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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: Paul Joseph Duran, M.D. Physician's & Surgeon's Certificate No A 60506 Respondent.	Case No.: 800-2019-058673

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Paul Joseph Duran, and the time for action having expired at 5:00 p.m. on December 14, 2020, the petition is deemed denied by operation of law.

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	Case No. 800-2019-058673
Paul Joseph Duran, M.D.	**ORDER GRANTING STAY**
Physician's & Surgeon's Certificate No A 60506	(Government Code Section 11521)
Respondent.	

Respondent, Paul Joseph Duran, has filed a Request for Stay of execution of the Decision in this matter with an effective date of December 4, 2020, at 5:00 p.m.

Execution is stayed until December 14, 2020, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: December 2, 2020

William Prasifka
Executive Director
Medical Board of California

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: Paul Joseph Duran, M.D. Physician's and Surgeon's Certificate No. A 60506 Respondent.	Case No. 800-2019-058673

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 4, 2020.

IT IS SO ORDERED November 5, 2020.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the First Amended Accusation

and Petition to Revoke Probation of:

PAUL JOSEPH DURAN, M.D., Respondent

Agency Case No. 800-2019-058673

OAH No. 2020021179

PROPOSED DECISION

Carla L. Garrett, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on August 3, 4, 5, 10, 11, 12, and 14, 2020, via videoconference and teleconference.

Vladimir Shalkevich, Deputy Attorney General, appeared and represented Christine J. Lally (Complainant), Interim Executive Director of the Medical Board of California (Board). Paul Joseph Duran, M. D. (Respondent) appeared and represented himself.

On July 17, 2020, Complainant moved for a protective order requesting that Exhibits 27 and 28 be placed under seal because the documents contain confidential information that is protected from disclosure to the public. Redaction of the

documents to obscure this information was not practicable and would not have provided adequate privacy protection. Respondent did not oppose Complainant's motion. The ALJ granted the motion and issued a Protective Order placing the above-referenced exhibits under seal. Exhibits 27 and 28 shall remain under seal and shall not be opened, except as provided by the Protective Order. A reviewing court, parties to this matter, their attorneys, and a government agency decision-maker or designee under Government Code section 11517 may review the documents subject to the Protective Order, provided that such documents are protected from release to the public.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on August 14, 2020.

FACTUAL FINDINGS

Jurisdictional Matters

1. Complainant made the First Amended Accusation and Petition to Revoke Probation in her official capacity.

2. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number A60506 to Petitioner on July 28, 1996. Respondent practiced as an anesthesiologist with a subspecialty in pain management. In 2001, Respondent took over the Pacific Pain Institute as sole owner.

3. On July 29, 2005, Petitioner surrendered his certificate, during the pendency of a disciplinary matter initiated by the Board in Accusation number 06-2002-138792.

4. On February 28, 2013, the Board, pursuant to its Decision in case number 27-2011-217318, reinstated Respondent's certificate, immediately revoked it, stayed the revocation, and placed Respondent's certificate on probation, subject to specific terms and conditions.

5. Respondent's certificate was in effect and subject to probation with various terms and conditions, at all relevant times. Respondent's certificate will expire on February 28, 2022, unless renewed.

Surrender of Certificate

6. Respondent surrendered his certificate, effective July 29, 2005, pursuant to a Stipulation for Surrender of License, in connection with an Accusation, a First Amended Accusation, and a Second Amended Accusation, filed in case number 06-2002-138792, on October 4, 2003, December 21, 2004, and July 29, 2005, respectively. Pursuant to the Stipulation for Surrender of License, Respondent admitted there was a factual and legal basis for imposition of discipline against his certificate under Business and Professions Code sections 2227 and 2234, and agreed that all of the allegations and the Causes for Discipline contained in the Second Amended Accusation were true and correct.

7. The Second Amended Accusation alleged, and Respondent agreed to culpability of, the following: (1) engaging in gross negligence and incompetence, by providing care and medications to a hospitalized patient, who was addicted to opioids, in a facility in which Respondent had no privileges to practice medicine; (2) engaging in gross negligence, incompetence, and labeling violations, by providing a hospitalized patient, who was addicted to opioids, envelopes containing dangerous drugs without proper labeling or instructions; (3) engaging in gross negligence, incompetence, drug

law violations, by prescribing controlled substances to a hospitalized patient, who was addicted to opioids, without medical indication or without first performing a good faith examination; (4) engaging in gross negligence, incompetence, and documentation violations, by failing to record in hospital records his interactions with the hospitalized patient, including the fact that he had provided the patient with controlled substances; (5) engaging in gross negligence, incompetence, and documentation violations, by regularly accepting from patients unwanted portions of controlled substances, and storing those drugs in his office for an indefinite period, without maintaining an inventory or log of the returned medications; (6) engaging in gross negligence and incompetence, by failing to evaluate a patient for possible addiction or other disorders, despite the patient exhibiting signs suggesting addiction, psychological or psychiatric problems, loss of control with medications, and worsening physical symptoms; (7) engaging in gross negligence, incompetence, and excessive prescribing, by allowing a patient "at will" access to quantities of controlled substances, despite demonstrated noncompliance, emotional instability, and deteriorating function (Exhibit 6, p. 000028); (8) engaging in sexual misconduct, by pursuing a sexual relationship with a patient while he was her treating physician; (9) engaging in repeated negligent acts, incompetence, and documentation violations, by failing to keep accurate and complete records of his patient's prescriptions and refill dates to facilitate regular monitoring of compliance; (10) engaging in repeated negligent acts and incompetence, by failing to comment on or obtain a consultation with a specialist in addiction medicine after receiving a report from a consulting neurologist diagnosing chemical dependency; (11) engaging in repeated negligent acts and incompetence, by failing to communicate with or coordinate treatment with his patient's psychiatrist; (12) engaging in repeated negligent acts and incompetence, by treating his patient's headache with round-the-clock short-acting medications,

despite the patient's increasing disability; (13) engaging in repeated negligent acts and incompetence, by failing to document that he had discussed with his patient the risks of the medications he had prescribed, alternative treatments, or potential medication side effects, or by obtaining informed consent from his patient; (14) engaging in gross negligence and incompetence in his overall care of his patient; (15) engaging in gross negligence and incompetence, by failing to recognize the seriousness of his patient's condition and to follow-up with appropriate evaluations, examinations, and referrals to specialists; (16) engaging in gross negligence and incompetence, by performing cervical facet injections and cervical selective nerve root blocks on his patient without understanding the anatomy and techniques necessary to perform them; (17) engaging in gross negligence and incompetence, by performing a cervical selective nerve root block on his patient with her in a prone position, which precluded an appropriate anterior/lateral approach to the neural foramen; (18) engaging in gross negligence, by lacking significant detail in his initial history and physical of his patient, reflecting the diagnoses described by his patient without noting any objective factors of disability or offering any rationale or support for them, and containing no discussion of his patient's previous drug and alcohol history; (19) engaging in gross negligence, by failing to provide his patient with informed consent including the risk of addiction when starting her on OxyContin, Adderall, and Ritalin; (20) engaging in gross negligence, incompetence, and excessive prescribing, by prescribing his patient excessive amounts of Demerol; (21) engaging in gross negligence, incompetence, and excessive prescribing, by prescribing excessive doses of Ritalin to his patient, despite his patient's history of drug and alcohol abuse and bipolar disorder; (22) engaging in gross negligence, incompetence, and excessive prescribing, by prescribing large amounts of oral opiate medication without objective factors of disability, without documentation for prescribing the medication, without improved function and with a

history of addiction to prescription medication and alcohol and bipolar disorder; (23) engaging in gross negligence, by failing to see his patient for a period of three to four months while prescribing significant quantities of opiates and amphetamines to her; and (24) engaging in repeated negligent acts, by engaging in the acts listed in items 1 through 23 above.

Reinstatement / Relevant Probation Conditions

8. On July 28, 2011, Respondent filed with the Board a Petition for Reinstatement of Surrendered Certificate.

9. After his surrender, Respondent completed several remedial courses. Specifically, Respondent completed the following courses at the University of California at San Diego (UCSD): Medical Record Keeping Course (April 19 through 20, 2007); Physician Prescribing Course (April 16 through 18, 2007); Professional Boundaries Program (September 9 through 11, 2009); Phase I of the Physician Assessment and Clinical Education (PACE) Program (June 10 through 11, 2010); and Phase II of the PACE Program (November 15 through 19, 2010, and March 14 through 18, 2011).

10. On November 14, 2012, Respondent completed another professional boundaries course, entitled "Professional Boundaries and Ethics: Maintenance and Accountability," through the University of California at Irvine. Additionally, Respondent, in an effort to remain abreast of developments in the fields of anesthesia and pain management, read a textbook on pain management and numerous online articles.

11. Respondent expressed remorse for his violations and stated, "I apologize for the people that I have hurt and for the mistakes I have made." He explained that when he bought his pain management practice, he "bought a lot of responsibility that

[he] did not foresee." According to Respondent, these "responsibilities overwhelmed [him] and led to a period where [he] did not think as clearly as [he] should have, and [his] judgment was impaired." However, he sought to assure the Board that he had "matured" and had learned how to interact with people. He also assured the Board that he had "worked to maintain and update [his] knowledge base in pain management medicine and believe[d] that [he] could be a good doctor again." He requested "a second chance" to treat patients again, to "redeem" himself, and "be a contributing member of society." Respondent stated that he would "understand and welcome" any conditions the Board would place on his re-licensure. (Exhibit 7, p. 000009-000010.)

12. Effective February 28, 2013, the Board reinstated Respondent's certificate, immediately revoked the certificate, stayed the revocation, and placed Respondent on probation for a period of six years, pursuant to specific terms and conditions.

13. Condition 3 (Obey All Laws) provided the following:

> [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.

(Exhibit 7, p. 000013.)

14. Condition 8 (Failure to Practice Medicine – California Resident) provided the following:

> In the event [Respondent] resides in the State of California and for any reason [Respondent] stops practicing medicine

in California, [Respondent] shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve [Respondent] of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which [Respondent] is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

[Respondent's] license shall be automatically cancelled if [Respondent] resides in California and for a total of two years, fails to engage in California in any of the activities

described in Business and Professions Code sections 2051 and 2052.[1]

(Exhibit 7, p. 000014-000015.)

15. Condition 10 (Probation Monitoring Costs) provided the following:

> [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. Failure to pay costs within 30 days of the due date is a violation of probation.

(Exhibit 7, p. 00015.)

16. Condition 11 (Controlled Substances – Maintain Records and Access to Records and Inventories) provided the following:

> [Respondent] shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by [Respondent], and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of

[11] At hearing, Complainant established that, due to due process issues, the Board no longer automatically cancels probationers' licenses.

Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

[Respondent] shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.

(Exhibit 7, p. 000016.)

17. Condition 12 (Practice Monitor) provided the following:

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(s), 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 monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of the 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.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, [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.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of [Respondent's] performance, indicating whether [Respondent's] practices are within the standards of practice, and whether [Respondent] is practicing medicine safely. It shall be the sole responsibility of [Respondent] to ensure that the monitor submits 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 five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 5 calendar days. If [Respondent] fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, [Respondent] shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. [Respondent] shall cease the practice of medicine within three calendar days after being so notified by the Board or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on

the premises, or to comply with this condition as outlined above is a violation of probation.

(Exhibit 7, p. 000016-000017.)

18. Condition 14 (Third Party Chaperone) provided the following:

During probation, [Respondent] shall have a third party chaperone present while consulting, examining or treating female patients, [Respondent] shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

Each third party chaperone shall initial and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

[Respondent] shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient name, address and telephone number; 2) medical record number; and 3) date of service. [Respondent] shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

> Failure to maintain a log of all patients requiring a third party chaperone, or to make the log available for immediate inspection and copying on the premises, is a violation of probation.

(Exhibit 7, p. 000017.)

Patient 1[2]

A. RESPONDENT'S CARE AND TREATMENT OF PATIENT 1

19. Respondent began working as a physician at 911 Biocare Age Intervention Center (Biocare) in January 2015, one time per week.

20. On August 28, 2015, Patient 1, a 37-year-old male, presented at Biocare for the first time and was seen by Respondent. Patient 1 complained of pain in his right shoulder, his low back and knees, fatigue, lack of energy, weight gain, decreased or absent sex drive, feeling hopeless and without motivation, change in mood, anxiety and/or depression, diminished strength, exercise tolerance, joint aches and/or arthritic symptoms, and dry eyes. Patient 1 signed an informed consent form for testosterone replacement therapy. Patient 1 also provided a blood sample for analysis, which revealed his testosterone levels were normal.

21. On September 11, 2015, Patient 1 returned to see Respondent to review laboratory results, provide a history, and to undergo an examination. Respondent noted Patient 1 had gained 50 pounds over the past eight years, suffered from limited energy, fatigue, low sex drive, depression with hopelessness and a lack of motivation,

[2] In order to protect their privacy, all patients are designated by number.

mood swings, and poor recovery after workouts. Respondent also noted that Patient 1 practiced jiu-jitsu five times per week, and underwent two prior arthroscopic surgeries on his knees, and a right shoulder surgery. Respondent's physical examination of Patient 1 revealed no abnormalities. Respondent diagnosed Patient 1 with hypogonadism and metabolic syndrome, and developed a treatment plan for Patient 1 to start undergoing biologically-identical hormone therapy. In that regard, Patient 1 signed up for a "Concierge Program" with Biocare, in which, Patient 1, for a monthly fee, would receive services not covered by insurance, such as hormone restoration, aesthetic procedures, weight loss plans, pain management, and other services. Respondent arranged for Patient 1 to receive hormone replacement therapy via injections, as prescribed by Respondent.

22. On December 7, 2015, Patient 1 returned to see Respondent. Patient 1 reported that, overall, he felt good, experienced improvement in the areas of energy level, sleep, and focus, and denied suffering any side effects from the testosterone therapy. Patient 1 also reported his right knee ached, prompting Respondent to note that knee injections should be considered. Respondent assessed Patient 1 with hypogonadism and instructed Patient 1 to follow up in two weeks. While Respondent failed to note in Patient 1's records, as well as in Respondent's probation-mandated prescription log, that Respondent had prescribed medication to Patient 1 during the December 7, 2015 visit, on the following day, Patient 1 filled prescriptions written by Respondent for 90 pills of 30 mg amphetamine salt combo (Adderall), Norco, and oxycodone.

23. On January 4, 2016, Respondent wrote Patient 1 prescriptions for Adderall, oxycodone, and Norco. On January 6, 2016, Patient 1 filled prescriptions written by Respondent for testosterone cypionate, oxycodone, and hydrocodone. On

January 12, 2016, Patient 1 filled a prescription for 90 pills of 30 mg Adderall, written by Respondent. Respondent included no entries in Patient 1's medical records documenting any prior examination or any medical indication for the prescriptions of Adderall, oxycodone, and hydrocodone.

24. On January 8, 2016, Patient 1 underwent a Magnetic Resonance Image (MRI) of his right knee, followed by a visit with Respondent on January 19, 2016 to review the results of the MRI. Respondent diagnosed Patient 1 with osteoarthritis in his right knee, and chronic tendonitis in his right ankle, prompting Respondent to inject Patient 1's right knee and ankle with corticosteroid. While Respondent failed to note in Patient 1's records, as well as in Respondent's probation-mandated prescription log, that Respondent had prescribed medication to Patient 1 during the January 19, 2016 visit, on February 1, 2016, Patient 1 filled prescriptions written by Respondent for oxycodone and hydrocodone, and on February 13, 2016, for 90 pills of 30 mg Adderall.

25. On February 15, 2016, Patient 1 returned to see Respondent. Patient 1 complained of chronic right shoulder pain with reduced range of motion in all directions due to pain. Respondent noted no muscle atrophy, no redness, no swelling no fever, and no weakness. Respondent diagnosed Patient 1 with osteoarthritis in his right shoulder, prompting Respondent to inject Patient 1's right shoulder with corticosteroid. While Respondent failed to note in Patient 1's records, as well as in Respondent's probation-mandated prescription log, that Respondent had prescribed medication to Patient 1 during the February 15, 2016 visit, on February 25, 2016, Patient 1 filled prescriptions written by Respondent for oxycodone and hydrocodone.

26. Patient 1's medical records prepared by Respondent contained a copy of a prescription number 420 for a Z-Pack, which is an antibiotic, and Phenergan, which is an antihistamine, as well as prescription number 419, for oxycodone, Norco, and 90

pills of Adderall, that Respondent wrote to Patient 1 on March 14, 2016. There are no corresponding entries in Respondent's medical records that document any prior examination and medical indication for prescriptions of antibiotics, an antihistamine, Adderall, oxycodone, and hydrocodone to Patient 1 on that date.

27. On March 14, 2016, Patient 1's health insurer, Blue Shield/Blue Cross, faxed Respondent a letter stating that it had received Respondent's prior authorization request for Patient 1 to receive Adderall 30 mg tablets, but, in order to remain consistent with Food and Drug Administration (FDA) guidelines, the insurer was only able to approve the medication for 180-quantity every 90-days.

28. Patient 1 filled a prescription for 135 pills of 20 mg Adderall, written to him by Respondent, on March 17, 2016. Patient 1 filled a prescription for oxycodone and hydrocodone, written to him by Respondent, on or about March 25, 2016.

29. On April 4, 2016, Patient 1 returned to see Respondent. Patient 1 complained of knee pain. Respondent examined both of Patient 1's knees and noted no symptoms other than reduced range of motion. Respondent diagnosed Patient 1 with osteoarthritis in both knees and performed corticosteroid injections. Respondent wrote prescription number 481 to Patient 1 for 100 pills of 30 mg oxycodone, 30 pills of 10/35 Norco, and 120 pills of Adderall, 20 mg.

30. On April 15, 2016, Patient 1 filled a prescription for 90 pills of 30 mg Adderall, written to him by Respondent.

31. On April 23, 2016, Patient 1 filled prescriptions for OxyContin and Norco, written to him by Respondent.

32. On May 10, 2016, Respondent submitted to Blue Shield/Blue Cross a prior authorization request to renew Adderall for Patient 1. On the authorization form, Respondent stated that Patient 1 suffered from "shift work sleep disorder" to justify prescribing Adderall to Patient 1. Other than this document, Respondent included no entry in Patient 1's records mentioning that Patient 1 had been diagnosed with a sleep disorder. In several communications with pharmacies, Respondent documented that he prescribed Adderall to Patient 1 on an as-needed basis for sedation.

B. INVESTIGATION BY VENTURA COUNTY SHERIFF NARCOTICS AND VENTURA COUNTY INTERAGENCY PHARMACEUTICAL CRIMES UNIT (VCIPCU)

33. In May 2016, Patient 1 was arrested for selling prescription drugs. Investigator Micah Weilbacher of the VCIPCU testified at hearing and explained that Patient 1 had been selling prescription drugs from his vehicle. Patient 1 confessed he had been receiving his drugs from Respondent exclusively, which prompted the VCIPCU to initiate an investigation against Respondent. Patient 1 agreed to cooperate with VCIPCU as a confidential witness. VCIPCU conducted a series of "controlled buys" by sending Patient 1 to obtain prescriptions from Respondent on three separate occasions: May 24, 2016, June 6, 2016, and August 29, 2016. Each visit was audio-recorded.

1. May 24, 2016 Visit

34. On May 20, 2016, Patient 1 called Biocare and spoke with front desk staff and inquired whether he could pick up a prescription without seeing the doctor. A front desk staff member told Patient 1 she would relay the question to Respondent. Patient 1 followed up on May 23, 2016 to ascertain whether he could pick up a

prescription without seeing the doctor. Front desk staff told Patient 1 he could pick up his prescription the following day, on May 24, 2016.

35. On May 24, 2016, in order to see if Respondent would issue a prescription for controlled substances to Patient 1 without performing a legitimate medical examination and/or without a medical justification, VCIPCU fitted Patient 1 with a wireless transmitting and recording device that allowed VCIPCU detectives to listen and record Patient 1's conversation. Patient 1 entered Biocare and was greeted by front desk staff, who handed Patient 1 a prescription written by Respondent. Patient 1 never saw or spoke with Respondent. Patient 1 then exited Biocare. The entire encounter lasted approximately 30 seconds.

36. Closer examination of the prescription showed it was labeled number 25, for 40 pills of Norco, 80 pills of oxycodone, and 80 pills of 20 mg Adderall. It was dated April 19, 2016, even though it was given to Patient 1 on May 24, 2016.

37. In addition to prescription number 25, Patient 1's medical records contain a copy of prescription number 323, also dated April 19, 2016, for 40 pills of Norco, 80 pills of oxycodone, and 80 pills of 20 mg Adderall, also written by Respondent. Respondent made no corresponding record of history or examination to justify either one of these prescriptions dated April 19, 2016, and did not document these prescriptions in his probation-mandated separate prescribing record.

2. June 6, 2016 Visit

38. Patient 1 returned to see Respondent on June 6, 2016. VCIPCU again fitted Patient 1 with a wireless transmitting and recording device that allowed VCIPCU detectives to listen and record Patient 1's conversation. After Patient 1 and Respondent had greeted each other, Patient 1 asked Respondent for more Norco, and

explained he injured his left elbow in a recent jiu-jitsu tournament. Patient 1 had not complained of pain in his elbow previously. Respondent responded, "Yeah. Absolutely. Are you good with everything else?" (Exhibits 11 and 15.) Patient 1 then asked Respondent for Xanax, claiming he had been experiencing work stress. Respondent had never prescribed Xanax to Patient 1 previously. Respondent asked Patient 1 what strength of Xanax he wanted prescribed to him. Patient 1 said he wanted 2 mg. Respondent asked Patient 1 how many Norco pills he wanted. Patient 1 asked for 20 or 30. Respondent then asked how many Xanax pills Patient 1 wanted. Patient 1 told Respondent he wanted enough to get through the month.

39. Respondent wrote prescription number 131 for 30 pills of 10/35 Norco and 10 pills of .5 mg Xanax. Respondent did not consider that he had prescribed 40 pills of Norco, 80 pills of oxycodone, and 80 pills of 20 mg Adderall to Patient 1 just 12 days prior, on May 24, 2016.

40. Patient 1's visit with Respondent lasted approximately three minutes. Respondent took no history and performed no examination, yet he falsely noted in Patient 1's medical record that Patient 1 suffered increased periarticular edema, heat, decreased active and passive range of motion, no redness, no lymphadenitis, and no crepitus. Respondent recorded a diagnosis of acute right elbow strain/sprain and immobility. Respondent noted that Patient 1's treatment plan included RICE (rest, ice, compress, elevate), prescriptions of Norco and Xanax, and a follow-up visit in two weeks.

41. In his probation-mandated separate prescribing log, Respondent recorded the Norco prescription, indicating that the diagnosis for which he prescribed it was "osteoarthritis" and indicated it was for "chronic joint pain." This statement was

false. Respondent did not document the Xanax prescription in his probation-mandated separate prescribing record.

3. August 29, 2016 Visit

42. Patient 1 returned to see Respondent on August 29, 2016. VCIPCU again fitted Patient 1 with a wireless transmitting and recording device that allowed VCIPCU detectives to listen and record Patient 1's conversation. The visit lasted approximately four minutes, during which Respondent took no history other than asking Patient 1 how his joints were doing. Patient 1 replied, "same-old, same-old, the same grind, jiu-jitsu, so I was wondering if I could get the refill for the Norcos." (Exhibits 12 and 15.) Respondent replied in the affirmative and then asked Patient 1 what medications he wanted. Patient 1 asked for "Oxy, Norco and Xanax." (*Id.*) Respondent then inquired, "Did that Adderall thing ever get worked out?" (*Id.*) Patient 1 replied in the affirmative. Respondent asked Patient 1 the number of Norco pills he wanted. Patient 1 asked for 60. Respondent then asked how many oxycodone pills he wanted. Patient 1 asked for 60. Respondent then asked, "It was .5 mg Xanax?" (*Id.*) Patient 1 responded in the affirmative and asked for 30.

43. Respondent wrote prescription number 132 to Patient 1 for 60 pills of Norco 10/35, 60 pills of oxycodone 30 mg, and 30 pills of Xanax .5 mg. Respondent performed no physical examination, yet noted in Patient 1's medical record that Patient 1's complaint was "chronic, intermittent right ankle/knee pain secondary to osteoarthritis/meniscus tear/ligamentous injury." Respondent documented that Patient 1 was alert and oriented to self, time and place; his cognition was intact; his speech was clear; his pupils were equal, round, and reactive to light; his skin was warm and dry; and that his right knee had inflammation and crepitus with flexion/extension. Respondent's noted Patient 1's diagnosis as osteoarthritis of the right knee and ankle,

and detailed his treatment plan, which included a prescription for oxycodone, Norco, and Xanax, as well as a follow-up visit in one month. Respondent did not record in his probation-mandated prescription record the controlled substance prescriptions he wrote to Patient 1.

Patient 2

44. VCIPCU continued its investigation by using another confidential informant, Patient 2, a 21-year-old male, to participate in controlled buys. Specifically, Patient 2 engaged in controlled buys on October 3, 2016 and October 27, 2016. Each visit was audio and video recorded.

A. OCTOBER 3, 2016 VISIT

45. On October 3, 2016, Patient 2 visited Biocare for the first time and saw Respondent. Patient 2 told Respondent he was referred by Patient 1, and wanted to gain muscle size and strength in order to join the fire academy. Patient 2 completed a Health Information Questionnaire and stated he suffered a shoulder injury in June 2015, and indicated his current pain level was "4" and a "7."

46. Patient 2 signed an informed consent for chiropractic treatment and discussed testosterone therapy with Respondent. Patient 2 asked Respondent to prescribe him Norco, because he suffered a shoulder injury the previous year as a result of an automobile accident, and his shoulder had become bothersome during his workouts. Patient 2 further explained that he had been prescribed Norco approximately one year prior to address his pain, and asked Respondent if he could prescribe Norco to complement the testosterone. Respondent responded in" the affirmative, but warned that the Center for Disease Control had begun monitoring controlled substances, and was "really coming down on prescriptions for Norco,

OxyContin, Soma, and Xanax." (Exhibits 13 and 15.) Patient 2 told Respondent that when he had been prescribed Norco, he would generally take 30 to 60 pills per month. Respondent replied, "All right, I will write you for 60. We can stay under the radar with that number." (*Id.*) Respondent wrote prescription number 43 for 60 pills of 10/325 Norco.

47. Respondent conducted no medical exam of Patient 2, yet noted in Patient 2's medical record that Patient 2 had suffered right shoulder pain for approximately two years, and had good results with Norco; had no operations or steroid injections; was oriented as to person, place and time; his cognition was intact; and his speech was clear. Respondent also stated Patient displayed a reduced range of motion, had no signs of inflammation, and was "neuro intact." Respondent noted his assessment of osteoarthritis of the right shoulder, and set forth a treatment plan for Patient 2 that included Norco for pain, possible steroid injections, and a follow-up visit in one month.

B. OCTOBER 27, 2016 VISIT

48. Patient 2 returned to see Respondent on October 27, 2016. During the visit, Respondent discussed testosterone therapy with Patient 2. Patient 2 asked Respondent for a refill of Norco, and explained that it had been helping Patient 2 manage his pain. Respondent agreed, but because writing a prescription on October 27, 2016 would have constituted an early refill of a controlled substance, Respondent told Patient 2 he would post-dated the prescription for October 31, 2016.

49. Patient 2 told Respondent that he had been undergoing additional stress for approximately one week and that his mother had given him Xanax that helped him with the stress of midterms. Consequently, Patient 2 asked Respondent if he could

prescribe him a months' supply of Xanax, 2 mg. Respondent replied, "That's harder. Right now, the CDC is monitoring controlled substances and, unfortunately, two of those are Norco and Xanax, and a lot of pharmacies won't fill them anymore. So, I've had several phone calls from pharmacies, saying we won't give your patients oxycodone, Norco, Xanax and Soma." Patient 2 then asked for a smaller dosage of Xanax—1 mg. instead of 2 mg. Respondent agreed.

50. Respondent wrote Patient 2 prescription number 351 for 60 pills of 10/325 Norco and 30 pills of 1 mg. Xanax, post-dating the prescription to October 31, 2016. Patient 2 then asked Respondent for Adderall, but Respondent declined.

51. Respondent performed no examination of Patient 2, documented no treatment plan in Patient 2's chart, and noted nothing about Patient 2 receiving Xanax from his mother, seeking an early refill of Norco, or requesting Adderall.

Conclusion of VCIPCU Investigation

52. In November 2016, VCIPCU compiled its audio and video recordings of the five controlled buys involving Patient 1 and Patient 2, as well as Respondent's Controlled Substance Utilization Review and Evaluation System (CURES)[3] prescriber history, and consulted Timothy Munzing, M.D.[4] to conduct an analysis and render an expert opinion as to whether Respondent's prescribing practices fell within the

[3] Supervising Investigator Marc Gonzalez of the Board testified at hearing and explained that the Board uses CURES reports as guidance to determine whether physicians prescribe controlled substances for legitimate medical purposes, among other things. Mr. Gonzalez obtained the CURES reports for Patient 1, Patient 3, and Patient 4 (Exhibits 23, 24, and 25).

[4] Dr. Munzing's credentials are discussed in more detail below.

standard of care and within the law. Dr. Munzing submitted a written report to VCIPCU, concluding Respondent acted outside the normal scope of practice and his actions rose to the level of felonious activity. He stated the following:

> I believe [Respondent's] manner of prescribing controlled substances to some of his patients is so far out of the scope of normal practice that it amounts to reckless conduct and is without legitimate medical purpose.

(Exhibit 9, p. 000025.)

53. In addition to Patient 1 and Patient 2, Dr. Munzing, after reviewing Respondent's CURES reports, identified two other patients who he believed could be diverting drugs, Patient 3 and Patient 4.

54. VCIPCU obtained a search warrant to obtain from Biocare the medical records of Patient 1, Patient 2, Patient 3, and Patient 4, carbon copies of prescriptions, blank prescription forms, and other documents.

55. VCIPCU arrested Respondent on December 22, 2016, and referred the case to the Ventura County District Attorney. VCIPCU recommended that Respondent be charged with violating Health and Safety Code sections 11153, subdivision (a), (issuing prescriptions for controlled substances without a legitimate medical purpose), and 11352, subdivision (a), (illegal sale of narcotics). Respondent surrendered his Drug Enforcement Administration (DEA) registration[5] on the day of his arrest.

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[5] DEA registration is required for persons "engaged in" the "dispens[ing] . . . of any controlled substance." (21 CFR 1301.11(a))

56. The Ventura County District Attorney later dismissed the case against Respondent, and referred the matter to the Board to initiate disciplinary proceedings.

Patient 3

57. Patient 3, a male who was approximately 32-years-old at the time, became Respondent's patient at Biocare in approximately May of 2015. At that time, Patient 3 complained of mid and low back pain stemming from lumbar strain and a herniated disk sustained in a car accident six years prior. He also complained of low energy and low sex drive. Patient 3 indicated he exercised five days per week and denied using drugs and alcohol. He indicated that he had a prior diagnosis of Attention Deficit Disorder (ADD) for which he was being prescribed medication by Dr. William Vicary, a psychiatrist.

58. On June 1, 2015, Patient 3 enrolled in Biocare's Concierge Program. Respondent diagnosed Patient 3 with hypogonadism and placed him on testosterone supplementation therapy starting on May 1, 2015. Respondent documented in his probation-mandated prescribing record that he prescribed testosterone cypionate to Patient 3 on May 1, 2015. He made no further entries about dispensing or prescribing testosterone to Patient 3 in his probation-mandated separate prescribing record.

59. On or about October 23, 2015, Respondent saw Patient 3 and documented a review of laboratory results. Patient 3 expressed that he felt "great" and was gaining muscle. Patient 3 denied symptoms of side effects of testosterone therapy and was progressing well. Respondent indicated that Patient 3 was alert and oriented as to place, time and person, was well-groomed and that his gait was normal. He also noted that Patient 3 displayed an increase in muscle mass. Respondent's plan was to continue with hormone supplementation and to follow up in four to six weeks.

60. On July 11, 2016, Respondent saw Patient 3. Respondent documented a review of laboratory results. Patient 3 expressed that he felt "great" and was gaining muscle. Patient 3 denied symptoms of side effects of testosterone therapy and was progressing well. Respondent's plan was to continue with hormone supplementation and to follow up in four to six weeks, and to repeat labs in six months.

61. Respondent made no additional progress notes for Patient 3, and did not document any other examination or indication for prescribing controlled substances to Patient 3. Respondent did not document any additional prescriptions in Patient 3's chart, and made no further entries into Respondent's probation-mandated separate prescribing record. Respondent never documented a treatment plan for Patient 3's pain, a physical examination to justify prescriptions of controlled substances, or any indication for prescribing controlled substances to Patient 3.

62. On or about December 7, 2015, Patient 3 filled prescriptions for 240 pills of 325/10 Norco, 60 pills of 30 mg Adderall, 120 pills of 350 mg carisoprodol, and 180 pills of 30 mg oxycodone, written to him by Respondent. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record, or in Patient 3's chart.

63. On January 4, 2016, Patient 3 filled prescriptions for 150 pills of 325/10 Norco, 120 pills of 350 mg Carisoprodol, and 180 pills of 30 mg oxycodone, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

64. On February 2, 2016, Patient 3 filled prescriptions for 60 pills of 10 mg zolpidem tartrate, 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, 150

pills of 325/10 Norco, 60 pills of 2 mg alprazolam, and 120 pills of 30 mg amphetamine salt combo, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

65. On March 1, 2016, Patient 3 filled prescriptions for 60 pills of 10 mg zolpidem tartrate, 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, 150 pills of 325/10 Norco, and 60 pills of 2 mg alprazolam, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

66. On April 1, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, and 180 pills of 325/10 Norco, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

67. On May 2, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, 180 pills of 325/10 Norco, and 120 pills of 30 mg amphetamine salt combo, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

68. On May 28, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, and 150 pills of 325/10 Norco, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

69. On June 24, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, and 150 pills of 325/10 Norco, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

70. On July 18, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, written to him by Respondent. Respondent did not document this prescription, or reasons for it, in his probation-mandated separate prescribing record or in Patient 3's chart.

71. On July 22, 2016, Patient 3 filled prescriptions for 180 pills of 350 mg carisoprodol, as well as 180 pills of 30 mg oxycodone, 180 pills of 325/10 Norco, and 90 pills of 2 mg clonazepam, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

72. On August 18, 2016, Patient 3 filled a prescription for 180 pills of 350 mg carisoprodol, prescribed to him by Respondent. Respondent did not document this prescription, or reasons for it, in his probation-mandated separate prescribing record or in Patient 3's chart.

73. On August 24 and 25, 2016, Patient 3 filled prescriptions for 180 pills of 350 mg carisoprodol, 180 pills of 325/10 Norco, and 90 pills of 2 mg clonazepam, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

74. On September 16, 2016, Patient 3 filled prescriptions for 120 pills of 325/10 Norco, 120 pills of 30 mg oxycodone, 180 pills of carisoprodol, and 10 vials of 200 mg/l depo-testosterone oil, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

75. On October 21, 2016, Patient 3 filled prescriptions for 120 pills of 325/10 Norco, and 120 pills of 30 mg oxycodone, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

76. On November 5, 2016, Patient 3 filled prescriptions for 30 pills of 150 mg armodafinil and 10 vials of depo-testosterone 200 mg/1 ml oil, written to him by Respondent. Respondent documented none of these prescriptions, or reasons for them, in his probation-mandated separate prescribing record or in Patient 3's chart.

Patient 4

77. Patient 4, a male who was approximately 41-years-old at the time, first saw Respondent at Biocare on May 1, 2015. At that time, Patient 4 complained of severe neck pain and numbness radiating to his right arm. Patient 4 indicated he was suffering from fatigue and low energy, feelings of hopelessness and lack of motivation, changes in mood with anxiety and/or depression, diminished strength and exercise tolerance, and poor sleep. Patient 4 reported a history of lower back surgeries in 1997 and 2009, and surgeries on his left knee in 1997 and left ankle in 1987. Patient 4 stated that he exercised four to five days per week. On May 1, 2015, Patient 4 signed informed consent for testosterone replacement therapy, and provided a blood sample.

78. On May 8, 2015, Patient 4 enrolled in Biocare's Concierge Program. Respondent took Patient 4's history, and noted a complaint of a pinched nerve with severe and constant neck and right upper back pain with radicular symptoms to the fourth and fifth fingers of Patient 4's right hand, with intermittent numbness, weakness, and tingling radiating from Patient 4's upper arm to his hand. Respondent also noted a past medical history of ADD, and that Patient 4 was taking Vyvance and Lamictal. Respondent noted that Patient 4 practiced jiu-jitsu four to five times per week. Respondent noted he performed a physical examination that revealed reduced range of motion in Patient 4's neck, and reduced sensation and motor reflexes in Patient 4's right arm. Respondent assessed Patient 4 with hypogonadism and cervical radiculitis/radiculopathy and myofascial pain syndrome/muscle spasm. Respondent's plan was to begin Patient 4 on hormone supplementation with testosterone, perform a cervical spine MRI, continue Lamictal, complete a trial of Neurontin, continue Medrol, and prescribe oxycodone as needed for pain. Respondent also planned to consider performing Botox injections into Patient 4's right trapezius, and consider chiropractic and massage therapy. On May 8, 2015, Respondent prescribed, on prescription number 168, a copy of which he retained in Patient 4's chart, 60 pills of 15 mg oxycodone, Neurontin, and Medrol, and noted the prescription of oxycodone in his probation-mandated prescribing record.

79. On May 22, 2015, Respondent noted that he educated Patient 4 on the injection technique and that Patient 4 elected to proceed with a testosterone injection plan at home. Respondent did not note testosterone prescriptions to Patient 4 in Respondent's probation-mandated separate prescribing record. Respondent documented no treatment plan to address Patient 4's pain.

80. On July 10, 2015, a chiropractor evaluated Patient 4 and noted Patient 4 had intermittent, achy, stiff, and radiating pain on the right side of Patient 4, which resulted from Patient 4's jiu-jitsu training or sleeping positions. On July 13, 2015, Respondent wrote prescription number 1, a copy of which he retained in the Patient 4's chart, for 60 pills of 15 mg oxycodone, and also for Neurontin, without obtaining, performing and/or documenting any further history or examination in Patient 4's medical chart. Respondent did not document this prescription in his probation-mandated separate prescribing record.

81. On August 7, 2015, Respondent conducted a telephonic interview with Patient 4. Patient 4 complained of continued pain and tingling, and reported that oxycodone provided inadequate pain relief. Patient 4 reported an eight-pound weight gain since commencing hormone therapy of testosterone. Respondent noted a review of Patient 4's cervical spine MRI, and assessed Patient 4 with cervical degenerative disk disease. Respondent noted he planned to discontinue Patient 4's oxycodone and begin him on Norco. Respondent issued prescription number 52 to Patient 4, a copy of which he retained in Patient 4's chart, for 60 pills of 10/325 Norco. Respondent did not document this prescription in his probation-mandated prescribing record.

82. Respondent noted a follow-up visit with Patient 4 on October 2, 2015. Patient 4 reported participating in a jiu-jitsu tournament and feeling better on hormone supplementation with reduced recovery time after workouts and increased strength. Patient 4 continued to complain of neck pain, but Respondent documented no treatment plan. Respondent issued prescription number 63, a copy of which he retained in Patient 4's chart, for 60 pills of 15 mg oxycodone and for Medrol. Respondent did not document this prescription in his probation-mandated prescribing record.

83. On October 16, 2015, Respondent issued prescription number 70, a copy of which he retained Patient 4's chart, for 90 pills of 15 mg oxycodone, with no corresponding chart entry, and without documenting this prescription in his probation-mandated separate prescribing record.

84. On November 2, 2015, Respondent saw Patient 4 and noted Patient 4 reported he felt better on testosterone and Sermorelin, and denied side effects of testosterone therapy. Respondent increased the dose of testosterone. Respondent documented that Patient 4's cervical radiculopathy was stable. Respondent did not contemplate or document a treatment plan for Patient 4's pain. Respondent issued prescription number 73 for 100 pills of 10/325 Norco, a copy of which he retained in the Patient 4 's chart. Respondent did not document this prescription in his probation-mandated prescribing record.

85. On November 23, 2015, even though he previously wrote that he would discontinue oxycodone for Patient 4 because it was not effective, Respondent issued prescription number 81, a copy of which he retained in Patient 4's chart, for 90 pills of 5/325 Percocet, and also for Medrol. Respondent made no chart entry, did not document the reason for this change back to oxycodone-based medication, and did not document an examination of Patient 4. Respondent did no00+t document this prescription in his probation-mandated prescribing record.

86. On December 7, 2015, Respondent issued prescription number 86, a copy of which he retained in Patient 4's chart, for 90 pills of 10/325 Norco. Respondent made no corresponding chart entry and made no note of examination of Patient 4. Respondent did not document this prescription in his probation-mandated prescribing record.

87. On December 21, 2015, Respondent issued prescription number 120, a copy of which he retained in Patient 4's chart, for 90 pills of 5/325 Percocet. Respondent made no corresponding chart entry and made no note of examination of Patient 4. Respondent did not document this prescription in his probation-mandated prescribing record.

88. On January 11, 2016, Respondent issued prescription number 135, a copy of which he retained in Patient 4's chart, for 120 pills of 10/325 Norco. Respondent made no corresponding chart entry and made no note of the examination of Patient 4. Respondent did not document this prescription in his probation-mandated prescribing record.

89. On February 1, 2016, Respondent issued prescription number 302, a copy of which he retained in Patient 4's chart, for 90 pills of 5/325 Percocet. Respondent made no corresponding chart entry and made no note of the examination of Patient 4. Respondent did not document this prescription in his probation-mandated prescribing record.

90. On February 22, 2016, Respondent issued prescription number 455, a copy of which he retained in Patient 4's chart, for 120 pills of 10/325 Norco. Respondent made no corresponding chart entry and made no note of examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

91. On February 29, 2016, Respondent issued prescription number 457, a copy of which he retained in Patient 4's chart, for 90 pills of 5/325 Percocet. Respondent made no corresponding chart entry and made no note of the examination

of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

92. On March 14, 2016, Patient 4 filled a prescription for 90 pills of Percocet, written to him by Respondent. On April 22, 2016, Patient 4 filled a prescription for 90 pills of Percocet written to him by Respondent. On May 2, 2016, Patient 4 filled another prescription for 180 pills of Percocet, written to him by Respondent.

93. On May 16, 2016, Respondent documented that Patient 4 reported a recent increase in life stresses and anxiety associated with his mother's health, as well as professionally, and with his children. Respondent documented that Patient 4 did not drink alcohol and did not use recreational or illegal drugs. Respondent wrote prescription number 51, and retained a copy of it in Patient 4's chart, for 120 pills of .25 mg Xanax, with a plan to follow up in two weeks. Respondent did not document this prescription in his Respondent's probation-mandated prescribing record.

94. On June 13, 2016, Respondent prescribed 120 pills of 10/325 Norco to Patient 4, without a corresponding chart note. Respondent noted in his probation-mandated prescribing record that this prescription was due to acute exacerbation of the right shoulder pain secondary to the diagnosis of severe osteoarthritis of Patient 4's right shoulder.

95. On June 27, 2016, Patient 4 filled another prescription for 120 pills of Percocet, written to him by Respondent. Respondent failed to make any corresponding chart entry documenting an examination or indication for this prescription and no corresponding entry in Respondent's probation-mandated prescribing record.

Medical Expert Testimony of Dr. Timothy A. Munzing

96. The Board retained Dr. Munzing to conduct a medical expert review in this matter regarding Patient 1, Patient 2, Patient 3, and Patient 4. Specifically, the Board requested Dr. Munzing reviewed the following: (1) law enforcement reports summarizing the three undercover visits (i.e., controlled buys) made by Patient 1, and the two undercover visits made by Patient 2; (2) law enforcement undercover audio-recordings of the three undercover visits made by Patient 1, and the two undercover visits of Patient 2; (3) audio-recordings of debriefing sessions with Patient 1 and Patient 2 regarding the undercover visits; (4) video-recordings of Patient 2 of his October 3, 2016 visit; (5) CURES report of Respondent's prescribing of controlled substances from November 2015 through November 2016; (6) the Board's online documents for Respondent (i.e., Department of Consumer Affairs Breeze); (7) Patient 1's medical records; (8) CURES report regarding Patient 1; (9) Patient 2's medical records; (10) Patient 3's medical records; (11) CURES report regarding Patient 3; (12) Patient 4's medical records; and (13) CURES report regarding Patient 4.

97. Dr. Munzing prepared a written report on November 21, 2016 outlining his conclusions and expert opinion based on his review of items 1 through 6 above. He prepared an addendum on January 17, 2018 after his receipt and review of medical records for Patient 1 and Patient 2, and a CURES report for Patient 1. Dr. Munzing prepared a second addendum on June 3, 2019 after his receipt and review of medical records and CURES reports for Patient 3 and Patient 4.

98. Dr. Munzing, who testified at hearing, is a family medicine physician at Southern California Permanente Medical Group (Kaiser Permanente), and has served in that capacity since 1985. He earned his bachelor's degree in biochemistry from California State University at Fullerton in 1978, his doctor of medicine degree from the University of California at Los Angeles in 1982, and completed his internship and residency in family practice at Kaiser Permanente from 1982 to June 1985. Dr. Munzing has been certified since 1985 by the American Board of Family Practice and, since 1988, as a fellow by the American Academy of Family Physicians.

99. Dr. Munzing is not board-certified in pain management, as family practitioners are not permitted to officially specialize in pain management; however, family practitioners are permitted to treat for acute and chronic pain, and, as such, are typically well-versed in pain management. Dr. Munzing has treated thousands of patients for acute and chronic pain.

100. Dr. Munzing has authored at least eight published articles, including the peer-reviewed article entitled *Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain*, published in the Permanente Journal in May 2017. The article addresses the guidelines and the standard of care for prescribing opioids.

101. Dr. Munzing has lectured extensively to physicians, including general practitioners, on the topics of chronic pain, pain management, opioid prescribing, and overprescribing. He has also lectured at DEA trainings, National Association of Drug Diversion Investigators (NADDI) trainings, Department of Justice trainings, and at other law enforcement agencies regarding opioid prescribing and overprescribing.

102. Dr. Munzing has been performing peer reviews for a number of years, in which he reviews the quality of care delivered by other physicians. Respondent has

served as a medical expert reviewer for the Board since 2004, and as a medical expert reviewer consultant with the DEA's Tactical Diversion Squad since 2014. Dr. Munzing has testified in approximately 15 Board matters, and has been asked to provide expert opinion in federal cases regarding the prescribing of controlled substances. Additionally, he has served as an expert in 15 to 20 criminal cases involving the prescribing of opioid medications.

STANDARD OF CARE

103. Dr. Munzing explained that, as a general matter, the overarching standard of care constitutes what another competent physician would reasonably do under similar circumstances.

104. The standard of care for prescribing controlled substance medications, particularly for pain management, requires that the physician substantially comply with the guidelines published by the Board, and applicable State and Federal laws regulating the prescribing of controlled substances. The standard of care also requires that the physician obtain a medical history of the patient, including an assessment of the pain, physical and psychological function, substance abuse history, history of prior pain treatment, assessment of underlying or coexisting diseases or conditions, and a documented presence of recognized medical indication for the use of a controlled substance.

105. Dr. Munzing explained that after obtaining a medical history, the standard of care requires the physician to perform a physical examination, including taking vital signs, listening to the patient's heart and lungs, taking the patient's pulse, looking for swelling or redness or masses, palpating the affected area, and observing the range of motion, among other things. Dr. Munzing further explained that

performing a physical examination is necessary prior to prescribing or furnishing a dangerous drug, and controlled substances constitute dangerous drugs. Dr. Munzing cited Business and Professions Code section 2242, subdivision (a), which provides that furnishing dangerous drugs without an appropriate prior examination and medical indication, constitutes unprofessional conduct.

106. Thereafter, the standard of care requires the physician to develop a treatment plan for the patient. The treatment plan should state objectives by which the treatment plan will be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

107. When prescribing controlled substances, the standard of care also requires informed consent. Specifically, the physician must discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient. Dr. Munzing explained that written consent or a pain agreement for chronic use is not required, but may make it easier for the physician to document patient education, the treatment plan, and the informed consent.

108. The standard of care requires the physician to periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of heath. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the

physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

109. Dr. Munzing further explained that the standard of care requires the physician to consider referring the patient, as necessary, for additional evaluation and treatment to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist. Physicians should also give special attention to those pain patients who are at risk for misusing their medications, including those whose living arrangements pose a risk for medication misuse or diversion.

110. The standard of care also requires the physician to keep accurate and complete records, including the medical history, physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan. Dr. Munzing explained that pain levels, levels of function, quality of life, subjective complaints, and objective findings by the physician should be documented.

111. The State of California now requires physicians to check CURES reports when they first prescribe controlled substances, and every four months thereafter. At the time Respondent treated Patient 1, Patient 2, Patient 3, and Patient 4, this requirement was not in effect.

112. In 2016, the Centers for Disease Control and Prevention issued guidelines against prescribing a combination of dangerous drugs, such as opioids and benzodiazepines, as they have been shown to increase the likelihood of overdose and death.

PATIENT 1 (UNDERCOVER VISITS)

113. Dr. Munzing noted a number of concerns regarding Respondent's care and treatment of Patient 1 during the three times Patient 1 visited Respondent in connection with law enforcement's undercover operation. Specifically, Respondent provided prescriptions for controlled substances at each visit, specifically opioids, even though no opiates were indicated. At no time did Respondent obtain an adequate and sufficient history, document information clarifying Patient 1's medical problems, or perform a physical examination or take any vital signs. When Patient 1 asked for medications, Respondent readily agreed, even asking the amount and strength Patient 1 wanted. Additionally, Respondent never documented discussing the specific risks of the controlled substance medications (i.e., opioids, benzodiazepines, etc.), and never documented treatment goals or functional assessment. Moreover, Respondent failed to consider other non-controlled medications as alternative therapies, failed to engage in medication monitoring (i.e., urine drug screens or obtaining CURES reports), failed to document anything about Patient 1's anxiety or mental health despite prescribing Alprazolam, and failed to avoid prescribing Patient 1 a dangerous combination of drugs (i.e., opioids and benzodiazepines).

114. Dr. Munzing concluded that during the three visits, Respondent's actions and inactions were egregious, he prescribed based on Patient 1's requests instead of a medically justified need, he potentially put Patient 1 at risk for diversion, overdose, or death, and his management of Patient 1's visits was "far outside the bounds of standard of care." (Exhibit 32, p. 000044.)

115. Dr. Munzing further concluded the care provided by Respondent was "dangerous and reckless" and his prescribing of controlled medications to Patient 1 constituted extreme departures from the standard of care. He also concluded

Respondent prescribed controlled substances to Patient 1 without a legitimate medical purpose.

116. Dr. Munzing also concluded that Respondent's failure to obtain a medical history or perform an examination on Patient 1 constituted an extreme departure from the standard of care, as well as his failure to discuss informed consent with Patient 1.

PATIENT 1 (MEDICAL RECORDS REVIEW)

117. Dr. Munzing reviewed the medical records of Patient 1, and noted a number of irregularities committed by Respondent. Specifically, during Patient 1's May 24, 2016 visit to Biocare, in which Patient 1 picked up from the front desk a prescription written by Respondent for oxycodone and Adderall, without seeing Respondent or undergoing a medical examination, neither Respondent nor anyone else from Biocare created a medical record for Patient 1's visit. Dr. Munzing also noted that the prescription written by Respondent was pre-dated April 19, 2016, and not May 24, 2016.

118. Dr. Munzing also noted that prior progress notes for Patient 1 revealed no medical justification for Norco, oxycodone, or Adderall. While Respondent stated in a May 10, 2016 Blue Cross/Blue Shield Adderall Authorization request form that he wished to prescribe Adderall to Patient 1, as needed for sedation for "shift work patient sleep disorder," Dr. Munzing noted Respondent documented nothing in Patient 1's medical charts showing that "shift work patient sleep disorder" was evaluated. (Ex. 32, p. 000055.)

119. In regard to Patient 1's June 6, 2016 visit with Respondent, in which Respondent prescribed Norco and Xanax, Dr. Munzing noted Respondent falsified Patient 1's medical chart by documenting an examination that never occurred, as

evidenced by law enforcement's recording of the June 6, 2016 visit. Additionally, Patient 1 requested Xanax due to work stress, but Respondent failed to include anything in Patient 1's medical charts evidencing he obtained Patient 1's history regarding the stress, performed an examination, or conducted an evaluation. Moreover, Respondent did not recognize that he had already prescribed Norco to Patient 1 fewer than two weeks prior. Finally, Dr. Munzing noted that the progress notes of June 6, 2016 provided no justification for Respondent to prescribe Norco or Xanax to Patient 1.

120. In regard to Patient 1's August 29, 2016 visit with Respondent, in which Respondent prescribed Norco, Oxycodone, and Xanax, Dr. Munzing noted the progress note lacked a large amount of required information when prescribing controlled substance medications, such as a detailed history, a detailed examination, and informed consent, among other things. Dr. Munzing also noted that the examination that was documented was falsified, as the audio recording did not include evidence of an examination performed during the August 29, 2016 visit. Dr. Munzing concluded that the progress notes of August 29, 2016 provided no justification for Respondent to prescribe Norco or Xanax to Patient 1.

PATIENT 2 (UNDERCOVER VISITS)

121. Dr. Munzing noted a number of concerns regarding Respondent's care and treatment of Patient 2 during the two times Patient 2 visited Respondent in connection with law enforcement's undercover operation. Specifically, Respondent provided prescriptions for controlled substances at each visit, specifically opioids, even though no opiates were indicated. At no time did Respondent obtain an adequate and sufficient history, document information clarifying Patient 2's medical problems and how they were addressed with controlled substance medications, perform a physical

examination, or take any vital signs. When Patient 2 asked for medications, Respondent readily agreed, even asking the amount and strength Patient 2 wanted. Additionally, Respondent never documented discussing the specific risks of the controlled substance medications (i.e., opioids, benzodiazepines, etc.), and never documented treatment goals or functional assessment. Moreover, Respondent failed to consider other non-controlled medications as alternative therapies, and failed to engage in medication monitoring (i.e., urine drug screens or obtaining CURES reports).

122. Dr. Munzing concluded that during the two visits, Respondent's actions and inactions were egregious, he prescribed based on Patient 2's requests instead of a medically justified need, and he potentially put Patient 2 at risk for diversion, overdose, or death.

123. Dr. Munzing further concluded the care provided by Respondent was "dangerous and reckless" and his prescribing of controlled medications to Patient 2 constituted extreme departures from the standard of care. He also concluded Respondent prescribed controlled substances to Patient 2 without a legitimate medical purpose.

124. Dr. Munzing also concluded that Respondent's failure to obtain a medical history or perform an examination on Patient 2 constituted an extreme departure from the standard of care, and also concluded his failure to discuss informed consent with Patient 2 constituted an extreme departure from the standard of care. Dr. Munzing also concluded that Respondent's prescribing of benzodiazepine to Patient 2 without any evaluation and management of anxiety constituted an extreme departure from the standard of care.

PATIENT 2 (MEDICAL RECORDS REVIEW)

125. Dr. Munzing reviewed the medical records of Patient 2, and noted a number of irregularities committed by Respondent. Specifically, during Patient 2's October 3, 2016 visit with Respondent, in which Respondent prescribed Norco, Respondent failed to include required information necessary when prescribing controlled substance medications, such as history, a detailed examination, and informed consent, among other things. Additionally, Respondent falsified Patient 2's medical records when he documented a shoulder examination that never happened, evidenced by the audio recording of the visit.

126. Dr. Munzing also noted Respondent did not consider safer pain management alternatives, such as non-steroid anti-inflammatory medication (e.g., ibuprofen, aspirin, Naprosyn, etc.), physical therapy, or heat, and considered no safer alternative to the management of stress.

127. Dr. Munzing concluded that, based on the recording and progress notes for Patient 2, Respondent had no medical justification for prescribing Norco or Xanax.

PATIENT 3

128. Dr. Munzing reviewed the medical records of Patient 3 and noted a number of irregularities. Specifically, on May 1, 2015, Patient 3 saw Respondent, and reported a history of ADD, as well as treatment from Psychiatrist Vicary, but the medical chart revealed no additional history obtained by Respondent. Additionally, Respondent listed Patient 3's medications as oxycodone, Soma, Strattera, gabapentin, human growth hormone (HGH), Levothyroxine (thyroid medication), and Cymbalta, but performed no physical examination and included no assessment or information about pain treatment.

129. On October 23, 2015, Patient 3 returned to see Respondent, and reported that he felt "great" and was gaining muscle. (Exhibit 32, p. 000084.) Respondent performed a minimal examination, and noted Patient 3 was well-groomed, had increased muscle mass, and that his gait was within normal limits. Respondent mentioned nothing about pain or controlled substance medications.

130. On July 11, 2016, Patient 3 returned to see Respondent and reported that he felt "great." (Exhibit 32, p. 000085.) Respondent performed a minimal examination. Respondent did not list in the medical chart that he had prescribed Patient 3 hydrocodone, Soma (i.e., muscle relaxant), clonazepam (i.e., benzodiazepine), and oxycodone, but the CURES reported indicated he had.

131. Dr. Munzing concluded Respondent engaged in multiple departures from the standard of care, and prescribed controlled substances without a legitimate medical purpose. Specifically, Respondent prescribed opioid medications without medical justification and without appropriate monitoring, which constituted an extreme departure from the standard of care. Additionally, Respondent prescribed and refilled opioids without an appropriate prior examination, which constituted an extreme departure from the standard of care. Respondent also prescribed the "holy trinity" combination of dangerous drugs (i.e., benzodiazepines, opioids, and muscle relaxants), which was especially dangerous because each of those medications depresses the central nervous system and a person's ability to breathe, and he did so without medical justification and without appropriate monitoring. Such conduct constituted an extreme departure from the standard of care. Moreover, Respondent prescribed a combination of dangerous combination of opioids and benzodiazepines without medical justification, and without appropriate monitoring, which constituted an extreme departure from the standard of care. Finally, Respondent prescribed

stimulant medications without medical evaluation or justification, and without appropriate monitoring, which constituted a departure from the standard of care.

PATIENT 4

132. Dr. Munzing reviewed the medical records of Patient 4 and noted a number of irregularities. Specifically, during Patient 4's May 8, 2015 visit with Respondent, Patient 4 presented "feeling fatigued, hopeless, decreased motivation, mood changes and anxiety," and also "complained of neck pain . . . [with] numbness in the right arm"(Exhibit 32, p. 000070), and while Respondent performed an examination and diagnosed Patient 4 with cervical radiculitis, radiculopathy, myofascial pain syndrome, and muscle spasm, Respondent prescribed Neurontin, oxycodone, Medrol dosepak (steroid), and Lamictal without discussing the specific risks of opioids.

133. Patient 4 returned to see Respondent on July 10, 2015, and complained of neck pain and right finger numbness. Patient 4 reported that he had a prior MRI showing a L4-5 laminectomy, but there was no copy of the MRI report in Patient 4's records. Despite this, Respondent performed no examination of Patient 4.

134. On August 7, 2015, Patient 4 left a telephone message for Respondent stating that he was experiencing tingling in his right upper extremity and the oxycodone was giving him "poor improvement." (Exhibit 32, p. 000071.) Respondent discontinued Patient 4's oxycodone, and prescribed Norco. Patient 4 returned to see Respondent on October 2, 2015 and complained of "intermittent, chronic, recurrent" neck pain, and had participated in a jujitsu tournament when his neck flared. Respondent prescribed Medrol dosepak (steroid), oxycodone, and other medications, after discontinuing oxycodone for not addressing Patient 4's pain adequately.

135. Patient 4 returned to see Respondent on May 16, 2016 and complained of increased stress and anxiety, due to the illness of his mother. Respondent conducted no physical examination. He diagnosed Patient 4 with anxiety and prescribed Xanax.

136. Dr. Munzing concluded Respondent prescribed many controlled substance medications to Patient 4, that were popular for abuse and/or diversion, and included combinations that put Patient 4 at higher risk for harm. Also, Dr. Munzing concluded Respondent failed to perform an appropriate exam, and the records included minimal and inadequate information. Specifically, the records lacked a detailed mental health history, lacked exploration of current and past drug and alcohol issues, and lacked confirmation of a discussion of the specific risks of opioids and combinations, including addiction, overdose, and death.

137. Mr. Munzing concluded that Respondent's care of Patient 4 was dangerous, and his prescribing of controlled substances included multiple departures from the standard of care, and were without a legitimate medical purpose. Specifically, Dr. Munzing concluded Respondent prescribed opioid medications without medical justification and without appropriate monitoring, which constituted an extreme departure from the standard of care. Moreover, Respondent's prescribing and refilling opioids without an appropriate prior examination, constituted an extreme departure from the standard of care. Finally, Respondent's prescribing a combination of drugs without medical justification and without appropriate monitoring constituted an extreme departure from the standard of care.

Probation Violations

138. Ruben Garcia has worked as a probation monitor in the Board's Probation Unit since 2012. Initially, Kevin Morris served as Respondent's probation monitor, but Mr. Garcia became Respondent's probation monitor shortly thereafter. Mr. Garcia testified at hearing.

139. It is the custom and practice of the Probation Unit to review the conditions of probation with a probationer during his/her first meeting, also known as an intake interview, with the assigned probation monitor. Mr. Morris held an intake interview with Respondent and explained the conditions of Respondent's probation, including Condition 12, which required a Board-approved practice monitor to oversee Respondent's practice; Condition 11, which required Respondent to maintain a controlled substance prescription log; Condition 14, which required the presence of a Board-approved third-party chaperone when Respondent consulted, examined, or treated female patients, and required him to maintain a chaperone log; Condition 4, which required Respondent to submit quarterly declarations, under penalty of perjury, disclosing his compliance with the conditions of his probation; and Condition 10, which required Respondent to pay, every year of probation, the costs associated with monitoring his probation.

140. Respondent failed to pay $2,361 in probation monitoring costs for 2014, $4,106 in probation monitoring costs for 2015, and $3,667 in probation monitoring costs for 2016. Consequently, on February 10, 2017, the Board issued a Citation and Order of Abatement for violating Condition 10. The Order of Abatement required Respondent to comply with all conditions of his probation and to pay the outstanding probation monitoring costs. Respondent remains in violation of the Order of Abatement.

141. On December 22, 2016, Respondent was arrested and charged with two felonies, in relation to his actions concerning Patient 1 and Patient 2. Respondent informed the Board that he had ceased practicing medicine on December 22, 2016, and submitted his quarterly declaration on January 27, 2017 for the fourth quarter of 2016, covering October 2016 through December 2016, in which he attested under penalty of perjury that he was not engaged in the practice of medicine.

142. Mr. Garcia explained at hearing that when a probationer ceases the practice of medicine, the probationer does not need a practice monitor during the period of non-practice, nor does the probationer need to maintain a controlled substance log or a third-party chaperone. However, the probationer is required to comply with all other conditions of probation during the period of non-practice.

143. Respondent continued to submit quarterly declarations to the Board, under penalty of perjury, attesting he was not practicing medicine. Specifically, he submitted quarterly declarations on April 27, 2017, July 7, 2017, October 10, 2017, January 8, 2018, April 9, 2018, July 11, 2018, October 5, 2018, January 9, 2019, April 10, 2019, and July 10, 2019. In his April 10, 2019 declaration, Respondent stated that he was seeking his DEA registration, which was pending. In his July 10, 2019 quarterly declaration, Respondent stated he had been offered a part-time position at Biocare in Redlands, to begin in mid to late July 2019, and provided Biocare's office number. However, Respondent continued to file quarterly declarations attesting he was not practicing medicine, specifically on October 9, 2019 and January 13, 2020.

144. Mr. Garcia ran a CURES report for the period of January 1, 2019 through March 1, 2020, to confirm Respondent's reported period of non-practice. The CURES report revealed Respondent had written hundreds of prescriptions for controlled substances in 2019, primarily hormonal medication (i.e., testosterone).

145. Mr. Garcia attempted to contact Respondent by telephone, but was unsuccessful. Mr. Garcia then contacted Biocare and spoke with the office manager, who confirmed Respondent had been practicing medicine at Biocare. Mr. Garcia later confirmed the same with Respondent, who confessed he had been practicing medicine, but elected not to alert the Probation Unit, because his financial hardship made it difficult to afford a practice monitor. Before his arrest, the University of California at San Diego's Probation Enhancement Program (PEP), which cost approximately $7,000 per quarter, had provided practice monitoring services to Respondent.

146. Respondent also admitted to Mr. Garcia that he saw female patients while practicing at Biocare, without the presence of a Board-approved third-party chaperone, and did not maintain a chaperone log. The CURES report showed Respondent had written prescriptions to at least three patients whose names are traditionally female. At hearing, Respondent explained that one of those names belonged to a man, one name belonged to his aunt, and one was an employee of Biocare.

147. On March 25, 2020, the Board issued a Cease Practice order for Respondent's failure to comply with Condition 12 of his probation (i.e., having a Board-approved practice monitor to oversee Respondent's practice). Respondent subsequently found a board-approved practice monitor, resulting in the Board issuing a Termination of Cease Practice order on June 4, 2020. Respondent also obtained a board-approved chaperone.

148. Respondent failed to pay $4,537 in probation monitoring costs for 2017, $4,749 in probation monitoring costs for 2018, and $4,969 in probation monitoring costs for 2019.

Respondent's Testimony

149. Respondent testified at hearing. He studied biochemistry at the University of California at Riverside (UC Riverside) and graduated in 1988. He graduated medical school in 1994 from the University of California at Davis (UC Davis). Respondent completed a one-year internship in general surgery in 1995, completed a three-year residency at UC Davis in 1998, and completed a pain fellowship at UC Davis in 1999. Respondent practiced as an anesthesiologist and "moonlighted" at various hospitals from 1998 through 1999 during his pain fellowship, and actively worked from 1995 through 2002.

150. Respondent practiced medicine for six years before he surrendered his license. When he returned to the practice of medicine, he encountered great difficulty in finding a job. After approximately two years, Respondent responded to an advertisement on Craig's List placed by a Biocare physician, who sought physicians to provide concierge medical services at his facility for first responders. Respondent explained that the first responder patients were active and motivated men and women who wanted to be healthier, and included a small population of chronic pain patients. Respondent began working at Biocare in January 2015, one time per week, until his arrest in December 2016. While there, Respondent saw approximately 80 patients per month, and applied his knowledge and experience as an anesthesiologist to pain management.

151. Patient 1 reported to Respondent that he was a former Marine who had injured himself performing "helicopter jumps" during his stint in the service, and suffered chronic pain as a result. Patient 1 also wanted to lose weight before his wedding. Respondent explained that Patient 1 had undergone MRI scans, steroid injections in his joints, massage therapy, physical therapy, and more, to address his

chronic pain. Respondent saw him approximately one time per month "and seemed to be doing well," "showed no evidence of addiction or other problems," and "raised no red flags." At one time, Patient 1 requested a reduction in his opioid medication, which Respondent accommodated.

152. With respect to Patient 1's June 6, 2016 visit, Respondent acknowledged his chart notes were "a little scattered." Respondent felt he "had a relationship" with Patient 1, and had considered him a good patient who had been taking his medication as instructed. Consequently, when Patient 1 claimed to be experiencing stress on the job and had requested Xanax, Respondent felt comfortable accommodating him. Respondent "did not know [Patient 1] had gotten in trouble with the police for selling prescription drugs" prior to the June 6, 2016 visit.

153. Patient 2 reported to Respondent that he was a college student who wanted to join the fire academy. Respondent described Patient 2 as "very small," as he was five-feet, five-inches tall, and weighed approximately 110 pounds. Patient 2 also reported shoulder pain. Respondent believed he could help Patient 2 gain 15 pounds of muscle and could address his shoulder pain.

154. Respondent explained that Patient 2 committed verbally and in writing that he would participate in Biocare's program for a minimum of four months. As such, Respondent believed he would be able to monitor Patient 2. Because Respondent worked at Biocare only one time per week, he did not want Patient 2 to run out of medication and then wait for Respondent to return to Biocare the following week. Consequently, he post-dated a prescription for Patient 2 that Patient 2 could fill on or after the post-date.

155. Respondent explained that, in April 2007, he had completed a PACE course in prescribing medication, and believed that post-dating prescriptions was acceptable at that time. However, in November 2007, the law changed in the area of prescription-writing, but he was unable to apply the new laws, because he had surrendered his license and was unaware of the law-change. Respondent now understands that post-dating a prescription is wrong.

156. Patient 3 reported to Respondent that he was a body builder, worked in private security, and worked as a bounty hunter. Respondent acknowledged that he had prescribed Patient 3 high doses of opioids, but Patient 3 never came into Biocare intoxicated, never raised any red flags, and was highly functional.

157. Respondent described Patient 4 as a highly functional man who performed mixed martial arts, practiced jiu-jitsu, had high energy, and was "in phenomenal shape." Patient 4 was "very knowledgeable" and showed no signs of intoxication.

158. With respect to his controlled substances log, Respondent generally completed it at the end of the day. He had no explanation for why he did not log in his separate controlled substances log, all of the controlled substances he had prescribed.

159. Respondent disagrees with the conclusion he engaged in gross negligence. Respondent explained that his practice involved more than 300 people, fewer than 10 percent were opioid patients, and "some were prescribed medication in unconventional ways." Patient 1, Patient 2, Patient 3, and Patient 4 were "outliers," but "they were all chronic pain patients who were getting great care," and "they did not raise any red flags."

160. Respondent disagrees with the conclusion he engaged in repeated negligent acts, because "[he] knew the patients and knew what was happening in their lives, which is good medicine." Additionally, he did not introduce Patient 1, Patient 2, Patient 3, and Patient 4 to opioids, because all of them had been on opioids before, and "no one was close to being hurt."

161. Respondent initially disagreed with the conclusion his record-keeping was below standard in relation to Patient 1, Patient 2, Patient 3, and Patient 4, but later acknowledged "the record-keeping was bad."

162. Respondent disagrees with the conclusion he created false medical documents. Despite the allegation that he did not examine patients, but created medical records showing he had, Respondent contends such an allegation stems from "someone who does not understand the value of observing the patient without the patient not even knowing."

163. Respondent disagrees with the conclusion he prescribed controlled substances without an appropriate prior examination and medical indication, because the patients received a full-examination upon their first visit. Respondent disagrees with Dr. Munzing that he needed to check the patient's heart, lungs, and pulse before prescribing controlled substances, but that an appropriate examination could include observations only depending on the case.

164. Biocare rehired Respondent in mid-June 2019, working three times per month. To supplement his income in 2019, while working at Biocare, Respondent worked at a West Los Angeles clinic as a pain physician for approximately eight months, two days per week. Respondent did not alert the Board that he had procured employment at either facility. He prescribed controlled substances to approximately

three patients at the West Los Angeles clinic during his tenure there. The owner of the West Los Angeles clinic required the presence of chaperones when treating female patients, but they were not Board-approved.

Credibility Findings[6]

165. Dr. Munzing was a credible and persuasive witness, as he testified in a clear, comprehensive, and concise manner, and demonstrated his wealth of pertinent

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

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

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or

knowledge in the area of pain management and record keeping, buttressed by his more than 30 years of experience practicing family medicine, teaching and training medical students, and treating thousands of patients. Additionally, Dr. Munzing has demonstrated expertise in the area of opioids, evidenced by his numerous presentations and his peer-reviewed publication on the subject. Dr. Munzing's testimony was persuasive with respect to establishing what acts and performances fell within the standard of care, and how his review of the medical records established that Respondent failed to operate within the standard of care. Overall, Dr. Munzing's testimony was afforded great weight.

166. Respondent proffered no expert witnesses on his behalf. Rather, Respondent proffered percipient testimony regarding his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. As discussed in the Legal Conclusions below, Respondent's testimony was not persuasive in explaining how his care and treatment fell within the standard of care. While most of Respondent's testimony appeared truthful, particularly in the areas of uncontroverted facts, some of his testimony was incredible, particularly his testimony explaining he did not falsify the medical records of Patient 1 and Patient 2, when the audio-recorded evidence demonstrated he clearly did. As such, Respondent's testimony was not credited over that of other witnesses, and was afforded little relative weight overall.

167. The testimony of Micah Weilbacher, Marc Gonzalez, and Ruben Garcia were deemed credible, as they each testified a clear and straightforward manner, and no material dispute arose regarding the substance of their individual testimony.

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all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

LEGAL CONCLUSIONS

First Amended Accusation

APPLICABLE LAW

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

2. The purpose of the Medical Practice Act[7] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack

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

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

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

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

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

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

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

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

ANALYSIS

First Cause for Discipline (Gross Negligence)

9. Complainant successfully met her burden of establishing clearly and convincingly that Respondent engaged in gross negligence, in violation of Business and Professions Code section 2234, subdivision (b), in relation to his care and treatment of Patient 1 and Patient 2. Specifically, the evidence established, through the credible expert testimony of Dr. Munzing, that the manner in which Respondent prescribed controlled substances or dangerous drugs to Patient 1 and Patient 2 constituted an extreme departure from the standard of care, in that during the visits that were the subject of audiotaped and videotaped undercover operations by law enforcement, Respondent prescribed controlled substances based on Patient 1's and Patient 2's requests instead of on a medically justified need, which potentially put

Patient 1 and Patient 2 at risk for diversion, overdose, or death. Respondent also failed to obtain a medical history or perform an examination on Patient 1 and Patient 2 before prescribing controlled substances to them, as well as failed to discuss informed consent, which constituted extreme departures of the standard of care. Additionally, with respect to Patient 2, Respondent's prescribing of benzodiazepine without any evaluation and management of anxiety constituted an extreme departure from the standard of care. (Factual Findings 19 through 56; 96 through 127; and 165 through 167; Legal Conclusions 1 through 8.)

10. With respect to Patient 3 and Patient 4, the evidence showed, through the credible testimony of Dr. Munzing, that Respondent prescribed and refilled many controlled substance medications to Patient 3 and Patient 4 without a legitimate medical purpose, and without performing appropriate exams and without appropriate monitoring, constituting extreme departures from the standard of care. Additionally, the records included minimal and inadequate information, lacked a detailed mental health history, lacked exploration of current and past drug and alcohol issues, and lacked confirmation of a discussion of the specific risks of opioids and combinations, including addiction, overdose, and death, all constituting extreme departures from the standard of care. Additionally, with respect to Patient 4, the evidence showed, through the credible testimony of Dr. Munzing, that Respondent prescribed a combination of dangerous combination of opioids and benzodiazepines, as well as stimulant medications, without medical justification and without appropriate monitoring, which constituted extreme departures from the standard of care. (Factual Findings 57 through 112; 128 through 137; and 165 through 167; Legal Conclusions 1 through 8.)

11. Given the above, cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), for gross

negligence, in relation to Respondent's care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4.

Second Cause for Discipline (Repeated Negligent Acts)

12. In light of the multiple departures of the standard of care, as established in Legal Conclusions 1 through 11 above, Complainant successfully met her burden of establishing clearly and convincingly that Respondent engaged in repeated negligent acts, in violation of Business and Professions Code section 2234, subdivision (c), in relation to his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. (Factual Findings 19 through 167; Legal Conclusions 1 through 8.) As such, cause exists to discipline Respondent's certificate.

Third Cause for Discipline (Record Keeping)

13. In light of the multiple departures of the standard of care related to record keeping, as established in Legal Conclusions 1 through 11 above, Complainant successfully met her burden of establishing clearly and convincingly that Respondent failed to keep adequate and accurate records of his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4, in violation of Business and Professions Code section 2266. (Factual Findings 19 through 167; Legal Conclusions 1 through 8.) As such, cause exists to discipline Respondent's certificate.

Fourth Cause for Discipline (Creating False Medical Documents)

14. Complainant successfully met her burden of establishing clearly and convincingly that Respondent knowingly made false representations in the medical records of Patient 1 and Patient 2. Specifically, the evidence showed that Respondent

created a false medical record, dated June 6, 2016, regarding his care and treatment of Patient 1, by documenting a physical examination that did not occur. Additionally, the evidence showed Respondent created an inaccurate medical record in his probation-mandated separate prescribing record, with regard to his June 6, 2016 Norco prescription to Patient 1.

15. The evidence showed Respondent also created false medical records, dated August 29, 2016 and October 3, 2016, regarding his care and treatment of Patient 1 and Patient 2, respectively, by documenting physical examinations that did not occur.

16. Given the above, cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code section 2261, for creating false medical documents, in relation to Respondent's care and treatment of Patient 1 and Patient 2. (Factual Findings 19 through 167; Legal Conclusions 1 through 8.)

Fifth Cause for Discipline (Violation of Laws Regulating Controlled Substances)

17. In light of the multiple departures of the standard of care, as established in Legal Conclusions 1 through 11 above, Complainant successfully met her burden of establishing clearly and convincingly that Respondent violated laws regulating controlled substances, in violation of Business and Professions Code section 2238, in relation to his care and treatment of Patient 1, Patient 2, Patient 3, and Patient 4. (Factual Findings 19 through 167; Legal Conclusions 1 through 8.) Additionally, the evidence showed Respondent post-dated a prescription for a controlled substance issued to Patient 2. (Factual Finding 48 through 50.) Given these factors, cause exists to discipline Respondent's certificate.

Sixth Cause for Discipline (Acts of Dishonesty or Corruption)

18. In light of the multiple departures of the standard of care, as established in Legal Conclusions 1 through 11 above, Complainant successfully met her burden of establishing clearly and convincingly that Respondent committed acts of dishonesty or corruption that are substantially related to the qualifications, functions, or duties of a physician and surgeon. Additionally, the evidence showed Respondent informed the Probation Unit on December 22, 2016 that he ceased practicing medicine, and submitted quarterly declarations thereafter attesting, under penalty of perjury, he was not engaged in the practice of medicine. However, the evidence showed Respondent returned to the practice of medicine in June 2019, but continued to submit quarterly declarations to the Board attesting he was not practicing medicine. When confronted, Respondent admitted he purposely failed to disclose he had returned to the practice of medicine, because he did not want to be required to pay for a practice monitor. The record also established Respondent did not maintain a separate record of controlled substances he prescribed to patients during this period he hid his practice from the Board, and he did not maintain a chaperone log, even though Respondent admitted to treating female patients during this period. Given these factors, cause exists to discipline Respondent's certificate, as set forth in (Factual Findings 19 through 167; Legal Conclusions 1 through 8.).

APPROPRIATE LEVEL OF DISCIPLINE

19. Complainant seeks revocation of Respondent's license, given his multiple acts of unprofessional conduct, as described above, and his previous record of discipline. A review of the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* shows that revocation falls within the range of discipline,

particularly given Respondent's multiple acts of gross negligence and his multiple acts of dishonesty. Respondent provided no persuasive evidence, mitigating or otherwise, demonstrating that revocation is not warranted in this matter, and his brazen acts of deceit, primarily his misrepresentations to the Board, under penalty of perjury, that he was not practicing medicine, when, in reality, he was, does nothing to engender confidence that Respondent will not engage in misconduct again in the future. As such, the public would not be adequately protected if Respondent received probation, in lieu of revocation, for his repeated acts of misconduct.

Petition to Revoke Probation

20. Cause exists to revoke Respondent's probation and impose the stayed revocation of Respondent's certificate for failure to comply with Condition Number 3 of his probation, in that Respondent failed to obey all federal, state, and local laws and all rules governing the practice of medicine in California, as set forth in Factual Findings 8 through 18 and 138 through 148.

21. Cause exists to revoke Respondent's probation and impose the stayed revocation of Respondent's certificate for failure to comply with Condition Number 8 of his probation, in that Respondent failed to engage in the practice of medicine for more than two years, specifically from December 2016, when he left Biocare after his arrest, to June 2019, when he returned to Biocare, as set forth in Findings 8 through 18 and 138 through 148. 22. Cause exists to revoke Respondent's probation and impose the stayed revocation of Respondent's certificate for failure to comply with Condition Number 10 of his probation, in that Respondent failed to pay the costs associated with probation monitoring, as set forth in Findings 8 through 18 and 138 through 148.23.

Cause exists to revoke Respondent's probation and impose the stayed revocation of Respondent's certificate for failure to comply with Condition Number 11

of his probation, in that Respondent failed to maintain a separate log of all controlled substances he prescribed to his patients, as set forth in Findings 8 through 18 and 138 through 148.

24. Cause exists to revoke Respondent's probation and impose the stayed revocation of Respondent's certificate for failure to comply with Condition Number 12 of his probation, in that Respondent failed to have a Board-approved practice monitor during all periods of his practice of medicine, as set forth in Findings 8 through 18 and 138 through 148.

25. Cause exists to revoke Respondent's probation and impose the stayed revocation of Respondent's certificate for failure to comply with Condition Number 14 of his probation, in that Respondent failed to have a Board-approved third party chaperone present when he consulted, examined, or treated female patients, as set forth in Findings 8 through 18 and 138 through 148.

APPROPRIATE LEVEL OF DISCIPLINE

26. Respondent has been on probation since February 2013, and has violated the terms of probation in one manner or the other, nearly since its inception. Specifically, Respondent failed to pay probation monitoring costs as early as 2014, and has continued to fail to pay monitoring costs every year since. He also engaged in multiple acts of misconduct concerning his care and treatment of four patients, which began in 2015 and did not end until his arrest in December 2016. Additionally, and most egregious, Respondent lied repeatedly to the Board, under penalty of perjury, that he had not been practicing medicine, when he had.

27. The foregoing bodes poorly for Respondent's future compliance with and successful completion of his probation. Consequently, revocation is the only avenue at this time which would sufficiently protect the public health, safety and welfare.

ORDER

Physician's and Surgeon's Certificate Number A 60506, issued to Respondent, Paul Joseph Duran, M.D., is hereby revoked.

DATE: September 24, 2020

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: PAUL JOSEPH DURAN, M.D. 23246 Schoenborn St. West Hills, CA 91304 Physician's and Surgeon's Certificate A 60506, Respondent.	Case No. 800-2019-058673 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. Christine J. Lally (Complainant) brings this First Amended Accusation and Petition to Revoke Probation solely in her official capacity as the Interim Executive Director of the Medical Board of California (Board).

2. On June 28, 1996, the Board issued Physician's and Surgeon's Certificate Number A60506 to Paul Joseph Duran, M.D. (Respondent). Respondent surrendered his Physician's and Surgeon's Certificate on or about July 29, 2005, while Accusation number 06-2002-138792 was pending against him. On or about February 28, 2013, Respondent's Physician's and Surgeon's Certificate Number A60506 was reinstated and revoked, the revocation was stayed, and the Respondent's Certificate Number A60506 was placed on probation with various terms and

conditions, pursuant to the Board's Decision in case number 27-2011-217318. Respondent's Physician's and Surgeon's Certificate Number A60506 was in effect and subject to probation with various terms and conditions, at all times relevant to the charges brought herein. Respondent's Physician's and Surgeon's Certificate Number A60506 will expire on February 28, 2022, unless renewed.

JURISDICTION

3. This First Amended Accusation and Petition to Revoke Probation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code), at the time of the violations alleged herein, 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.

5. Section 2228 of the Code states:

> The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

6. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) 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) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

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

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

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

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

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

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

(e) Section 2314 shall not apply to this section.

7. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

negligent act.

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

(d) Incompetence.

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

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

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

8. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

9. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding the treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishingdangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

10. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

11. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

12. 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.

13. Health and Safety Code section 11172 states:

No person shall antedate or postdate a prescription.

14. At all times relevant to the allegations herein, Respondent's Physician and Surgeon's certificate was, and continues to be, revoked, with the revocation stayed and his certificate placed on probation, subject to probationary terms and conditions, including, but not limited to, the following:

Condition 3 of Respondent's probation provides:

Petitioner 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.

Condition 8 of Respondent's probation provides:

In the event Petitioner resides in the State of California and for any reason Petitioner stops practicing medicine in California, Petitioner shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Petitioner of the responsibility to comply with the terms and conditions of probation. Non-practice is

defined as any period of time exceeding thirty calendar days in which Petitioner is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Petitioner's license shall be automatically cancelled if Petitioner resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

Condition 11 of Respondent's probation provides:

Petitioner shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Petitioner, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient: 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Petitioner shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises. is a violation of probation.

DEFINITIONS

15. Amphetamine salt combo is a combination medication, generally used to treat attention deficit hyperactivity disorder and narcolepsy, known by the brand name Adderall. It contains a combination of amphetamine salts, a stimulant, and is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (d)(1).

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16. Armodafinil is a stimulant, usually used to treat narcolepsy. It is a dangerous drug pursuant to Business and Professions Code section 4022. It is a Schedule IV controlled substance pursuant to the federal Controlled Substances Act.

17. Carisoprodol is a skeletal muscle relaxant, known by the brand name Soma. It is a dangerous drug pursuant to Business and Professions Code section 4022. On December 12, 2011, the Drug Enforcement Agency ruled under the Controlled Substances Act that all Carisoprodol products are to be reclassified as Schedule IV controlled substances as of January 12, 2012, due to the high potential for abuse and addictive qualities. It is a Schedule IV controlled substance pursuant to the federal Controlled Substances Act.

18. Clonazepam, also sold under the brand name Klonopin, is a depressant commonly used for short-term relief of anxiety and certain types of seizures. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11507, subdivision (d)(7), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Norco is a combination narcotic used for relief of moderate to severe pain. It contains an opioid pain reliever hydrocodone and a non-opioid pain reliever acetaminophen. Norco is a dangerous drug pursuant to Business and Professions Code section 4022, and, because it contains hydrocodone, it a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (I).

20. Oxycodone is an opioid narcotic used for relief of moderate to severe pain. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

21. OxyContin is a brand name of an opioid narcotic used for relief of moderate to severe pain that contains oxycodone, with a time-released feature. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

22. Percocet is a combination narcotic used for relief of moderate to severe pain. It contains an opioid pain reliever oxycodone and a non-opioid pain reliever acetaminophen. Percocet is a dangerous drug pursuant to Business and Professions Code section 4022, and,

because it contains oxycodone, it a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

23. Testosterone cypionate is an androgen and anabolic steroid medication that is used mainly in the treatment of low testosterone levels in men. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule III controlled substance pursuant Health and Safety Code section 11056, subdivision (f)(30).

24. Xanax is a brand name of alprazolam, a benzodiazepine depressant, used to treat anxiety. Xanax is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 11057, subdivision (d)(1).

25. Zolpidem tartrate is a sedative that is also called a hypnotic, and is known by the brand name Ambien. It is used to treat insomnia. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 110575, subdivision (d)(32).

FACTUAL ALLEGATIONS

Patient 1[1]

26. Patient 1, a male, first saw Respondent at a clinic called 911 Biocare Age Intervention Center (911 Biocare hereafter), on or about August 28, 2015, when he was approximately 37-years old. Patient 1 provided history information on a questionnaire, where he complained of weight gain and lack of energy for the past 10 years. He marked a pre-printed diagram to indicate that he suffered from pain in his right shoulder, low back and knees, although he left blank the portions of the form indicating the severity of the pain. Patient 1 indicated that he had leg/arm strains or sprains and that his last physical exam occurred six months prior. He reported a family history of alcoholism, arthritis, cancer, diabetes, high blood pressure and high cholesterol. During that first visit, Patient 1 also reported, on a patient questionnaire, that he weighed 290 pounds and was 5 feet and 10 ½- inches tall. By checking various boxes on a pre-printed history

[1] Patients are designated by number in order to protect their privacy. Their names are known to Respondent and will be disclosed to Respondent in response to a Request for Discovery.

form, Patient 1 indicated that his symptoms included fatigue and lack of energy, decreased or absent sex drive, feeling hopeless and without motivation, change in mood, anxiety and/or depression, diminished strength and exercise tolerance, joint aches and/or arthritic symptoms, weight gain/weight loss and dry eyes. During that first visit, Patient 1 signed an informed consent form for testosterone replacement therapy. He also provided a blood sample for analysis. This blood sample revealed that Patient 1's testosterone levels were normal.

27. Patient 1 returned to see Respondent on or about September 11, 2015. Respondent reviewed lab results, obtained a history and examined him. The history and exam were documented by circling items on a pre-printed form, with additional notations. The patient provided a history of weight gain, and Respondent noted that the patient had gained 50 pounds during the past eight years. The other items circled were: limited energy, fatigue, low sex drive, depression (with hopelessness and lack of motivation noted), mood swings and poor recovery after workouts. Respondent also noted that Patient 1 exercised five times a week practicing jiu-jitsu, that he consumed moderate amounts of alcohol and caffeine, did not smoke and that the patient lost 130 pounds from his maximum weight. How quickly this weight loss occurred was not noted. Respondent also noted that Patient 1 had prior knee arthroscopies on both knees and a right shoulder surgery. Respondent also noted that the patient was taking multi-vitamins and testosterone. The physical exam on or about September 11, 2015, showed no abnormalities. Respondent's assessment of Patient 1 was hypogonadism and metabolic syndrome. The treatment plan was to start biologically identical hormone therapy.

28. On September 11, 2015, Patient 1 signed up for a "Concierge Program" with 911 Biocare, where, for a monthly fee, he would receive non-insurance covered physician consultations/exams reference to weight loss, hormone restorations, aesthetic procedures, and pain management, in addition to other services. Patient 1 proceeded to receive hormone replacement therapy via injections prescribed by Respondent or administered on his orders.

29. The next examination note in Respondent's medical record is dated December 7, 2015. It quotes that Patient 1 reported: "I feel really good" and "My right knee is aching more often." The patient's history indicated that he denied side effects of testosterone therapy and

reported improvements in his energy level, sleep, and focus. Respondent's exam noted that the patient was alert and oriented as to person, place and time, was neurologically intact, well-groomed and that his gait was normal. Respondent assessed Patient 1 with hypogonadism – not optimized, and considered knee injections. The patient was told to follow up in two weeks. Respondent did not note and did not log any prescriptions given to Patient 1 on December 7, 2015, but on December 8, 2015, Patient 1 filled a prescription for 90 pills of 30 mg amphetamine salt combo (Adderall) as well as Norco and Oxycodone, written for him by Respondent, at a local Walgreens pharmacy in Oxnard, California.

30. Respondent's medical records for Patient 1 contain copies of prescriptions for Cialis (a prescription medicine used to treat erectile dysfunction) and Medrol (a prescription medicine used to treat inflammation). Both Medrol and Cialis are dangerous drugs, pursuant to Business and Professions Code section 4022. Both of these prescriptions are dated December 21, 2015, but there is no corresponding entry in Respondent's medical records that documents any prior examination or a medical indication for these prescriptions.

31. Respondent's medical record for Patient 1 contains a copy of a prescription for Adderall, oxycodone, and Norco, dated January 4, 2016, and on or about January 6, 2016, Patient 1 filled a prescription for testosterone cypionate, oxycodone, and hydrocodone, written to him by Respondent, at a local Walgreens pharmacy in Oxnard, California. Patient 1 filled a prescription for 90 pills of 30 mg amphetamine salt combo, written to him by Respondent, on January 12, 2016, at the same pharmacy. There are no corresponding entries in Respondent's medical records for Patient 1 that document any prior examination and a medical indication for the prescriptions of Adderall, oxycodone, and hydrocodone to Patient 1.

32. Patient 1 underwent an MRI of his right knee on January 8, 2016, and Respondent saw Patient 1 on January 19, 2016. After reviewing the MRI, Respondent diagnosed Patient 1 with osteoarthritis in his right knee and chronic tendonitis in his right ankle. Respondent injected corticosteroid into Patient 1's right knee and ankle on that day. Respondent's medical record makes no mention of any prescriptions written to Patient 1 at that time, nor does Respondent's probation-mandated separate prescribing record. However, Patient 1 filled prescriptions for

oxycodone and hydrocodone, written to him by Respondent, on February 1, 2016, at a local Walgreen's pharmacy in Oxnard. Patient 1 also filled a prescription for 90 pills of 30 mg amphetamine salt combo, written to him by Respondent, on February 13, 2016, at the same pharmacy.

33. Respondent next saw Patient 1 on or about February 15, 2016. According to Respondent's medical records for Patient 1, the Patient was a jiu-jitsu fighter who was complaining of chronic right shoulder pain with reduced range of motion in all directions because of pain. The exam documented no muscle atrophy, no redness, no swelling, no fever, and no weakness. Respondent diagnosed Patient 1 with osteoarthritis in his right shoulder and performed a corticosteroid injection into the right shoulder. The patient was told to follow up by phone in 5-7 days. Respondent's medical record makes no mention of any prescriptions written to Patient 1 at that time, nor does Respondent's probation-mandated separate prescribing record. However, Patient 1 filled a prescription for oxycodone and hydrocodone, written to him by Respondent, on February 25, 2016, at a local Walgreen's pharmacy in Oxnard.

34. Patient 1 was not able to obtain Adderall, as on March 14, 2016, Respondent received a fax from Patient 1's health insurer Blue Cross/Blue Shield, advising him: "we have received your prior authorization request for Adderall 30 mg tablet; however, we are only able to approve the medication for 180-quantity every 90-days, which is consistent with FDA prescription guidelines."

35. Respondent's medical records for Patient 1 contain a copy of a prescription #420 for a Z-Pack, an antibiotic, and Phenergan, an antihistamine, as well as prescription #419, for oxycodone, Norco and 90 pills of Adderall that Respondent wrote to Patient 1 on March 14, 2016. There are no corresponding entries in Respondent's medical records that documents any prior examination and a medical indication for prescriptions of antibiotics, an antihistamine, Adderall, oxycodone and hydrocodone to Patient 1 on that date. Patient 1 filled a prescription for 135 pills of 20 mg amphetamine salt combo, written to him by Respondent, from Walgreens pharmacy in Oxnard, on or about March 17, 2016. Patient 1 filled a prescription for oxycodone and hydrocodone, written to him by Respondent, at the same pharmacy on or about March 25, 2016.

36. Patient 1 returned to see Respondent on April 4, 2016, complaining of knee pain. Both knees were examined, and no symptoms other than reduced range of motion were noted. Respondent diagnosed Patient 1 with osteoarthritis in both knees and performed corticosteroid injections. On April 4, 2016, Respondent wrote prescription, #481, to Patient 1, for 100 pills of 30 mg oxycodone, 30 pills of 10/35 Norco and 120 pills of Adderall, 20 mg. On or about April 15, 2016, Patient 1 filled a prescription for 90 pills of 30 mg amphetamine salt combo, written to him by Respondent, at a local pharmacy in Oxnard, California. He filled prescriptions for OxyContin and Norco, written to him by Respondent, on April 23, 2016, at the same pharmacy.

37. On or about May 10, 2016, Respondent submitted to Blue Cross/Blue Shield a prior authorization request to renew Adderall for Patient 1. On the prior authorization form, Respondent indicated that the diagnosis justifying Adderall for Patient 1 was "shift work sleep disorder." Other than this document, Respondent's records for Patient 1 contain no mention of Patient 1 ever having been diagnosed with a sleep disorder. In several communications with pharmacies, which were retained by Respondent in Patient 1's medical chart, Respondent documented that Adderall was being prescribed PRN (as needed) for sedation.

38. At approximately this time, Patient 1 became a police informant, and all of his subsequent visits with Respondent were monitored and recorded by law enforcement. Patient 1 visited 911 Biocare on May 24, 2016. Patient 1 did not see Respondent and was not examined. The front office staff member gave Patient 1 a prescription, #323, for 40 pills of Norco, 80 pills of oxycodone and 80 pills of 20 mg Adderall, which was written by Respondent. This prescription was dated April 19, 2016, even though it was given to Patient 1 on May 24, 2016.[2] In addition to prescription #323, Respondent's medical record for Patient 1 also contains a copy of prescription #25, also dated April 19, 2016, for 40 pills of Norco, 80 pills of oxycodone and 80 pills of 20 mg Adderall, written by Respondent to Patient 1. Respondent made no corresponding record of history or examination to justify either one of these prescriptions and did not document these prescriptions in his probation-mandated separate prescribing record.

[2] Antedating a prescription is a violation of Health and Safety Code section 11172.

39. Patient 1 returned to see Respondent on June 6, 2016. This visit was also monitored and recorded by law enforcement. After Patient 1 and Respondent greeted each other, Patient 1 asked Respondent for more Norco, because his left elbow was hurt in a recent jiu-jitsu tournament. Patient 1 had never previously complained of pain in his elbow.[3] Upon this request, Respondent said: "Yeah. Absolutely. Are you good with everything else?" Patient 1 then asked Respondent for Xanax, claiming work stress. Respondent had never prescribed Xanax to Patient 1 previously. Rather than appropriately examining Patient 1 to determine what medication, and what strength of medication and how many doses of medication were indicated, Respondent asked Patient 1 what strength of Xanax he wanted prescribed to him. Patient 1 said he wanted 2 mg. After some casual conversation, Respondent asked Patient 1 how many Norco he wanted. Patient 1 asked for 20 or 30. Respondent then asked how many Xanax Patient 1 wanted. Patient 1 related he wanted enough to get through the month. Respondent wrote prescription, #131, for 30 pills of 10/35 Norco and 10 pills of .5 mg Xanax. Patient 1's visit with Respondent lasted approximately three (3) minutes; Respondent took no history and performed no examination of Patient 1. Respondent's medical record for Patient 1's visit of June 6, 2016 notes an increased "periarticular edema," heat, decreased active and passive range of motion, no redness, no lymphadenitis, and no crepitus. Respondent recorded a diagnosis of acute right elbow strain/sprain and immobility. Respondent's recorded treatment plan was RICE (rest, ice, compress, elevate) and prescriptions of Norco and Xanax, with a follow up in two weeks. The record reflecting the physical examination is false, because the examination recorded in Respondent's June 6, 2016, medical record for Patient 1, did not occur. In his probation-mandated separate prescribing record, Respondent recorded the Norco prescription, indicating that the diagnosis for which it was prescribed "osteoarthritis" and the indication for it was "chronic joint pain." This was an inaccurate statement in a document directly related to Respondent's medical practice. Respondent did not document the Xanax prescription to Patient 1 in his probation-mandated separate prescribing record, and did not consider that Patient 1 was

[3] Patient 1 had received a prescription from Respondent for eighty (80) Oxycodone pills, forty (40) Norco pills and eighty (80) Adderall pills only twelve days earlier.

asking for Norco only twelve days after receiving a prescription for a month's supply of controlled pain medications.

40. Patient 1 returned to see Respondent on August 29, 2016. His visit was monitored and recorded by law enforcement. The visit lasted approximately four minutes, during which Respondent took no history other than asking Patient 1 how his joints were doing, to which Patient 1 replied "same-old, same-old, the same grind, jiu-jitsu, so I was wondering if I could get the refill for the Norcos." Respondent immediately said: "Yes," and then asked what medications Patient 1 wanted. Patient 1 asked for "Oxy, Norco and Xanax." Respondent then inquired, "Did that Adderall thing ever get worked out?" To which Patient 1 answered that it did. After a minute of casual conversation, Respondent asked Patient 1 how many Norco pills he wanted. Patient 1 asked for 60. Respondent then asked how many oxycodone pills he wanted. Patient 1 asked for 60. Respondent then asked: "It was .5 mg Xanax?" Patient 1 confirmed and asked for "30 of those." Respondent performed no physical examination. Respondent wrote prescription #132, to Patient 1, for 60 pills of Norco 10/35, 60 pills of oxycodone 30 mg and 30 pills of Xanax .5 mg. In Patient 1's medical records for this visit, Respondent wrote that the patient's complaint was "chronic, intermittent right ankle/knee pain secondary to osteoarthritis/meniscus tear/ligamentous injury." Respondent documented that Patient 1 was alert and oriented to self, time and place, his cognition was intact and his speech was clear; that his pupils were equal, round, reactive to light; that his skin was warm and dry; and that his right knee had inflammation and crepitus with flexion/extension. Respondent's diagnosis was recorded as osteoarthritis of the right knee and ankle, and his plan was to prescribe oxycodone/Norco/Xanax and to follow up in a month. The record reflecting Respondent's physical examination of Patient 1 on August 29, 2016, is false, because the examination recorded in Respondent's August 29, 2016, medical record for Patient 1 did not occur. Respondent did not record the controlled substance prescriptions he wrote to Patient 1 on this date in his probation-mandated prescription record.

Patient 2

41. Patient 2 was a 21-year-old male, serving as a police informant, who visited Respondent at 911 Biocare, twice: on October 3, 2016 and October 27, 2016. Both of the visits were audio and video recorded and monitored by law enforcement.

42. On October 3, 2016, Patient 2 saw Respondent, claiming that he was referred by Patient 1, and wanted to gain muscle size and strength in order to join the fire academy. Patient 2 was given a Health Information Questionnaire, on which he related a shoulder injury in June 2015. He also marked a body illustration, showing an ache on the back of his shoulder, indicating that his current pain level was "4" and a "7" to indicate "your symptoms when they are at their worst." Patient 2 then signed an informed consent for chiropractic treatment and met with Respondent to discuss testosterone therapy. After a five-minute discussion of testosterone, during which Respondent asked if Patient 2 went to "EDC,"[4] Patient 2 asked Respondent to prescribe him Norco. Patient 2 said: "I have a shoulder injury on the right side from a car accident last year, and so generally when I work out it has been relatively bothersome. About a year ago, I was prescribed Norcos, just to deal with the pain, and so I was wondering if that could happen just to compliment the testosterone." Respondent immediately answered: "I could do that. The thing about Norco, which is brand new, is that they are starting to... The Center for Disease Control are monitoring it and so they contacted the pharmacies just about three or four weeks ago. So they are really coming down on prescriptions for Norco, OxyContin, Soma, and Xanax. So, how many Norco pills do you usually take, or would you take a day?" Patient 2 stated, "Generally, I think I would say, depending on how the pain was, I would take one to two." Respondent said: "I will write..." but was interrupted by Patient 2, who said: "Generally, for a month I would range from like 30 to 60." Respondent said: "All right, I will write you for 60. We can stay under the radar with that number." Respondent then asked Patient 2 where he grew up and where he went to high school and what he studied in college and where he works. Respondent then asked about Patient 2's insurance. When Patient 2 said that he would pay out of pocket, Respondent assured him, "If your insurance covers it, because there won't be any trace to this, if that's your concern." Respondent conducted no medical exam of any kind for Patient 2,

[4] EDC stands for Electric Daisy Carnival.

and agreed to write the prescription for Norco almost immediately after Patient 2 requested it. Respondent wrote prescription, #43, for 60 pills of 10/325 Norco to Patient 2. Respondent then created a medical record of the visit, where he recorded that Patient 2 had right shoulder pain for approximately two years, and had good results with Norco; that the patient has had no operations or steroid injections; that the patient was oriented as to person, place and time, his cognition was intact, and his speech was clear. Respondent also documented that the patient displayed a reduced range of motion, had no signs of inflammation and "neuro intact." Respondent indicated his assessment as osteoarthritis of the right shoulder and his plan was to take Norco for pain and to consider steroid injections, with a follow up in a month. The record reflecting Respondent's physical examination of Patient 2 on October 3, 2016, is false, because the examination recorded in Respondent's October 3, 2016, medical record for Patient 2 did not occur.

43. Patient 2 returned to see Respondent on October 27, 2016. This visit was video recorded and monitored by members of law enforcement. During the visit, Respondent discussed testosterone therapy with Patient 2. As the visit was wrapping up, Patient 2 asked for a refill of Norco, "because it had been really helping with the pain." Respondent agreed but wanted to obscure the fact that this was going to be an early refill of a controlled substance. Respondent stated: "I just have to write it for the first. I can write it for the thirty-first, for Monday, because I wrote it for the third." Patient 2 then explained that for about a week he had been going through additional stress. Patient 2 told Respondent: "my mom gave me some Xanax and it had really helped me with the stress for midterms and I was wondering if I could get about a months' supply of two milligrams." Respondent stated: "That's harder. Right now the CDC is monitoring controlled substances and, unfortunately, two of those are Norco and Xanax, and a lot of pharmacies won't fill them anymore. So I've had several phone calls from pharmacies, saying we won't give your patients oxycodone, Norco, Xanax and Soma." Patient 2 then asked for a smaller dosage, as it has been helpful in calming his nerves. Respondent then agreed to "do the 1 mg Xanax also." Respondent then wrote Patient 2 a prescription, #351, for 60 pills of 10/325 Norco and 30 pills of 1 mg Xanax, post-dating the prescription to October 31, 2016. Patient 2 then asked Respondent for Adderall. Respondent said "no we don't do those." No exam was

performed or documented in Respondent's chart for Patient 2 during this visit. Respondent did not contemplate or document a treatment plan. The fact that the patient indicated that he took Xanax that was diverted from another person and not prescribed to him, that he was seeking an early refill of Norco, and that he asked for Adderall, was not considered by Respondent or noted in Respondent's records for Patient 2.

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Patient 3

44. Patient 3, a male who was approximately 32-years-old at the time, became Respondent's patient at 911 Biocare in approximately May of 2015[5]. At that time Patient 3 complained of mid and low back pain because of lumbar strain and a herniated disk sustained in a car accident six years prior. He also complained of low energy and low sex drive. The patient stated that he exercised five days a week and denied using drugs and alcohol. He indicated that he has had a prior diagnosis of ADD Disorder for which he was being prescribed medication by Dr. Vicary.[6] On or about June 1, 2015, Patient 3 enrolled in a "Concierge Program" with 911 Biocare, where, for a monthly fee, he would receive non-insurance covered physician consultations/exams reference to weight loss, hormone restorations, aesthetic procedures, and pain management, in addition to other services. Respondent diagnosed Patient 3 with hypogonadism and placed him on testosterone supplementation therapy starting on or about May 1, 2015. Respondent documented in his probation-mandated prescribing record that he prescribed testosterone cypionate to Patient 3 on May 1, 2015. He made no further entries about dispensing or prescribing testosterone to Patient 3 in his probation-mandated separate prescribing record.

45. On or about October 23, 2015, Respondent saw Patient 3 and documented a review of laboratory results, and that Patient 3 told him, "I feel great. I'm gaining muscle." Respondent noted that Patient 3 denied symptoms of side effects of testosterone therapy and was progressing

[5] The Patient Registration form appears to have been mistakenly dated May 24, 2014.

[6] Dr. William T. Vicary surrendered his license effective on or about March 3, 2019, while an Accusation alleging prescribing irregularities was pending against him.

well. Respondent indicated that Patient 3 was alert and oriented as to place, time and person, was well-groomed and that his gait was normal. He also noted that Patient 3 displayed an increase in muscle mass. Respondent's plan was to continue with hormone supplementation and to follow up in four to six weeks.

46. On or about July 11, 2016, Patient 3 was seen by Respondent, who documented a review of laboratory results, and that Patient 3 told him: "I feel great." Respondent noted that Patient 3 denied symptoms of side effects of testosterone therapy and was progressing well. Respondent's plan was to continue with hormone supplementation, and to follow up in four to six weeks and to repeat labs in six months.

47. Respondent made no additional progress notes for Patient 3, and did not document any other examination or indication for prescribing controlled substances to Patient 3. Respondent did not document any additional prescriptions in Patient 3's chart, and made no further entries into Respondent's probation-mandated separate prescribing record. Despite prescribing pain medications to Patient 3, as alleged below, Respondent never documented a plan for treatment of Patient 3's pain, or a physical examination to justify prescriptions of controlled substances. Respondent never documented any indication for prescribing controlled substances to Patient 3.

48. On or about December 7, 2015, Patient 3 filled prescriptions for 240 pills of 325/10 Norco, 60 pills of 30 mg amphetamine salt combo, 120 pills of 350 mg carisoprodol, and 180 pills of 30 mg oxycodone, written to him by Respondent, at Dr. Ike's Pharmacy in Studio City, California. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record, or in Patient 3's chart.

49. On or about January 4, 2016, Patient 3 filled prescriptions for 150 pills of 325/10 Norco, 120 pills of 350 mg carisoprodol, and 180 pills of 30 mg oxycodone, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

50. On or about February 2, 2016, Patient 3 filled prescriptions for 60 pills of 10 mg zolpidem tartrate, 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, 150 pills of 325/10 Norco, 60 pills of 2 mg alprazolam, and 120 pills of 30 mg amphetamine salt combo, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record, or in Patient 3's chart.

51. On or about March 1, 2016, Patient 3 filled prescriptions for 60 pills of 10 mg zolpidem tartrate, 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, 150 pills of 325/10 Norco, and 60 pills of 2 mg alprazolam, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

52. On or about April 1, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, and 180 pills of 325/10 Norco, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

53. On or about May 2, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, 180 pills of 325/10 Norco, and 120 pills of 30 mg amphetamine salt combo, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

54. On or about May 28, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, 180 pills of 30 mg oxycodone, and 150 pills of 325/10 Norco, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

55. On or about June 24, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, and 180 pills of 30 mg oxycodone, and 150 pills of 325/10 Norco written to him by

Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

56. On or about July 18, 2016, Patient 3 filled prescriptions for 120 pills of 350 mg carisoprodol, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

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57. On or about July 22, 2016, Patient 3 filled prescriptions for 180 pills of 350 mg carisoprodol, as well as 180 pills of 30 mg oxycodone, 180 pills of 325/10 Norco, and 90 pills of 2 mg clonazepam, written to him by Respondent, at Dr. Ike's Pharmacy.[7] None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

58. On or about August 18, 2016, Patient 3 filled a prescription for 180 pills of 350 mg carisoprodol, prescribed to him by Respondent, at Dr. Ike's Pharmacy. This prescription, or reasons for it, was not documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

59. On or about August 24 and 25, 2016, Patient 3 filled prescriptions for 180 pills of 350 mg carisoprodol, 180 pills of 325/10 Norco, and 90 pills of 2 mg clonazepam, written to him by Respondent, at Dr. Ike's Pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

60. On or about September 16, 2016, Patient 3 filled prescriptions for 120 pills of 325/10 Norco, 120 pills of 30 mg oxycodone, 180 pills of carisoprodol, and 10 vials of 200 mg/1ml depo-testosterone oil, written to him by Respondent, at Dr. Ike's pharmacy in Studio City, California. None of these prescriptions, or reasons for them, were documented in Respondent's

[7] Patient 3 filled a prescription for 120 pills of carisoprodol, which Respondent wrote for him, only four days earlier.

probation-mandated separate prescribing record. Only testosterone was documented in Patient 3's chart.

61. On or about October 21, 2016, Patient 3 filled prescriptions for 120 pills of 325/10 Norco, and 120 pills of 30 mg oxycodone, written to him by Respondent, at Dr. Ike's pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record or in Patient 3's chart.

62. On or about November 5, 2016, Patient 3 filled prescriptions for 30 pills of 150 mg armodafinil and 10 vials of depo-testosterone 200 mg/1ml oil, written to him by Respondent, at Dr. Ike's pharmacy. None of these prescriptions, or reasons for them, were documented in Respondent's probation-mandated separate prescribing record. Only testosterone was documented in Patient 3's chart.

63. During the course of treatment with Respondent, Patient 3's testosterone level was initially below normal, and testosterone supplementation was appropriate. However, during the course of treatment, Patient 3's testosterone level became elevated and the patient began to exhibit possible side effects of excessive testosterone levels. His laboratory studies, which Respondent ordered, initially showed a normal LDL with elevated liver functions in April of 2015, and normal cholesterol levels, in October, 2015. However, by June, 2016 Patient 3's laboratory studies showed markedly elevated cholesterol level, a markedly elevated LDL level and a markedly elevated LDL to HDL ratio. These changes could have been side effects of testosterone that Respondent caused to be administered to Patient 3. Hepatic problems and marked changes in Patient 3's lipid profile were indicative of increased cardiovascular risk. Yet, Respondent did not address Patient 3's metabolic changes. Respondent did not note, did not comment upon, and otherwise did not take any care whatsoever to evaluate these negative changes in Patient 3's health, or to refer Patient 3 to be evaluated by another physician. Respondent did not consider, and did not document consideration, to reduce or cease Patient 3's testosterone supplementation.

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Patient 4

64. Patient 4, a male who was approximately 41-years-old at the time, first saw Respondent at 911 Biocare on or about May 1, 2015. At that time, Patient 4 complained of severe neck pain and numbness radiating to his right arm. On a pre-printed patient questionnaire, Patient 4 indicated that he was suffering from fatigue and low energy, feelings of hopelessness and lack of motivation, changes in mood with anxiety and/or depression and diminished strength and exercise tolerance, and poor sleep. Patient 4 reported a history of lower back surgeries in 1997 and 2009, and surgeries on his left knee in 1997 and left ankle in 1987. Patient 4 stated that he exercised 4-5 days a week. On May 1, 2015, Patient 4 signed an informed consent for testosterone replacement therapy and provided a blood sample.

65. On or about May 8, 2015, Patient 4 enrolled in a "Concierge Program" with 911 Biocare, where, for a monthly fee, he would receive non-insurance covered physician consultations/exams reference to weight loss, hormone restorations, aesthetic procedures, and pain management, in addition to other services. Respondent took Patient 4's history, and noted a complaint of a "pinched nerve" with severe and constant neck and right upper back pain with radicular symptoms to the 5th and 4th fingers of the patient's right hand, with intermittent numbness/weakness/tingling in Patient 4's upper arm to the hand. Respondent failed to ascertain and document the extent or severity of this patient's pain. Respondent also noted a past medical history of attention deficit disorder (ADD), and that Patient 4 was taking Vyvance and Lamictal. Respondent noted that Patient 4 practiced jiu-jitsu 4-5 times per week. Respondent documented a physical examination that noted a reduced range of motion in the patient's neck in all planes and reduced sensation and motor reflexes in the patient's right arm. Respondent assessed Patient 4 with hypogonadism and cervical radiculitis/radiculopathy and myofascial pain syndrome/muscle spasm. Respondent's plan was to begin hormone supplementation with testosterone, perform a cervical spine MRI, continue Lamictal, do a trial of Neurontin, continue Medrol, and to prescribe oxycodone as needed for pain. Respondent also planned to consider Botox injections into the patient's right trapezius and "chiro/pt/massage therapy." On May 8, 2015, Respondent prescribed, on prescription #168, a copy of which he retained in the patient's chart, 60 pills of 15

mg oxycodone, Neurontin and Medrol to Patient 4, and noted the prescription of oxycodone in his probation-mandated prescribing record.

66. On May 22, 2015, Respondent noted that he educated Patient 4 on the injection technique and that the patient elected to proceed with a testosterone injection plan at home. Respondent did not note testosterone prescriptions to Patient 4 in Respondent's probation-mandated separate prescribing record. Except as detailed below, Respondent made no further entries in his probation-mandated log, even though Patient 4 continued to receive testosterone and other controlled substances on a regular basis. Respondent made/documented no plan for treatment of Patient 4's pain.

67. Patient 4 was evaluated by a chiropractor on July 10, 2015, who noted dull intermittent, achy, stiff and radiating pain, level 2, on the right side of the patient's neck, which was reportedly caused by jiu-jitsu training or sleeping in certain positions. Palliative factors were noted as rest, sleeping on back and ice. On July 13, 2015, Respondent wrote a prescription, #1, a copy of which he retained in the patient's chart, for 60 pills of 15 mg oxycodone, and also for Neurontin, for Patient 4, without obtaining, performing and/or documenting any further history or examination in Patient 4's medical chart. Respondent did not document this prescription in his probation-mandated separate prescribing record.

68. Patient 4 had a telephone follow up with Respondent on August 7, 2015. During the telephone follow up, Patient 4 complained of continued pain and tingling, and reported that oxycodone provided inadequate pain relief. Respondent failed to assess and document the extent or severity of Patient 4's pain. The patient reported an 8-pound weight gain since starting testosterone. Respondent noted a review of the patient's cervical spine MRI, and assessed the patient with cervical degenerative disk disease and planned to discontinue oxycodone and to begin Patient 4 on Norco. Respondent issued a prescription, #52, to Patient 4, a copy of which he retained in the patient's chart, for 60 pills of 10/325 Norco on August 7, 2015. This prescription was not documented in Respondent's probation-mandated separate prescribing record. Respondent did not consider, and did not document a plan for treatment of the patient's complaints of pain.

69. Respondent noted a follow up with Patient 4 on October 2, 2015. The patient reported participating in a jiu-jitsu tournament and feeling better on hormone supplementation with reduced recovery time after workouts and increased strength. The patient continued to complain of neck pain, though no details, such as pain level, duration, exacerbating, or relieving factors were documented by Respondent. No treatment plan was created or documented. Respondent issued a prescription, #63, to Patient 4, a copy of which he retained in the patient's chart, for 60 pills of 15 mg oxycodone and also for Medrol, without documenting this prescription in his probation-mandated separate prescribing record.

70. On October 16, 2015, Respondent issued prescription #70 to Patient 4, a copy of which he retained in the patient's chart, for 90 pills of 15 mg oxycodone, with no corresponding chart entry whatsoever, and without documenting this prescription in his probation-mandated separate prescribing record.

71. Respondent next saw Patient 4 on or about November 2, 2015, and noted that the patient said "I feel better on testosterone and Sermorelin" and that Patient 4 denied side effects of testosterone therapy. Respondent increased the dose of testosterone. Respondent documented that patient's cervical radiculopathy was stable. Respondent did not contemplate or document a treatment plan for Patient 4's pain. On November 2, 2015, Respondent issued prescription #73 to Patient 4, for 100 pills of 10/325 Norco, a copy of which he retained in the Patient 4's chart. This prescription was not documented in Respondent's probation-mandated separate prescribing record.

72. On November 23, 2015, even though he previously wrote that he would discontinue oxycodone for Patient 4 because it was not effective, Respondent issued prescription #81 a copy of which he retained in the patient's chart, to Patient 4, for 90 pills of 5/325 Percocet, and also for Medrol. Respondent made no chart entry, did not document the reason for this change back to oxycodone-containing medication, and did not document an examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

73. On December 7, 2015, Respondent issued prescription #86, a copy of which he retained in the patient's chart, to Patient 4, for 90 pills of 10/325 Norco. Respondent made no corresponding chart entry and made no note of examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

74. On December 21, 2015, Respondent issued a prescription # 120, a copy of which he retained in the patient's chart, to Patient 4, for 90 pills of 5/325 Percocet. Respondent made no corresponding chart entry and made no note of examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

75. On January 11, 2016, Respondent issued prescription #135, a copy of which he retained in the patient's chart, to Patient 4, for 120 pills of 10/325 Norco. Respondent made no corresponding chart entry and made no note of the examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

76. On February 1, 2016, Respondent issued prescription # 302, a copy of which he retained in the patient's chart, to Patient 4, for 90 pills of 5/325 Percocet. Respondent made no corresponding chart entry and made no note of the examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

77. On February 22, 2016, Respondent issued prescription #455, a copy of which he retained in the patient's chart, to Patient 4, for 120 pills of 10/325 Norco. Respondent made no corresponding chart entry and made no note of examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

78. On February 29, 2016, Respondent issued prescription #457, a copy of which he retained in the patient's chart, to Patient 4, for 90 pills of 5/325 Percocet. Respondent made no corresponding chart entry and made no note of the examination of Patient 4. Respondent did not document this prescription in his probation-mandated separate prescribing record.

79. Respondent continued to prescribe controlled opiates to Patient 4, without retaining copies of prescriptions in the patient's chart, and without making any corresponding chart entries or documenting examination of Patient 4, an indication for prescribing, a plan of treatment, or documenting prescriptions in his probation-mandated separate prescribing record. On March 14,

2016, Patient 4 filled a prescription for 90 pills of Percocet, written to him by Respondent, at CVS pharmacy in Newbury Park. On April 22, 2016, Patient 4 filled a prescription for 90 pills of Percocet written to him by Respondent; and on May 2, 2016, Patient 4 filled another prescription for 180 pills of Percocet, written to him by Respondent.

80. Respondent documented an encounter with Patient 4 on May 16, 2016. He documented that the patient reported a recent increase in life stresses and anxiety associated with his mother's health, as well as professionally, and with his children. Respondent documented that Patient 4 does not drink alcohol and does not use recreational/illegal drugs. Respondent wrote a prescription #51, to patient 4, and retained a copy of it in Patient 4's chart, for 120 pills of .25 mg Xanax, with a plan to follow up in two weeks. This prescription was not documented in Respondent's probation-mandated separate prescribing record.

81. On June 13, 2016, Respondent prescribed 120 pills of 10/325 Norco to Patient 4, without a corresponding chart note. Respondent noted in his probation-mandated separate prescribing record that this prescription was due to "acute exacerbation" of the right shoulder pain secondary to the diagnosis of severe osteoarthritis of the patient's right shoulder. The patient filled this prescription at CVS pharmacy on the same day.

82. On June 27, 2016, Patient 4 filled another prescription for 120 pills of Percocet, written to him by Respondent. Respondent failed to make any corresponding chart entry documenting an examination or indication for this prescription and no corresponding entry in Respondent's probation-mandated separate prescribing record.

83. During the course of his treatment with Respondent, Patient 4 exhibited consistently elevated blood pressure, ranging from the low of 137/91 to a high of 159/110. Respondent, however, never addressed Patient 4's hypertension and never referred him to his primary care physician for treatment or evaluation of the elevated blood pressure.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

84. Respondent Paul Joseph Duran, M.D. is subject to disciplinary action under section 2234, subdivision (b) in that he committed gross negligence in the care and treatment of four patients. The circumstances are as follows:

85. The allegations of paragraphs 26 through 83, inclusive, are incorporated herein by reference.

86. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 1 constitutes an extreme departure from the standard of care.

87. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 2 constitutes an extreme departure from the standard of care.

88. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing or dispensing or administering controlled substances or dangerous drugs, to Patient 3 constitutes an extreme departure from the standard of care.

89. Respondent's failure to address, or to document consideration of Patient 3's elevated testosterone levels and the exhibited side effects of testosterone supplementation constitutes an extreme departure from the standard of care.

90. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 4 constitutes an extreme departure from the standard of care.

91. Respondent's failure to take any care whatsoever to refer Patient 4 to his primary care physician to address Patient 4's abnormal blood pressure constitutes an extreme departure from the standard of care.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

92. Respondent Paul Joseph Duran, M.D. is subject to disciplinary action under section 2234, subdivision (c) in that he committed repeated acts of negligence in the care and treatment of four patients. The circumstances are as follows:

93. The allegations of the First Cause for Discipline are incorporated herein by reference.

94. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 1 constitutes a departure from the standard of care.

95. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 2 constitutes a departure from the standard of care.

96. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 3 constitutes a departure from the standard of care.

97. Respondent's failure to address, or to document consideration of Patient 3's elevated testosterone levels and the exhibited side effects of testosterone supplementation constitutes a departure from the standard of care.

98. The manner in which Respondent provided care and treatment, including without limitation, prescribing, furnishing, dispensing or administering controlled substances or dangerous drugs, to Patient 4 constitutes a departure from the standard of care.

99. Respondent's failure to manage Patient 4's hypertension or take any care whatsoever to refer Patient 4 to his primary care physician to address Patient 4's abnormal blood pressure constitutes a departure from the standard of care.

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THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

100. Respondent Paul Joseph Duran, M.D. is subject to disciplinary action under section 2266 in that Respondent failed to keep adequate and accurate records of his care and treatment of four patients. The circumstances are as follows:

101. The allegations of the First and Second Causes for Discipline are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Creating False Medical Documents)

102. Respondent Paul Joseph Duran, M.D. is subject to disciplinary action under section 2261 in that he knowingly made or signed documents directly or indirectly related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts with regard to his care and treatment of two patients. The circumstances are as follows:

103. The allegations of the First, Second and Third Causes for Discipline are incorporated herein by reference.

104. Respondent created a false medical record, dated June 6, 2016, in his care and treatment of Patient 1 by documenting a physical examination that did not occur.

105. Respondent created an inaccurate medical record in his probation-mandated separate prescribing record, with regard to the June 6, 2016 Norco prescription to Patient 1.

106. Respondent created a false medical record dated August 29, 2016, in his care and treatment of Patient 1 by documenting a physical examination that did not occur.

107. Respondent created a false medical record dated October 3, 2016, in his care and treatment of Patient 2 by documenting a physical examination that did not occur.

108. Respondent stated false facts in documents directly related to the practice of medicine as alleged in Paragraph 37 herein, by claiming that he was prescribing Adderall to Patient 1 for "shift work sleep disorder."

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FIFTH CAUSE FOR DISCIPLINE

(Violation of Laws Regulating Controlled Substances)

109. Respondent Paul Joseph Duran, M.D. is subject to disciplinary action under section 2238 in that he violated laws regulating prescribing of controlled substances. The circumstances are as follows:

110. Allegations of First, Second, Third and Fourth Causes for Discipline are incorporated herein by reference.

111. Respondent violated Business and Professions Code sections 2241.5 and 2242 by issuing controlled substance and dangerous drug prescriptions to Patient 1 without an appropriate prior examination and a medical indication.

112. Respondent violated Business and Professions Code sections 2241.5 and 2242 by issuing dangerous drug prescriptions to Patient 2 without performing and/or documenting an appropriate prior examination and identifying and/or documenting a medical indication therefor.

113. Respondent violated Business and Professions Code Business and Professions Code sections 2241.5 and 2242 by issuing controlled substance and dangerous drug prescriptions to Patient 3 without performing and/or documenting an appropriate prior examination and identifying and/or documenting a medical indication therefor.

114. Respondent violated Business and Professions Code Business and Professions Code sections 2241.5 and 2242 by issuing controlled substance and dangerous drug prescriptions to Patient 4 without performing and/or documenting an appropriate prior examination and identifying and/or documenting a medical indication therefor.

115. Respondent violated Health and Safety Code section 11172 by antedating a controlled substance prescription issued to Patient 1 as alleged in Paragraph 38 herein.

116. Respondent violated Health and Safety Code section 11172 by postdating a controlled substance prescription issued to Patient 2 as alleged in Paragraph 43 herein.

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SIXTH CAUSE FOR DISCIPLINE

(Acts of Dishonesty or Corruption)

117. Respondent Paul Joseph Duran, M.D. is subject to disciplinary action under section 2234, subdivision (e) in that he committed acts of dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

118. Allegations of First, Second, Third, Fourth and Fifth Causes for Discipline are incorporated herein by reference.

119. The following specific acts alleged hereinabove were dishonest or corrupt in violation of section 2234, subdivision (e):

A) Respondent' manner of prescribing controlled substances to Patients 1, 2, 3, and 4;

B) Antedating or postdating a prescription issued to Patient 1;

C) Antedating or postdating a prescription issued to Patient 2;

D) Creating or signing medical records that falsely reflected that a physical examination of Patient 1 occurred; and

E) Creating or signing medical records that falsely reflected that a physical examination of Patient 2 occurred;

120. In addition to the foregoing, Respondent Paul Joseph Duran, M.D. is further subject to disciplinary action under section 2234, subdivision (e) in that he committed additional acts of dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

121. As alleged previously, at all times relevant to the allegations herein, Respondent's license was revoked, but the revocation was stayed and his physician's and surgeon's certificate was placed on probation with terms and conditions. Respondent's license was reinstated and immediately placed on probation because he previously surrendered his license while Accusation number 06-2002-138792 was pending against him. The allegations in Accusation 06-2002-138792 included inappropriate prescribing of controlled substances and sexual misconduct.

Respondent's license was reinstated and placed on probation for six years, effective January 29, 2013.

122. Conditions of Respondent's probation include the requirement of having a Board-approved practice monitor oversee his practice (Condition 12), maintenance of a controlled substance prescription log-to be made immediately available to his probation monitor upon request (Condition 11), a Board-approved third-party chaperone whenever he sees female patients (Condition 14); and the submission of quarterly declarations, under penalty of perjury, disclosing whether or not Respondent is in compliance with the conditions of his probation (Condition 4).

123. Probation Condition 10 required: "Petitioner 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. Failure to pay costs within 30 calendar days of the due date is a violation of probation." As alleged in paragraph 142 below, Respondent was subjected to a Citation and Fine for failure to pay probation monitoring costs. Respondent was issued an Order of Abatement, requiring Respondent to pay probation monitoring costs.

124. On or about December 22, 2016, Respondent informed his probation monitor with the Board that he ceased practicing medicine on or about December 22, 2016. Thereafter Respondent submitted quarterly declarations in which he attested under penalty of perjury that he was not engaged in the practice of medicine. In his quarterly declaration for the fourth quarter of 2019, covering the period of October 2019 through December 2019, Respondent attested under penalty of perjury that he was not engaged in the practice of medicine.

125. Respondent's probation monitor accessed a CURES report of Respondent's prescribing of controlled substances, to verify Respondent's non-practice. The probation monitor discovered that Respondent was, in fact, practicing medicine and prescribing controlled substances to patients during the fourth quarter of 2019. The names of patients to whom Respondent prescribed controlled substances suggest that these patients are female.

126. The probation monitor's investigation revealed where Respondent was practicing medicine. The probation monitor visited Respondent's place of practice and discovered that Respondent was practicing medicine. Respondent admitted to the Board's probation monitor that he attempted to avoid the Order of Abatement by dishonestly claiming that he was not practicing medicine. Respondent did not have a record of controlled substances he prescribed to patients available for immediate inspection. Respondent admitted that he was seeing female patients, but he did not have a Board-approved third party chaperone. Respondent also admitted that he did not have a Board-approved practice monitor. Pursuant to Probation Condition 12, Respondent was ordered to cease practice of medicine.

127. The following specific acts alleged hereinabove were dishonest or corrupt in violation of section 2234, subdivision (e):

A) Lying on his quarterly declaration for the fourth quarter of 2019.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Abide by Probation Condition 3)

128. The probation of the Physician and Surgeon's Certificate issued to Respondent Paul Joseph Duran, M.D. is subject to revocation because he failed to abide by Condition 3 of his Probation, in that he failed to obey all federal, state and local laws and all rules governing the practice of medicine in California. The circumstances are as follows:

129. The allegations of paragraphs 26 through 126 are incorporated herein by reference.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Abide by Probation Condition 8)

130. The probation of the Physician and Surgeon's Certificate issued to Respondent Paul Joseph Duran, M.D. is subject to revocation because he failed to abide by Condition 8 of his Probation. Condition 8 provides, in pertinent part, that Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in the practice of medicine in California. Non-practice is defined as any period of time exceeding thirty calendar days in which Petitioner is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code. The circumstances are as follows:

131. Respondent has not engaged in the legitimate practice of medicine for a period of at least two years beginning on or about December 22, 2016.

THIRD CAUSE TO REVOKE PROBATION

(Failure to Abide by Probation Condition 10)

132. The probation of the Physician and Surgeon's Certificate issued to Respondent Paul Joseph Duran, M.D. is subject to revocation because he failed to abide by Condition 10 of his Probation. Condition 10 requires, in pertinent part, Respondent to pay the costs associated with probation monitoring. Respondent has failed to pay probation monitoring costs. The circumstances are as follows:

133. The Allegations of the Sixth Causes for Discipline, above, and paragraph 142, *infra*, are incorporated herein by reference.

FOURTH CAUSE TO REVOKE PROBATION

(Failure to Abide by Probation Condition 11)

134. The probation of the Physician and Surgeon's Certificate issued to Respondent Paul Joseph Duran, M.D. is subject to revocation because he failed to abide by Condition 11 of his Probation. Condition 11 requires, in pertinent part, Respondent to maintain, in a separate file or ledger, in chronological order, a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by him, showing the name and address of patient, the date, the character and quantity of controlled substances involved, and the indications and diagnosis for which the controlled substances were furnished. Respondent failed to maintain a prescribing file, ledger or log accurately, or at all. The circumstances are as follows:

135. The Allegations of paragraphs 26 through 126, inclusive, are incorporated herein by reference.

FIFTH CAUSE TO REVOKE PROBATION

(Failure to Abide by Probation Condition 12)

136. The probation of the Physician and Surgeon's Certificate issued to Respondent Paul Joseph Duran, M.D. is subject to revocation because he failed to abide by Condition 12 of his Probation. Condition 12 requires, in pertinent part, Respondent to have a Board-approved

practice monitor, who would monitor Respondent's practice and submit a quarterly written report evaluating Respondent' s performance. Respondent failed to have a Board-approved practice monitor. The circumstances are as follows:

137. The Allegations of the Sixth Cause for Discipline, above, are incorporated herein by reference.

SIXTH CAUSE TO REVOKE PROBATION

(Failure to Abide by Probation Condition 14)

138. The probation of the Physician and Surgeon's Certificate issued to Respondent Paul Joseph Duran, M.D. is subject to revocation because he failed to abide by Condition 14 of his Probation. Condition 14 requires Respondent, in pertinent part, to have a Board-approved third party chaperone present while consulting, examining or treating female patients. Respondent failed to have a Board-approved third party chaperone present when he consulted, examined or treated female patients. The circumstances are as follows:

139. The Allegations of Sixth Cause for Discipline, above, are incorporated herein by reference.

DISCIPLINARY CONSIDERATIONS

140. To determine the degree of discipline, if any, to be imposed on Respondent Paul Joseph Duran, M.D., Complainant alleges that on or about July 29, 2005, in a prior disciplinary matter, case number 06-2002-138792, before the Medical Board of California, an Interim Suspension Order was issued prohibiting Respondent to practice medicine. On January 23, 2006, Respondent surrendered his license while a First Amended Accusation against him was pending before the Medical Board of California. At a later reinstatement hearing, Respondent admitted, *inter-alia*, injuring one patient with improper injection technique, having a sexual relationship with a patient to whom he was improperly prescribing controlled substances, improper prescribing of controlled substances to two additional patients and improperly storing medications in his office. Respondent's license was reinstated and placed on probation on or about February 28, 2013.

141. To determine the degree of discipline, if any, to be imposed on Respondent Paul Joseph Duran, M.D., Complainant further alleges that on April 30, 2008, in the Superior Court of California for the County of San Diego, in Case Number CE257621, Petitioner was convicted, on his plea of guilty, of violation of Penal Code section 653m, subdivision (a), making a threatening phone call to the Board's expert witness in the Medical Board disciplinary matter that was pending at the time. Petitioner was placed on probation for three years and ordered to complete a 20-hour anger management course.

142. To determine the degree of discipline, if any, to be imposed on Respondent Paul Joseph Duran, M.D., Complainant further alleges that on February 10, 2017, the Medical Board of California issued a Citation and Order of Abatement, number 800-2017-029684, for violation of Condition 10 of Respondent's probation, failing to pay probation monitoring costs within the required time frame. As of the time of this Accusation and Petition to Revoke Probation, Respondent is in violation of said Order of Abatement.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60506, issued to Paul Joseph Duran, M.D.;
2. Revoking Paul Joseph Duran, M.D.'s probation and carrying out the disciplinary order that was stayed in the Board's Decision of February 28, 2013;
3. Revoking, suspending or denying approval of Paul Joseph Duran, M.D.'s authority to supervise physician assistants and advanced practice nurses;
4. Ordering Paul Joseph Duran, M.D., if placed on probation, to pay the Board the costs of probation monitoring
5. If placed on probation, ordering Paul Joseph Duran, M.D. to provide disclosure pursuant to Business and Professions Code section 2228.1; and
6. Taking such other and further action as deemed necessary and proper.

DATED: JUN 04 2020

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

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