

52. On or about February 13, 2018, according to Patient B's CURES report, Patient B filled a prescription issued by Respondent for 60 tablets of tramadol, however there are no patient records corresponding to this prescription.

53. On or about March 5, 2018, Patient B presented with complaints of pain in her arms, insomnia and anxiety. Respondent prescribed to Patient B 60 tablets of Soma and 60 tablets of alprazolam.

54. On or about March 5, 2018, Patient B's last visit with Respondent, Patient B and Respondent signed an agreement for opioid therapy.

55. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 970 tablets of Norco (10/325).

56. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 420 tablets of Percocet (10/325).

57. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 270 tablets of Soma (350 mg).

58. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 540 tablets of Fioricet (325/50/40).

59. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 196 tablets of triazolam (0.125 mg).

60. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 250 tablets of lorazepam (2 mg).

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61. According to the CURES report for Patient B, from on or about October 15, 2015, through on or about April 30, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 130 tablets of tramadol (50 mg).

62. Respondent committed gross negligence in his care and treatment of Patient B, which included, but is not limited to, the following:

A. Paragraphs 33 through 61, above, are incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to perform a proper evaluation of Patient B to establish a diagnosis of medical necessity for chronic opioid therapy, including the failure to use appropriate screening tools and the failure to identify the potential benefits and risks of opioid therapy;

C. Respondent failed to undertake risk stratification of Patient B for prescribing long-term use of controlled substances, including the failure to use various screening tools and the failure to fully evaluate potential risks of combined opiate therapy (narcotic, benzodiazepine and barbiturates);

D. Respondent failed to develop a treatment plan and objective for Patient B, including the failure to specify measurable goals and objectives and the failure to include an exit strategy for discontinuing narcotic therapy;

E. Respondent failed to provide sufficient information to obtain proper patient consent from Patient B regarding the potential risks of long-term opioid use, combined opioid use, combined narcotic and benzodiazepine use, combined barbiturate, narcotic and benzodiazepine use; including the failure to discuss potential side effects or risk of misuse, dependence, addiction and overdose, or the limited evidence of benefit of long-term opioid therapy;

F. Respondent failed to undertake proper compliance monitoring of Patient B, including the failure to perform random drug testing, review of CURES reports, or conduct pill counting;

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G. Respondent failed to perform ongoing assessments of Patient B's treatment, including the failure to document Patient B's progress toward treatment objectives, pain status, evidence of side effects, the failure to discuss possible medication abuse or diversion, and the failure to consider concerning signs and symptoms for continued use of controlled substances;

H. Respondent failed to place Patient B on a controlled substance contract during his care and treatment of Patient B in 2015, 2016 and 2017; and

I. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient B, including the failure to document a detailed and consistent history of present illness for Patient B's various complaints, the failure to provide a detailed plan and rationale for diagnosis, the failure to document his discussions with Patient B regarding medications chosen or discontinued and their risks, benefits and side effects.

Patient C

63. From on or about December 2012, through on or about January 2018, Respondent provided care and treatment to Patient C for, among other things, anxiety, depression, insomnia, abdominal pain, numerous muscle-skeletal pain and gastritis.

64. From on or about December 2012, through on or about January 2018, Respondent prescribed several controlled substances to Patient C, including, but not limited to, Norco (10/325), Percocet (10/325), alprazolam, lorazepam, and clonazepam.[28]

65. From on or about December 2012, through on or about January 2018, Respondent provided care and treatment to Patient C at approximately 51 visits.

66. On or about December 28, 2012, Patient C presented with complaints of anxiety, depression, pain and body aches and chills. During this visit, Patient C also reported a recent fall

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

causing severe pain to her right shoulder. Respondent prescribed to Patient C 40 tablets of Norco (10/325), 30 tablets of Ambien, and an unknown number of tablets of alprazolam (0.5 mg).

67. On or about March 5, 2013, Patient C presented with complaints of heavy bleeding and lower abdominal pain. During this visit, Patient C reported undergoing a recent uterine ablation resulting in severe pain. Respondent prescribed to Patient C 40 tablets of Norco (10/325), 30 tablets of Ambien, 30 tablets of alprazolam (0.5 mg), and 30 tablets of amitriptyline.[29]

68. On or about December 6, 2013, Patient C presented with complaints of a large burn along her right shoulder, neck and upper back area due to reported accident with a pot of boiling water. During this visit, Patient C also reported suffering severe head trauma from a car accident in 2010 resulting in pain in her neck and back for several years. Respondent prescribed to Patient C 90 tablets of Norco (10/325) and 60 tablets of alprazolam (1 mg).

69. On or about March 6, 2014, Patient C presented with complaints of asthma. During this visit, Patient C informed Respondent she had recently been hospitalized at Kaiser Health for one week. Respondent prescribed to Patient C, among other things, 90 tablets of Norco (10/325), 60 tablets of clonazepam, 60 tablets of naproxen, an unknown quantity of prednisone.

70. On or about July 23, 2014, Patient C's pharmacy informed Respondent that Patient C was attempting to fill her medications early, stating her recent prescription for Norco and clonazepam was last filled on July 9, 2014. Respondent authorized the early refill for Norco.

71. On or about August 16, 2014, Patient C presented with complaints of severe pain in her left shoulder after she fell, hit her shoulder, and where she had a third degree burn and a skin graft that seemed infected. During this visit, Patient C mentioned she was scheduled for a total

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[29] Amitriptyline is a tricyclic antidepressant. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

hysterectomy surgery. Respondent prescribed to Patient C, among other things, 90 tablets of Norco (10/325), 60 tablets of clonazepam, 60 tablets of gabapentin, and 180 tablets of bupropion.[30]

72. On or about September 6, 2014, Patient C presented requesting Respondent inspect her incision from her recent hysterectomy. Respondent prescribed to Patient C, among other things, 60 tablets of clonazepam, 15 tablets of prednisone, and 30 tablets of naproxen.

73. On or about September 25, 2014, Patient C presented requesting medication refills, claiming she lost her handbag and pain medications. During this visit, Patient C also reported being diagnosed with Stage IV cancer. Records for this visit indicate Respondent did not have a copy of Patient C's medical records to confirm this diagnosis. Respondent prescribed to Patient C, among other things, 90 tablets of Norco (10/325), 60 tablets of alprazolam (1 mg), 120 tablets of bupropion, and an unknown quantity of gabapentin.

74. On or about October 22, 2014, Patient C presented requesting Respondent inspect her incision from her recent total hysterectomy and lower abdomen abscess treated at Kaiser. During this visit, Patient C also reported undergoing radiation therapy for stage IV cervical cancer. Records for this visit indicate Respondent did not have a copy of Patient C's medical records to confirm this diagnosis. Respondent prescribed to Patient C, among other things, 90 tablets of Norco (10/325), 60 tablets of alprazolam (1 mg), 60 tablets of gabapentin, and an unknown quantity of naproxen.

75. On or about January 13, 2015, Patient C presented requesting treatment of an infected incision and difficulty urinating. Respondent prescribed to Patient C, among other things, 90 tablets of Norco (10/325) and 60 tablets of clonazepam.

76. On or about January 13, 2015, after the clinical visit, Patient C contacted Respondent by telephone and informed him that she had been diagnosed with cervical cancer. Patient C stated her anxiety had increased. Respondent then prescribed to Patient C 20 tablets of alprazolam (2 mg).

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[30] Bupropion, brand name Wellbutrin, is used to treat withdrawal effects and depression. It is classified as a dangerous drug pursuant to Business and Professions Code section 4022.

77. On or about January 15, 2015, Patient C's pharmacy informed Respondent that Patient C was requesting an early refill of alprazolam after receiving an additional 20 tablets of alprazolam just two days earlier at another pharmacy.

78. On or about September 16, 2015, Patient C presented for a general check up. During this visit, Patient C reported a recent lung biopsy due to cervical and uterine cancer. Patient C also reported past removal of her gallbladder. Records for this visit indicate Respondent did not have a copy of Patient C's medical records to confirm any of the events reported by Patient C. Respondent prescribed to Patient C, among other things, 100 tablets of Norco (10/325), 90 tablets of clonazepam, and 60 tablets of gabapentin.

79. On or about December 14, 2015, Patient C presented with complaints of a cough. During this visit, Patient C informed Respondent she was receiving chemotherapy treatment at Stanford Medical Center for uterine and cervical cancer. Respondent prescribed to Patient C, among other things, 100 tablets of Norco (10/325), 90 tablets of clonazepam, and 60 tablets of promethazine.

80. On or about January 23, 2016, Patient C presented with complaints of headaches and stomach inflammation. During this visit, Patient C informed Respondent of a recent hospitalization for abdominal pain, and specified she had sixteen additional chemotherapy treatments at Stanford Medical Center. Respondent prescribed to Patient C, among other things, 100 tablets of Norco (10/325) and 90 tablets of clonazepam.

81. On or about March 24, 2016, Patient C presented with a request for an early refill of her medications claiming she was traveling out of town. Respondent prescribed to Patient C, among other things, 100 tablets of Norco (10/325) and 90 tablets of clonazepam.

82. On or about April 19, 2016, Patient C presented with complaints of a migraine. During this visit, Patient C mentions feeling dizzy at all times, states her lung biopsy came back as positive for cancer and discusses upcoming chemotherapy. Records for this visit indicate Patient C reported losing one week's supply of medications. Respondent prescribed to Patient C 25 tablets of Norco (10/325) and 25 tablets of clonazepam.

83. On or about June 13, 2016, Patient C presented with complaints of vomiting, diarrhea and dizziness. During this visit, Patient C informed Respondent she recently went to the emergency department for a severe migraine episode and had a spinal tap procedure. Respondent prescribed to Patient C, among other things, 90 tablets of Norco (10/325) and 90 tablets of clonazepam.

84. On or about June 16, 2016, Patient C and Respondent signed an agreement for opioid therapy.

85. On or about July 20, 2016, Patient C presented requesting medication refills. During this visit, Patient C reported experiencing dizziness and vomiting. Patient C also informed Respondent she had ongoing pain in her abdomen since her hysterectomy and believed something was left behind in her abdomen area. Records for this visit indicate a request for medical records was submitted to Kaiser Health. Respondent prescribed to Patient C, among other things, 100 tablets of Norco (10/325) and 90 tablets of clonazepam.

86. On or about November 14, 2016, Patient C presented with complaints of pain after a recent motor vehicle accident. Respondent prescribed to Patient C, among other things, 100 tablets of Norco (10/325), 90 tablets of clonazepam, and 60 tablets of naproxen.

87. On or about February 8, 2017, Patient C presented with complaints of high blood pressure and headaches. During this visit, Patient C informed Respondent the foreign object left behind in her abdomen area from the hysterectomy procedure had been removed. Respondent prescribed to Patient C, among other things, 120 tablets of Norco (10/325) and 90 tablets of clonazepam.

88. On or about April 3, 2017, Patient C presented requesting pain medications. During this visit, Patient C informed Respondent she fell when she woke up at night and her left leg was numb. Respondent prescribed to Patient C, among other things, 120 tablets of Norco (10/325) and 90 tablets of clonazepam.

89. On or about July 25, 2017, Patient C presented with complaints of pain and insomnia. During this visit, Patient C informed Respondent she lost her medication and has been experiencing nausea, vomiting, blurry vision and constipation. Records for this visit indicate

Respondent still did not have a copy of Patient C's medical records from Kaiser. Respondent issued two separate prescriptions to Patient C for alprazolam, one prescription for 90 tablets of alprazolam (2 mg), and one prescription for 15 tablets of alprazolam (2 mg).

90. On or about August 30, 2017, Patient C presented with complaints of pain after experiencing another recent fall. Respondent prescribed to Patient C, among other things, 120 tablets of Norco (10/325) and 60 tablets of alprazolam (2 mg).

91. In or around October 2017, Patient C and Respondent signed an agreement for opioid therapy.

92. On or about February 19, 2018, Respondent obtained a copy of Patient C's medical records from Kaiser Health.

93. Based upon Patient C's medical records from Kaiser, from in or around 2016, through in or around 2018, Patient C was concurrently receiving care and treatment at Kaiser, under a different last name.

94. According to the CURES report for Patient C, from in or around 2015, through in or around 2018, Patient C obtained several controlled substances based upon prescriptions and refills issued or authorized by other health care providers through Kaiser, including but not limited to, Norco (10/325), Norco (5/325), Percocet (5/325), hydromorphone,[31], clonazepam, alprazolam, and lorazepam, Ambien and tramadol.

95. According to the CURES report for Patient C, from on or about June 12, 2015, through on or about January 20, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 3,360 tablets of Norco (10/325).

96. According to the CURES report for Patient C, from on or about June 12, 2015, through on or about January 20, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 2,080 tablets of clonazepam (2 mg).

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[31] Hydromorphone, brand name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid used to treat moderate to severe pain.

97. According to the CURES report for Patient C, from on or about June 12, 2015, through on or about January 20, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 375 tablets of alprazolam (2 mg).

98. According to the CURES report for Patient C, from on or about June 12, 2015, through on or about January 20, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 440 tablets of alprazolam (1 mg).

99. According to the CURES report for Patient C, from on or about June 12, 2015, through on or about January 20, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 120 tablets of Percocet (10/325).

100. According to the CURES report for Patient C, from on or about June 12, 2015, through on or about January 20, 2018, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 100 tablets of lorazepam (2 mg).

101. Respondent committed gross negligence in his care and treatment of Patient C, which included, but is not limited to, the following:

A. Paragraphs 63 through 100, above, are incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to perform a proper evaluation of Patient C to establish a diagnosis of medical necessity for chronic opioid therapy, including the failure to use appropriate screening tools, the failure to corroborate numerous diagnoses reported by Patient C, and the failure to obtain lab studies, imaging studies, and medical records from other providers;

C. Respondent failed to undertake risk stratification of Patient C for chronic opioid use, including the failure to fully evaluate the potential risks of combining opiates and benzodiazepines (Norco, Percocet, alprazolam, clonazepam and lorazepam);

D. Respondent failed to develop a treatment plan and objective for Patient C, including the failure to specify measurable goals and objectives, the failure to include an exit strategy for discontinuing narcotic therapy, and the failure to show patient progress with both pain and mental health issues;

E. Respondent failed to provide sufficient information to obtain proper patient consent from Patient C regarding the potential risks of long-term opioid use and combined opiate and benzodiazepine use, including the failure to discuss potential side effects, risk of impaired motor skills, risk of misuse, dependency, addiction and overdose, or the limited evidence of benefit of long-term opioid therapy;

F. Respondent failed to undertake proper compliance monitoring of Patient C, including the failure to perform random drug testing, review of CURES reports, or conduct pill counting;

G. Respondent failed to perform ongoing assessments of Patient C's treatment, including the failure to document Patient C's progress toward treatment objectives, the failure to document any decrease in pain, the failure to discuss improvement in the level of function, experience of side effects, and the failure to discuss possible medication abuse or diversion; and

H. Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of Patient C, including the failure to document a detailed and consistent history of present illness for Patient C's various complaints, the failure to provide a detailed plan and rationale for diagnosis, and the failure to document his discussions with Patient C regarding medications chosen or discontinued and their risks, benefits and side effects.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

102. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 98670 to disciplinary action under section 2227 and 2234, as defined by 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

A. Paragraphs 7 through 101, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to place Patient A on a controlled substance contract during his care and treatment of Patient A in 2014 and 2015; and

C. Respondent failed to place Patient C on a controlled substance contract during his care and treatment of Patient C in 2014 and 2015.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

103. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 98670 to disciplinary action under section 2227 and 2234, as defined by 2266, of the Code, in that he failed to keep adequate and accurate medical records in his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 7 through 101, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Violations of Provisions of the Medical Practice Act)

104. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 98670 to disciplinary action under section 2227 and 2234, as defined by 2234, subdivision (a), of the Code, in that he committed a violation or violations of a provision or provisions of the Medical Practice Act in his care and treatment of Patients A, B, and C, as more particularly alleged in paragraphs 7 through 103, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 98670, issued to Respondent Carlos Ramirez, M.D.;

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

3. Ordering Respondent Carlos Ramirez, 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: May 7, 2019

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

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