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

In the Matter of the Accusation Against: Royce Lewis Hutain, M.D. Physician's and Surgeon's Certificate No. G 35907 Respondent.	Case No. 800-2017-030471

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 31, 2021.

IT IS SO ORDERED January 7, 2021.

MEDICAL BOARD OF CALIFORNIA

For: William Prasifka REJI VARGHESE
Executive Director DEPUTY DIRECTOR

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **ROYCE LEWIS HUTAIN, M.D.** **955 W. Imperial Way, #110** **Brea, CA 92821-3812** **Physician's and Surgeon's Certificate No. G 35907** Respondent.	Case No. 8002017030471 OAH No. 2020040618 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board).[1] This action was brought by then Complainant Christine J. Lally, Interim Executive Director, solely in her official capacity. Complainant is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Tessa L. Heunis, Deputy Attorney General.

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[1] Mr. Prasifka became the Executive Director of the Medical Board on June 15, 2020.

2. Royce Lewis Hutain, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about December 30, 1977, the Board issued Physician's and Surgeon's Certificate No. G 35907 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 8002017030471 and will expire on November 30, 2022, unless renewed.

JURISDICTION

4. On February 11, 2020, Accusation No. 8002017030471 was filed before the Board and is currently pending against Respondent. A true and correct copy of the Accusation and all other statutorily required documents were properly served on Respondent on February 11, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 8002017030471 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 8002017030471. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 8002017030471 and that his Physician's and Surgeon's Certificate No. G 35907 is therefore subject to discipline. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G 35907 for the Board's formal acceptance with an agreed upon effective date of March 31, 2021.

9. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G 35907, all of the charges and allegations contained in Accusation No. 8002017030471 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

10. Respondent understands that by signing this stipulation, he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate No. G 35907 without further process.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 35907 without further notice to, or opportunity to be heard by, Respondent.

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and

Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 35907, issued to Respondent Royce Lewis Hutain, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate No. G 35907 and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order which shall be on March 31, 2021.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If he ever applies for licensure or petitions for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 8002017030471 shall be deemed to be true, correct, and admitted by Respondent when the Board determines whether to grant or deny the application or petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 8002017030471 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney Raymond J. McMahon. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G 35907. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/23/2020

ROYCE LEWIS HUTAIN, M.D.
Respondent

I have read and fully discussed with Respondent Royce Lewis Hutain, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: December 23, 2020

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: December 23, 2020

Respectfully submitted,

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

TESSA L. HEUNIS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 8002017030471

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Feb 11 2020
BY [signature] ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2017-030471
Royce Lewis Hutain, M.D. **955 W. Imperial Hwy #110** **Brea, CA 92821-3812** **Physician's and Surgeon's Certificate No. G 35907,** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about December 30, 1977, the Medical Board issued Physician's and Surgeon's Certificate Number G 35907 to Royce Lewis Hutain, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2020, unless renewed.

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JURISDICTION

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

4. Section 2220 of the Code states, in pertinent part, that the Board may take action against all persons guilty of violating the Medical Practice Act, and shall have all the powers granted in Division 5, Chapter 5, of the Code, for these purposes.

5. 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.
>
> ...

6. 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.

...

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

...

7. Section 2228 of the Code states:

The authority of the board ... 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.

8. Section 2266 of the Code states:

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

9. Section 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 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 furnishing dangerous drugs or recommending medical cannabis.

...

(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.

...

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. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

...

11. Section 4021 of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

12. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

...

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

13. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member of good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

DEFINITIONS

14. Oxycontin is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Morphine sulfate is a Schedule II controlled substance pursuant to Health and Safety Code section 11057, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is sold under the brand name MS Contin.

16. Dextroamphetamine Saccharate, Amphetamine Aspartate, Dextroamphetamine Sulfate, Amphetamine Sulfate is a single-entity amphetamine product, often referred to as an amphetamine salt combo. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is frequently sold under the brand name Adderall, which is used for the treatment of Attention Deficit (Hyperactivity) Disorder (ADD/ADHD).

17. Vyvanse is a brand name for lisdexamfetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat ADD/ADHD.

18. Oxymorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

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19. Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. Dilaudid is a brand name for hydromorphone.

20. Norco is a brand name for hydrocodone bitartrate acetaminophen, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Hydrocodone belongs to a class of drugs known as opioids.

21. Soma is a brand name for carisoprodol, a Schedule IV controlled substance under the Uniform Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Xanax is a brand name for alprazolam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It belongs to a class of drugs called benzodiazepines.

23. Ativan is a brand name for lorazepam, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

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

25. Ambien is a brand name for zolpidem tartrate, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Valsartan is used to treat high blood pressure and heart failure and belongs to a class of drugs called angiotensin receptor blockers. It is a dangerous drug pursuant to Business and Professions Code section 4022.

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27. Klor-Con is a brand name for potassium chloride, a mineral supplement used to treat or prevent low amounts of potassium in the blood. It is a dangerous drug pursuant to Business and Professions Code section 4022.

28. Gabapentin is most commonly prescribed to relieve nerve pain, and is a dangerous drug pursuant to Business and Profession Code section 4022.

29. Zoloft (sertraline) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRI's). It is a dangerous drug pursuant to Business and Professions Code section 4022.

30. Angiotensin II is a chemical formed in the blood that causes muscles surrounding blood vessels to contract, thereby narrowing the vessels. This narrowing increases the pressure within the vessels and can cause high blood pressure (hypertension). Angiotensin II receptor blockers (ARB's) prevent angiotensin II from binding to angiotensin II receptors on the muscles surrounding blood vessels. As a result, blood vessels dilate and blood pressure is reduced.

31. Angiotensin-converting enzyme (ACE) inhibitors are heart medications that widen, or dilate, your blood vessels. Lisinopril is an ACE inhibitor.

32. International normalized ratio (INR) is a system established by the World Health Organization (WHO) and the International Committee on Thrombosis and Hemostasis for reporting the results of blood coagulation (clotting) tests.

33. Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California. It is compiled by the California Department of Justice, Bureau of Criminal Identification and Investigative Services as part of its Prescription Drug Monitoring Program.

34. Hyperalgesia is an enhanced pain response that can result from either injury to part of the body or from use of opioid painkillers. In the latter instance, the condition is called opioid-induced hyperalgesia.

35. Morphine equivalent dosing determines a patient's cumulative intake of any drugs in the opioid class over 24 hours. Each opioid (that the patient is likely to take per day) is assigned a morphine equivalent value, and these values are added to find the daily morphine equivalent dose.

FACTUAL ALLEGATIONS

36. At all relevant times, Respondent was board-certified in Family Medicine.

37. The standard of care for physicians prescribing controlled substances is that the physician should do so in substantial compliance with the published guidelines from the Board. In addition, the provider must follow applicable State and Federal laws regulating the prescribing of controlled substances. These guidelines include the following requirements:

a. The documentation of an independent, good faith interview and face-to-face examination of the patient and patient records in order to confirm the presence of specific conditions that necessitate potentially addictive pain medication. In addition, regular office visit follow ups are required. Informed consent for the use of controlled substances should be documented.

b. Physicians should make efforts to use less risky alternatives than controlled substances, when available, and document discussions of risks with patients. Trials of non-pharmacological treatment modalities, such as physical therapy, and medications that are not controlled substances, must be documented before prescribing opiates for chronic, non-malignant pain.

c. The patient's baseline level of functioning must be documented, both initially and in follow up. Frequent, ongoing monitoring is necessary with the goal of lowering or eliminating opioids and controlled substance medications whenever possible.

d. Physicians prescribing opioids and other controlled substances must be aware of, on the lookout for, and respond appropriately to, red flags of opioid misuse and diversion.

e. The physician must refer the patient to specialists when appropriate, including pain management specialists and addiction specialists, among others.

38. The standard of care when a patient presents to a clinic with elevated blood pressure requires that the provider document a history of present illness or injury. If applicable, any symptoms referable to the blood pressure should be determined and on-going organ damage ruled out or treated. Previous blood pressure problems or complications must be documented as well as any pharmacologic and non-pharmacologic therapies that have been tried. Elevated blood

pressures should be retested to determine if the elevation persists. An electrocardiogram and various lab tests including kidney function, electrolytes, urinalysis, lipid panel and blood sugar testing should be done as part of an initial evaluation of hypertension. Appropriate follow up for repeat blood pressure checks should be arranged.

39. The standard of care is to keep timely, accurate, complete and legible medical records.

40. The standard of care for primary care physicians when their patients have a manic episode or psychotic break is to ensure proper diagnosis and follow up by a psychiatrist after discharge from a psychiatric facility. When the patient is stabilized, prescribing and care may be transferred to a primary care physician with periodic input and co-management by a psychiatrist.

41. The standard of care for the evaluation and management of ADD/ADHD in adults requires that the condition be appropriately diagnosed. A substance use history must be documented to ensure patient safety. To warrant evaluation and treatment, the symptoms of ADHD must be severe enough to cause significant social impairment. These social impairments need to be documented, along with age of symptom onset and impairment. Medications can have significant side effects and periodically the patient should be assessed for appetite suppression, elevated bloodpressure, weight loss, dry mouth and mood abnormliaites. The patient's response to therapy should be documented. When ADHD and anxiety disorder co-exist, the first line of treatment should include an SSRI to prevent additional risk of misuse of benzodiazepines.

Patient A: [1]

42. Patient A is a male person, born in 1952.

43. Between January 2015 and August 2018, at least once a month, Patient A filled prescriptions written by Respondent for 240 x Norco 10/325 tablets.[2] From September 2018 to December 2018, Respondent alternated between monthly prescriptions for 210 and 180 tablets before resuming monthly prescriptions for 240 tablets in January 2019.

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[1] The names have been omitted for all patients referenced in this pleading. Respondent is aware of the patients' identities.

[2] Patient A's CURES report does not show prescriptions filled during April 2015, October 2015, and February 2016.

44. During the course of the four year period from 2015 through 2019,[3] Respondent had seven face-to-face visits with Patient A.

45. On or about March 4, 2015,[4] Patient A presented to Respondent for "follow up of diabetes medication." Patient A complained of toe bruising from "hiling" (sic) and some night sweats due to low blood sugar. Respondent's progress note for this visit contains no documented history of any other painful condition. Under the heading "current meds," there are nine medications listed, including Valsartan and Lisinopril for diabetes and three medications to control blood pressure. The list also includes Norco 10/325 tablets, 2 tablets "every 4 hours as needed for pain." Patient A's vital signs include the notation, "Blood Pressure not obtained; BP not obtained Unable to obtain BP..." Respondent records a negative systems review, including "no musculoskeletal symptoms" and "no neurological symptoms," with the rest of the physical exam being apparently normal. There is no documented diabetic foot exam. Respondent's assessment at this visit includes "painful diabetic neuropathy." No follow up plan is documented.

46. The next chart entry for Patient A is dated March 6, 2015. No history or physical exam is recorded, and the orders are to renew the prescription for Norco 10/325, 2 tablets every 4 hours as needed for pain, quantity 240.

47. Patient A is next seen by Respondent on or about December 14, 2015, when he presented "for follow up of medications." According to Respondent's chart notes, Patient A is "doing well most of the pain is due to severe diab[etic] neuropathy - has tried lyrica but can't handle only 2 lyrica as a rule per day has been on the same dosage of hydrocodone for yrs with no increase." Patient A's systems review was documented as all normal. His vital signs included a blood pressure of 164/80, heart rate 61 beats per minute and the rest of Patient A's physical exam was normal. Respondent's assessments at this visit included painful diabetic neuropathy, hypertension, chronic pain in the right foot, chronic pain in the left foot, and controlled diabetes mellitus. There is no documented diabetic foot exam.

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[3] The medical records of Patient A, Patient B, and Patient C, were obtained on or about January 24, 2019, and consequently no treatment by Respondent of these three patients beyond that date was reviewed.

[4] March 4, 2015, is the earliest date for which Patient A's medical records were available.

48. On or about March 23, 2016, Patient A again presents to Respondent, for a "preventive physical exam and f/u on meds." Respondent records that Patient A "has pain in feet - - this is all due to peripheral neuropathy plays volleyball indoors - - it is wood. Will not give up volleyball. Plays 2-3 hrs a day." Respondent notes, further, that Patient A "has anxiety due to dad's death has insomnia as well spoke about the amount of pills and possible liver damage." Respondent's physical exam of Patient A includes a recorded blood pressure of 148/72, and "feet showed abnormalities [bilateral] foot pain tender." The notes provide no indication of which part(s) of the feet were affected. The assessments included chronic pain in the right foot, chronic pain in the left foot, controlled diabetes mellitus, and narcotic dependence.

49. From on or about March 23, 2016, in addition to the monthly Norco x 240 tablets as previously mentioned, Patient A started filling prescriptions written by Respondent for 30 x Ativan 1 mg tablets, to be taken one at bedtime.

50. Patient A is next seen by Respondent on or about July 21, 2016, when he presents for "follow up of anxiety and medications." Respondent documents the history of present illness (HPI) as "Pt doesn't want colonoscopy - wants the FIT test - - wants Ativan for bedtime. Constant neuropathic pain of [bilateral] feet - - toe!nad @ very numb." Respondent's chart note for this date of service contains no further history. Patient A's blood pressure is recorded as 145/86 with a heart rate of 72 beats per minute. No other physical exam is recorded. Respondent's assessment at this visit includes chronic insomnia, anxiety, "history of painful diabetic neuropathy (E11.40); Resolved: 21Jul2016" and "painful diabetic neuropathy (E11.40)."

51. On or about March 2, 2017, Patient A again presents to Respondent, for "complaints of medication refill." Respondent's HPI notes include "[p]ain is severe at the bottom of the feet near the metatarsals as well as the dorsum - - has had pain 15-20 yrs - - felt to be neuropathy – tried meds and surgeries due to the severity of the pain – if takes every 4 hours no pain whatsoever then 100% pain not as worse on feet – plays volleyball in hard wood floor gym indoors." Respondent's review of systems is positive for "pain in the lower extremities, pain localized to one or more joints, joint swelling localized to one or more joints and joint stiffness localized to one or more joints." No indication is provided of the specific joint(s) affected.

Patient A's blood pressure is recorded as 181/90 at this visit, with a heart rate of 97 beats per minute. The blood pressure measurement was not repeated. Patient A's pain scale is documented as "0/10." Respondent notes that Patient A's "feet showed abnormalities." Respondent's assessments include chronic pain in the right foot, chronic pain in the left foot, narcotic dependence, painful diabetic neuropathy, controlled diabetes mellitus, and hypertension.

52. The final documented visit by Patient A is on or about June 7, 2017, when he presented to Respondent for "follow up on medication." The HPI is documented as "has severe peripheral neuropathy [bilateral] feet has tried lyrica but can't take 2 has tried gabapentin and is not effective has tried anti-inflammatory has gastritis so has to rely on hydrocodone and 7-8 a day seem to allow a semblance of normal life liver has been followed." Patient A's blood pressure is recorded at this visit as 148/94, pulse rate 93 beats per minute, and the rest of the vital signs are normal. Patient A's pain scale is documented as "0/10." Respondent's physical exam notes include the following: "both feet with swelling, warmth, dorsal tenderness, plantar tenderness, lateral tenderness and decreased range of motion of toes," and also, "normal appearance, no deformity, no erythema, no tenderness and full range of motion of toes," with "normal bilateral foot strength" and "decreased bilateral foot sensation." Respondent's assessments included chronic pain in the right foot, chronic pain in the left foot, and hypertension.

53. Respondent did not conduct foot sensation testing with a monofilament, and did not refer Patient A to a podiatrist or other specialist for evaluation and treatment of his severe diabetic neuropathy.

54. Respondent's documented plan for Patient A on or about June 7, 2017, includes "Start: Valsartan 320 mg oral tablet [for blood pressure]..." Valsartan is also included under Patient A's "current meds" at every prior visit. Along with Valsartan (an ARB), Respondent also prescribed Lisinopril (an ACE-inhibitor) to be taken concurrently over the four year period reviewed.

55. Respondent did not address Patient A's frequently elevated blood pressures with any recommendations.

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56. During the four year period from 2015 through 2019, Patient A was subjected to only one drug screen test. Respondent did not increase the quantity of Norco he prescribed to Patient A, nor did he document any attempts to taper to lower doses.

57. Respondent did not justify in his records the use of long-term benzodiazepines, nor does Patient A's medical chart reflect a discussion about the increased risks of taking opioids and benzodiazepines concurrently.

Patient B:

58. Patient B is a male person, born in 1928.

59. From January 2015 through January 2016, Patient B filled almost monthly prescriptions written by Respondent for 210 x Norco 10/325 tablets.[5] From February 2016 through February 2019, these monthly prescriptions were for 180 tablets. During the months August, September and October 2018, and January 2019, the prescriptions were for 140 tablets. No explanation for the change in monthly prescribing can be found in Patient B's chart.

60. During the four year period from 2015 through 2019, Patient B was subjected to only one drug screen test, which proved negative for all substances tested, including opioids.

61. On or about January 13, 2015,[6] Patient B presented to Respondent "for follow up of evaluation of all medication." Respondent's chart note for this visit indicates the HPI as "[patient] wants to take Lasix even in spite of chf sx - - goes every 20 minutes at times – wants change in his potassium." The HPI includes the comment "[patient] does not walk due to arthritis in the knees." The note lists twenty-four (24) "active problems," and contains no mention of the status of any painful condition. The list of "current meds" includes two prescriptions for Norco 10/325 and one for potassium chloride ER 10 mEq. Respondent's assessments included "CHF, chronic," hypertension, and gastroesophageal reflux disease (GERD). Respondent's orders on this date include "Klor-Con M20 20 mEq oral tablet Extended Release." The potassium chloride ER 10 mEq is not discontinued.

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[5] Patient B's CURES report does not show prescriptions filled during August 2015 and September 2015.

[6] January 13, 2015, is the earliest date for which Patient B's medical records were available.

62. On or about February 23, 2015, Patient B presented with "complaints of lightheaded x 1 month" and had also "been experiencing numbness on right hand x 3 months." The note contains no status of any painful condition. The list of "current meds" at this date includes two prescriptions for Norco 10/325, and two prescriptions for potassium chloride. The two Norco 10/325 prescriptions and the prescription for Klor-Con M20 20 mEq tablets are discontinued at this visit without explanation.

63. On or about March 30, 2015, Patient B visited Respondent for left knee pain following a fall. Under the review of systems, for musculoskeletal Respondent noted "pain in the lower extremities, pain localized to one or more joints, joint swelling localized to one or more joints, and joint stiffness localized to one or more joints." Respondent's assessment was "left knee pain," and he ordered X-rays of that knee.

64. On or about April 2, 2015, Patient B presented for follow up of left knee and the results of his X-rays. Under the HPI, Respondent documented that Patient B was "doing well with the exception of his pain in the left knee – cortisone usually helps." Under the review of systems, for musculoskeletal Respondent noted "pain localized to one or more joints, joint swelling localized to one or more joints, and joint stiffness localized to one or more joints - - knee osteoarthritis." Respondent's assessment was osteoarthritis of both knees, and he gave Patient B an intramuscular injection of cortisone.

65. On or about April 15, 2015, Patient B saw Respondent "for complaints of L left pain, [patient] also here to discuss insomnia, shortness of breath, and discuss Coumadin." Under HPI, Respondent documents "[patient complains of] pain in the left knee and referred pain to the l thigh - received cortisone shot - it has helped - occurring less frequently - maybe a reaction to the cortisone shot. Also getting INRs done, his level has not changed will give him 2 mg a day x 6 days and 3 mg." Respondent's assessments include insomnia, dyspnea, and osteoarthritis of the knees. Also at this visit, Respondent adds a prescription for gabapentin 100 mg at bedtime.

66. Patient B returned to Respondent on or about November 23, 2015 for "complaints of L knee pain," and requested a cortisone injection. According to the HPI, Patient B "has had cortisone shot in the past and it worked well – no falls." Respondent's chart note for this date

includes two prescriptions for Norco 10/325. No information regarding the Norco prescription(s), or whether the Norco is effective, is provided in the note. Respondent's assessments were chronic pain of the left knee and pharyngoesophageal dysphagia. Respondent referred Patient B to gastroenterology and administered an injection of cortisone into the right deltoid muscle.

67. During the period under review, Respondent saw Patient B on a further nine (9) occasions. During these visits, Respondent continues to refill the Norco prescriptions. The notes provide no information on how (or whether) the Norco was helping Patient B's symptoms, whether he had any side effects, or Patient B's activity level.

68. On or about May 31, 2017, Respondent documented Patient B's visit in a chart note in which sixty-one (61) "active conditions" were listed, including decubitus ulcer of right heel. The same condition is listed as an active condition in Respondent's notes dated January 24, 2017, and December 15, 2016, though none of these notes includes any physical exam of the right heel, nor any mention of the condition in the HPI or assessments.

69. On or about November 15, 2017, the final visit for which a chart note is available, Respondent documents the following observations for Respondent's physical exam of Patient B: "Both hands with deformities, erythema, swelling, warmth, dorsal tenderness, palmar tenderness, tenderness of thenar eminence, tenderness of hypothenar eminence, decreased extension of the fingers and decreased abduction of the fingers," and also, contradictorily, "normal appearance, no tenderness and normal range of motion." Patient B's knee exam provides: "Left knee with swelling, warmth, medial joint line tenderness and lateral joint line tenderness, but normal appearance, no erythema, no ecchymosis, no joint effusion, no joint hypertrophy, no genu valgum, no genu varus, no patellar tendon tenderness, normal range of motion, normal flexion and normal extension." Respondent's assessments include chronic pain syndrome, chronic systolic congestive heart failure, osteoarthritis of both knees and hand arthritis.

70. Patient B's chart contains no comment on the inconsistent results of the urine drug screen test, which was negative for opioids on or about November 15, 2017.

71. There is no indication in his chart that Respondent followed up on any referral made for Patient B.

Patient C:

72. Patient C is a male person, born in 1987. During the period January 1, 2015, through September 4, 2018, Respondent prescribed the following controlled substances to Patient C:

DATE FILLED	DRUG	STRENGTH	QUANTITY
2015/1/5	CARISOPRODOL	350 MG	60
2015/1/5	ADDERALL XR	30 MG	30
2015/1/5	HYDROMORPHONE HCL	8 MG	180
2015/1/5	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/1/5	MORPHINE SULFATE	100 MG	120
2015/1/6	ZOLPIDEM TARTRATE	12.5 MG	30
2015/1/26	MORPHINE SULFATE	100 MG	120
2015/1/26	OXYCODONE HCL	30 MG	180
2015/1/26	CARISOPRODOL	350 MG	90
2015/1/29	ZOLPIDEM TARTRATE	12.5 MG	30
2015/2/4	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/2/4	ADDERALL XR	30 MG	30
2015/2/16	MORPHINE SULFATE	100 MG	120
2015/2/16	CARISOPRODOL	350 MG	90
2015/2/17	OXYCODONE HCL	30 MG	180
2015/2/20	ZOLPIDEM TARTRATE	12.5 MG	30
2015/3/5	MORPHINE SULFATE	100 MG	120
2015/3/5	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/3/5	ZOLPIDEM TARTRATE	12.5 MG	30
2015/3/5	CARISOPRODOL	350 MG	90
2015/3/5	OXYCODONE HCL	30 MG	180
2015/3/5	ADDERALL XR	30 MG	30
2015/3/21	CARISOPRODOL	350 MG	90
2015/3/26	MORPHINE SULFATE	100 MG	120
2015/3/27	ZOLPIDEM TARTRATE	12.5 MG	30
2015/3/27	OXYCODONE HCL	30 MG	180
2015/4/7	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/4/7	CARISOPRODOL	350 MG	90
2015/4/7	ADDERALL XR	30 MG	30
2015/4/15	MORPHINE SULFATE	100 MG	120
2015/4/18	ZOLPIDEM TARTRATE	12.5 MG	30
2015/4/18	OXYCODONE HCL	30 MG	180
2015/4/22	CARISOPRODOL	350 MG	90
2015/5/4	MORPHINE SULFATE	100 MG	120
2015/5/4	OXYMORPHONE HCL	10 MG	180
2015/5/5	ADDERALL XR	30 MG	30
2015/5/5	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/5/11	ZOLPIDEM TARTRATE	12.5 MG	30
2015/5/14	CARISOPRODOL	350 MG	90
2015/5/22	MORPHINE SULFATE	100 MG	120
2015/5/26	OXYMORPHONE HCL	10 MG	180
2015/6/1	ADDERALL XR	30 MG	30
2015/6/1	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/6/2	ZOLPIDEM TARTRATE	12.5 MG	30
2015/6/5	CARISOPRODOL	350 MG	90

2015/6/10	MORPHINE SULFATE	100 MG	120
2015/6/17	OXYMORPHONE HCL	10 MG	180
2015/6/24	ZOLPIDEM TARTRATE	12.5 MG	30
2015/6/27	CARISOPRODOL	350 MG	90
2015/6/29	OXYCODONE HCL	80 MG	120
2015/6/30	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/6/30	ADDERALL XR	30 MG	30
2015/7/9	OXYMORPHONE HCL	10 MG	180
2015/7/16	ZOLPIDEM TARTRATE	12.5 MG	30
2015/7/18	MORPHINE SULFATE	100 MG	120
2015/7/20	CARISOPRODOL	350 MG	90
2015/7/29	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/7/29	ADDERALL XR	30 MG	30
2015/8/4	OXYMORPHONE HCL	10 MG	180
2015/8/6	OXYCONTIN	80 MG	120
2015/8/7	ZOLPIDEM TARTRATE	12.5 MG	30
2015/8/11	CARISOPRODOL	350 MG	90
2015/8/24	OXYCODONE HCL	30 MG	180
2015/8/28	OXYCONTIN	80 MG	120
2015/8/29	ZOLPIDEM TARTRATE	12.5 MG	30
2015/8/29	ADDERALL XR	30 MG	30
2015/8/29	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/9/2	CARISOPRODOL	350 MG	90
2015/9/14	OXYCODONE HCL	30 MG	180
2015/9/19	OXYCONTIN	80 MG	120
2015/9/24	CARISOPRODOL	350 MG	120
2015/9/24	ZOLPIDEM TARTRATE	12.5 MG	30
2015/9/29	ADDERALL XR	30 MG	30
2015/9/29	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/10/5	OXYCODONE HCL	30 MG	180
2015/10/9	OXYCONTIN	80 MG	120
2015/10/19	ZOLPIDEM TARTRATE	12.5 MG	30
2015/10/19	CARISOPRODOL	350 MG	120
2015/10/24	OXYMORPHONE HCL	10 MG	180
2015/10/28	ADDERALL XR	30 MG	60
2015/10/28	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/10/31	OXYCONTIN	80 MG	120
2015/11/13	OXYCODONE HCL	30 MG	240
2015/11/13	ZOLPIDEM TARTRATE	12.5 MG	30
2015/11/13	CARISOPRODOL	350 MG	120
2015/11/23	OXYCONTIN	80 MG	120
2015/11/25	ADDERALL XR	30 MG	60
2015/11/25	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2015/12/3	OXYCODONE HCL	30 MG	240
2015/12/7	ZOLPIDEM TARTRATE	12.5 MG	30
2015/12/7	CARISOPRODOL	350 MG	120
2015/12/12	OXYCONTIN	80 MG	120
2015/12/22	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2015/12/22	ADDERALL XR	30 MG	60
2015/12/23	OXYCODONE HCL	30 MG	240
2016/1/12	OXYCODONE HCL	30 MG	240
2016/1/23	ADDERALL XR	30 MG	60
2016/1/23	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/1/23	ZOLPIDEM TARTRATE	12.5 MG	30

2016/1/23	CARISOPRODOL	350 MG	120
2016/1/25	OXYCONTIN	80 MG	120
2016/2/1	OXYCODONE HCL	30 MG	240
2016/2/15	OXYCODONE HCL	30 MG	240
2016/2/15	CARISOPRODOL	350 MG	90
2016/2/15	ZOLPIDEM TARTRATE	12.5 MG	30
2016/2/16	OXYCONTIN	80 MG	120
2016/3/1	ADDERALL XR	30 MG	60
2016/3/1	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/3/7	OXYCODONE HCL	30 MG	240
2016/3/7	CARISOPRODOL	350 MG	120
2016/3/8	ZOLPIDEM TARTRATE	12.5 MG	30
2016/3/9	OXYCONTIN	80 MG	120
2016/3/28	OXYCODONE HCL	30 MG	240
2016/3/31	OXYCONTIN	80 MG	120
2016/3/31	ADDERALL XR	30 MG	60
2016/3/31	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/4/4	CARISOPRODOL	350 MG	120
2016/4/4	ZOLPIDEM TARTRATE	12.5 MG	30
2016/4/16	OXYCODONE HCL	30 MG	240
2016/4/22	OXYCONTIN	80 MG	120
2016/4/27	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/4/27	ADDERALL XR	30 MG	60
2016/4/30	ZOLPIDEM TARTRATE	12.5 MG	30
2016/4/30	CARISOPRODOL	350 MG	120
2016/5/6	OXYCODONE HCL	30 MG	240
2016/5/14	OXYCONTIN	80 MG	120
2016/5/25	CARISOPRODOL	350 MG	120
2016/5/25	OXYCODONE HCL	30 MG	240
2016/5/25	ZOLPIDEM TARTRATE	12.5 MG	30
2016/5/27	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	60
2016/5/27	ADDERALL XR	30 MG	60
2016/6/4	OXYCONTIN	80 MG	120
2016/6/15	OXYCODONE HCL	30 MG	240
2016/6/18	ZOLPIDEM TARTRATE	12.5 MG	30
2016/6/18	CARISOPRODOL	350 MG	120
2016/6/25	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/6/25	ADDERALL XR	30 MG	60
2016/6/25	OXYCONTIN	80 MG	120
2016/7/5	OXYCODONE HCL	30 MG	240
2016/7/11	CARISOPRODOL	350 MG	120
2016/7/11	ZOLPIDEM TARTRATE	12.5 MG	30
2016/7/18	OXYCONTIN	80 MG	120
2016/7/27	OXYCODONE HCL	30 MG	240
2016/8/2	ZOLPIDEM TARTRATE	12.5 MG	30
2016/8/2	CARISOPRODOL	350 MG	120
2016/8/9	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/8/9	OXYCODONE HCL	80 MG	120
2016/8/9	ADDERALL XR	30 MG	60
2016/8/16	OXYCODONE HCL	30 MG	240
2016/8/22	ZOLPIDEM TARTRATE	12.5 MG	30
2016/8/22	CARISOPRODOL	350 MG	120
2016/8/29	MORPHINE SULFATE	200 MG	120
2016/9/6	OXYCODONE HCL	30 MG	240
2016/9/10	ADDERALL XR	30 MG	60
2016/9/10	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90

2016/9/16	CARISOPRODOL	350 MG	120
2016/9/16	ZOLPIDEM TARTRATE	12.5 MG	30
2016/9/20	MORPHINE SULFATE	100 MG	120
2016/9/27	OXYCODONE HCL	30 MG	240
2016/10/8	ADDERALL XR	30 MG	60
2016/10/8	DEXTROAMPH SACC-AMPH ASP-DEXTROAM S	20 MG	90
2016/10/11	CARISOPRODOL	350 MG	120
2016/10/11	ZOLPIDEM TARTRATE	12.5 MG	30
2016/10/12	MORPHINE SULFATE	100 MG	120
2016/10/19	OXYCODONE HCL	30 MG	240
2017/1/18	CARISOPRODOL	350 MG	120
2017/2/12	CARISOPRODOL	350 MG	120
2017/3/14	CARISOPRODOL	350 MG	120
2017/3/20	ZOLPIDEM TARTRATE	12.5 MG	30
2017/3/30	ALPRAZOLAM	1 MG	90
2017/4/14	CARISOPRODOL	350 MG	120
2017/4/17	ZOLPIDEM TARTRATE	12.5 MG	30
2017/4/18	HYDROCODONE BITARTRATE-ACETAMINOPHEN	10/325 MG	20
2017/4/19	OXYCODONE HCL	30 MG	90
2017/4/27	ALPRAZOLAM	1 MG	90
2017/4/29	OXYCODONE HCL	30 MG	180
2017/5/9	MORPHINE SULFATE	100 MG	60
2017/5/11	CARISOPRODOL	350 MG	90
2017/5/15	ZOLPIDEM TARTRATE	12.5 MG	30
2017/5/16	OXYCODONE HCL	30 MG	240
2017/5/24	ALPRAZOLAM	1 MG	60
2017/6/1	MORPHINE SULFATE	100 MG	60
2017/6/12	OXYCODONE HCL	30 MG	240
2017/6/15	ZOLPIDEM TARTRATE	12.5 MG	30
2017/6/15	CARISOPRODOL	350 MG	90
2017/6/26	MORPHINE SULFATE	100 MG	60
2017/6/27	ALPRAZOLAM	1 MG	60
2017/7/6	HYDROCODONE BITARTRATE-ACETAMINOPHEN	10/325 MG	20
2017/7/7	OXYCODONE HCL	30 MG	240
2017/7/16	ZOLPIDEM TARTRATE	12.5 MG	30
2017/7/16	CARISOPRODOL	350 MG	90
2017/9/25	LORAZEPAM	1 MG	10
2017/10/9	ALPRAZOLAM	1 MG	60
2017/10/9	CARISOPRODOL	350 MG	90
2017/10/9	ZOLPIDEM TARTRATE	12.5 MG	30
2017/12/5	ZOLPIDEM TARTRATE	12.5 MG	30
2017/12/6	CARISOPRODOL	350 MG	90
2017/12/27	MORPHINE SULFATE	60 MG	90
2018/1/5	OXYCODONE HCL	30 MG	198
2018/1/26	MORPHINE SULFATE	100 MG	60
2018/2/1	CLONAZEPAM	1 MG	90
2018/2/2	OXYCODONE HCL	30 MG	240
2018/2/23	MORPHINE SULFATE	100 MG	60
2018/2/28	CLONAZEPAM	1 MG	90
2018/3/2	OXYCODONE HCL	30 MG	42
2018/3/2	OXYCODONE HCL	30 MG	168
2018/3/23	MORPHINE SULFATE	100 MG	60
2018/3/30	OXYCODONE HCL	30 MG	168
2018/3/30	CLONAZEPAM	1 MG	90

2018/3/30	OXYCODONE HCL	30 MG	42
2018/4/19	MORPHINE SULFATE	100 MG	60
2018/4/24	CLONAZEPAM	1 MG	90
2018/4/27	OXYCODONE HCL	30 MG	42
2018/4/27	OXYCODONE HCL	30 MG	138
2018/5/11	MORPHINE SULFATE	100 MG	90
2018/5/21	CLONAZEPAM	1 MG	90
2018/5/23	OXYCODONE HCL	30 MG	42
2018/5/23	OXYCODONE HCL	30 MG	138
2018/6/6	MORPHINE SULFATE	100 MG	90
2018/6/18	OXYCODONE HCL	30 MG	42
2018/6/18	OXYCODONE HCL	30 MG	138
2018/6/18	CLONAZEPAM	1 MG	90
2018/6/27	CARISOPRODOL	350 MG	15
2018/7/2	MORPHINE SULFATE	100 MG	90
2018/7/13	CLONAZEPAM	1 MG	90
2018/7/27	MORPHINE SULFATE	100 MG	90
2018/8/7	CLONAZEPAM	1 MG	90
2018/8/10	OXYCODONE HCL	30 MG	180
2018/8/21	MORPHINE SULFATE	100 MG	90
2018/9/4	OXYCODONE HCL	30 MG	210

73. Patient C's chart contains a pain management consultation dated July 6, 2011, which states that Patient C likely had opioid-induced hyperalgesia as a result of his high dose opioid therapy, and that inpatient opioid detoxification was recommended at that time. The chart contains no subsequent communications from or to any pain management specialist.

74. Patient C's chart contains a letter by Respondent, dated March 25, 2014, stating that Patient C had then been his patient for five years for a shoulder injury, and was receiving opioid therapy for chronic pain in the left shoulder. Patient C reportedly had two surgeries prior to becoming Respondent's patient. The letter states, further, that Patient C was taking Ambien CR 12.5 mg x 30, Dilaudid 8 mg every 4 – 6 hours as needed for pain x 180, and MS Contin 100 mg every 4 – 6 hours as needed for pain x 120.

75. On or about September 25, 2014, Patient C presented to Respondent "for follow up of medications check." The HPI states that the patient "[complains of] pain still present but [u]nder better control with the meds. Can be worse at times but definitely not out of control. Seeing pain counselor, using cognitive pain management. Meds should remain the same." On this date, Respondent's musculoskeletal review of systems documents "no back pain, no localized joint pain, and no localized joint swelling." The note reveals no physical exam of Patient C's shoulder,

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and no other documentation of the specific location of the pain nor what triggered the pain that Respondent was treating with controlled substances.

76. In early 2015, Respondent was prescribing Ambien 12.5 mg for Patient C to take every night. No sleep history is documented, nor does the chart indicate that safer sleep-inducing non-pharmacological and pharmacological alternatives were attempted first.[7]

77. In May and June 2016, Respondent was prescribing more than 1000 mg of morphine equivalents to Patient C per day, along with multiple benzodiazepines and Soma, a habit-forming muscle relaxer. Respondent did not seek expert input before escalating Patient C's medications to these quantities.

78. On or about September 28, 2016, Patient C presented to Respondent for follow up of chronic pain, needing refills. The HPI for this visit includes the comment by Respondent that Patient C "is 270 lbs and needs [MS Contin Extended Release, one tablet every 4 – 6 hours for pain, quantity 120] for control of the pain. Oxycontin is too expensive. He does not have any side effects with the meds x of constipation." In addition to the MS Contin, Respondent renewed prescriptions for Patient C for oxycodone (240 x 30 mg tablets), zolpidem tartrate (30 x 12.5 tablets), and carisoprodol (120 x 350 mg tablets).

79. Patient C's chart references no ongoing discussion about his previously documented opioid-induced hyperalgesia.

80. Patient C's chart references no discussion of the risks of these high dose opioids or of the combination of opioids and benzodiazepines.

81. In 2016, according to a CURES report obtained for Patient C, the last prescription he filled for any opioid, Ambien or Soma, was on or before October 19, 2016.

82. On or about December 7, 2016, Respondent documented in Patient C's chart that Patient C had been admitted to Canyon Ridge psychiatric hospital from November 5 through November 11, 2016. The HPI states that Patient C "had a bipolar break – was manic – went to hospital … he is hyperreligious … believes he can completely interpret the book of revelation….

[7] Respondent's chart note dated January 5, 2015, includes four prescriptions for Ambien, three for Oxycodone, and three for MS Contin under "current meds."

His mission is to play music convert people and ride dirt bikes..." On or about January 5, 2017, Respondent noted in Patient C's chart that he was taking the antipsychotic, Zyprexa. Respondent discontinued the Zyprexa on or about January 6, 2017.

83. On or about January 18, 2017, Patient C presented to Respondent with the complaint that "both ears hurt." The HPI states that Patient C had "tension in the abdominal muscles as well as the back – will use Soma." Respondent's chart note for this visit reveals no physical exam of the Patient C's abdomen or back. At this visit, Respondent restarted Patient C on carisoprodol (120 x 350 mg) "for severe muscle spasm."

84. Respondent's chart note for Patient C, dated March 20, 2017, lists two prescriptions for carisoprodol 350 mg tablets under "current meds." The HPI states Patient C "is still feeling well - has mild anxiety or may be due to the lack of opioids in the system – he will not start again." The chart note contains no documentation of Patient C's sleep history. Respondent ordered Ambien 12.5 mg CR for bedtime, and gabapentin for pain.

85. On or about March 30, 2017, Respondent documented in Patient C's chart that he was "not doing as well - has had physical anxiety [probably] related to the post withdrawal of pain meds." Respondent's psychological system review documents "[a]nxiety. No depression and a desire to continue living. No disturbing or unusual thoughts, feelings, or sensations and not crying for no reason." Other than anxiety, no psychiatric symptoms are mentioned in the chart note. Respondent prescribed alprazolam 1 mg (three times daily), as well as Zoloft 50 mg one daily.

86. On or about April 18, 2017, Patient C presented with "complaints of withdrawal symptoms." Respondent's notes in the HPI include that Patient C "feels he is in opiate withdrawals – feels sick somewhat nauseated sometimes vomiting - - constant anxiety to the point can't think straight – can't concentrate hardly at all mom had a few painkillers in the cabinet took norco 10/325 all at one time didn't touch the anxiety – the tolerance is very high – had some pain but minimal – doesn't want pain meds." Respondent's assessment for this visit was "withdrawal symptoms drug or narcotic." Under the heading "[d]iscussed," Respondent documented, "will plan to decrease the med slowly to avoid the withdrawal effect which seems to be delayed every

month we will decrease the dosage." After an apparent six month hiatus from prescribing opioids to Patient C, Respondent restarted Patient C on oxycodone 30 mg x 90 tablets, and Norco 10/325 mg, 1 tablet twice daily[8] for what he regarded as the manifestation of opiate withdrawal symptoms. Respondent did not re-refer Patient C to a pain management specialist.

87. On or about April 27, 2017, Patient C presented to Respondent "to discuss medications. Still having the sx of withdrawal placed back on med but the dosage is way too low to prevent the sx his tolerance is too high for the meds has mild pain in the right shoulder but not severe at this point." Under HPI, Respondent included "as above he has noticed irritability has noted severe anxiety that manifest itself as going from hot to col[d] and severe anxiety this is not surprising due to coming off meds which he had taken regularly for 7 yrs at the snap of the finger." Patient C's current meds were listed as alprazolam, Soma (two prescriptions listed), gabapentin, Norco, oxycodone, sertraline and Ambien. The chart note contains no psychiatric or sleep-related systems review. Respondent noted "[o]ur plan is to wean slowly off the pain med so as not to have the withdrawal which is now manifesting after complete sudden cessation of the pain meds." His orders on this date were for Patient C to stop Soma and Norco and double his dose of oxycodone to two 30 mg tablets, three times a day. The alprazolam prescription was also renewed.

88. Respondent did not refer Patient C to a psychiatrist for management of his psychiatric symptoms. The chart contains no indication that Respondent assessed Patient C's treatment response to Zoloft.

89. Respondent did not follow up on the recommendations of the pain management specialist, made in 2011, that Patient C needed inpatient detoxification for his opioid-induced hyperalgesia, nor did Respondent attempt a slow taper of opioids in primary care.

90. Patient C's chart contains one urine drug screening dated January 5, 2018, in which the prescribed medications are listed as alprazolam, hydrocodone, oxycodone and morphine. The screen was negative for oxycodone, hydrocodone, and alprazolam. There is no indication in Patient C's chart that Respondent followed up on this apparently inconsistent drug screen result.

[8] Current medications at this visit include two prescriptions for carisoprodol.

Patient D:

91. Patient D is a female person, born in 1955.

92. During the period January 13, 2014, through November 9, 2014, Respondent prescribed Adderall 20 mg x 60 tablets to Patient D on six occasions, and alprazolam .25 mg x 90 tablets on two occasions. Respondent also prescribed a four-day supply of Iophen-C NR, a cough mixture containing codeine, on one occasion during this period, and again on or about October 19, 2016, and on or about February 26, 2017.

93. Respondent's medical chart for Patient D consists of a single progress note with a date of service of February 26, 2017. The note contains no recorded vital signs, no documented physical examination, no assessments, and no treatment plan for Patient D.

94. Patient D's medical chart documents no medical indication for any of the controlled substances prescribed, the status of Patient D's conditions, any side effects, or Patient D's response to treatment. There is similarly no documentation to support the diagnosis of ADD/ADHD, and no documentation of any social impairments or justification of medication treatment.

Patient E:

95. Patient E is a male person born in 1980.

96. Between March 14, 2014, and February 10, 2017, Respondent issued the following prescriptions to Patient E:

DATE FILLED	DRUG	STRENGTH	QUANTITY
2014/3/14	ALPRAZOLAM	.25 MG	90
2014/8/11	VYVANSE	40 MG	30
2014/10/9	VYVANSE	40 MG	30
2014/12/6	AMPHETAMINE SALT COMBO	20 MG	60
2015/2/17	VYVANSE	40 MG	30
2015/4/1	VYVANSE	40 MG	30
2015/5/8	VYVANSE	40 MG	30
2015/7/1	VYVANSE	40 MG	30
2015/8/18	VYVANSE	40 MG	30
2015/12/28	VYVANSE	40 MG	30
2016/2/1	VYVANSE	40 MG	30
2016/6/15	ALPRAZOLAM	.25 MG	60
2016/8/9	ALPRAZOLAM	.25 MG	60
2017/2/10	ALPRAZOLAM	.25 MG	60

97. Respondent's medical chart for Patient E contains only two progress notes, dated October 8, 2014, and March 26, 2015, respectively.

98. Respondent's note dated October 8, 2014, states Patient E "presents today for complaints of medication." The HPI includes an assessment for ADD/ADHD. Vyvanse 40 mg is listed under "current meds." Respondent's note for this date includes a negative review of systems and a physical examination of Patient E. Patient E's vital signs are within normal limits. Respondent's assessment was "ADD (attention deficit hyperactivity disorder, inattentive type)."

99. The note dated March 26, 2015, indicates ADD as an active problem. The list of "current meds" includes three prescriptions for Vyvanse 40 mg, and one for Adderall 20 mg. The note contains no history of present illness, no vital signs nor any physical examination. Similarly, there is no current assessment section and Respondent's orders are to "renew amphetamine-dextroamphetamine 20 mg tablet (Adderall); take 1 tablet twice daily..."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

100. Respondent has subjected his Physician's and Surgeon's Certificate No. G 35907 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E, as more particularly alleged hereafter:

Patient A:

a. Respondent failed to treat Patient A's hypertension appropriately, in that he failed to address Patient A's elevated blood pressures with any recommendation, did not keep clear documentation about Patient A's anti-hypertensive program, and maintained Patient A on an ARB with concurrent use of an ACE-inhibitor, among others.

b. Respondent failed to evaluate Patient A's severe diabetic neuropathy, including his failure to document accurate physical examinations, not conducting foot sensation testing with a monofilament, and not referring Patient A to a podiatrist or other specialist for evaluation and treatment, among others.

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Patient B:

c. Respondent failed to maintain substantial compliance with appropriate controlled substance prescribing practices, including his failure to document the status of Patient B's painful conditions, the condition for which Patient B was taking Norco and whether (or how much) it was ameliorating his pain and/or whether Patient B enjoyed any functional improvement as a result of taking controlled substances, the failure to try safer treatment alternatives first, the failure to follow up on the inconsistent urine drug screen, and the failure to document an explanation for the monthly quantity changes in Norco, among others.

Patient C:

d. Respondent failed to maintain substantial compliance with appropriate controlled substance prescribing practices, including that he prescribed controlled substances without any indication that non-controlled substances or other modalities of treatment had been attempted first, failed to make appropriate referrals, failed to warn Patient C of the risks of combining benzodiazepines and opioids, failed to conduct and/or document physical and other exams to justify the high doses of controlled substances Patient C was receiving, and failed to follow-up on the inconsistent drug screen test, among others.

e. Respondent failed to ensure proper treatment for a patient with a history of psychotic symptoms.

Patient D:

f. Respondent failed to maintain adequate and accurate records for his care and treatment of Patient D.

g. Respondent failed to appropriately evaluate and manage Patient D's reported ADD/ADHD.

Patient E:

h. Respondent failed to maintain adequate and accurate records for his care and treatment of Patient E.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

101. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 35907 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E, as more particularly alleged hereafter:

102. Paragraphs 36 through 99, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient A:

a. Respondent failed to treat Patient A's hypertension appropriately, in that he failed to address Patient A's elevated blood pressures with any recommendation, did not keep clear documentation about Patient A's anti-hypertensive program, and maintained Patient A on an ARB with concurrent use of an ACE-inhibitor, among others.

b. Respondent failed to evaluate Patient A's severe diabetic neuropathy by failing to document accurate physical examinations, not conducting foot sensation testing with a monofilament, and not referring Patient A to a podiatrist or other specialist for evaluation and treatment, among others.

c. Respondent failed to maintain substantial compliance with controlled substances prescribing guidelines, including that he failed to assess Patient A regularly during office visits, failed to justify in his records the use of long-term benzodiazepines, and failed to document a discussion with Patient A regarding the increased risks of taking opioids and benzodiazepines concurrently, among others.

Patient B:

d. Respondent failed to maintain substantial compliance with appropriate controlled substance prescribing practices, including his failure to document the status of Patient B's painful conditions, the condition for which Patient B was taking Norco and whether (or how much) it was ameliorating his pain and/or whether Patient B enjoyed any functional improvement as a result of

taking controlled substances, the failure to try safer treatment alternatives first, the failure to follow up on the inconsistent urine drug screen, and the failure to document an explanation for the monthly quantity changes in Norco, among others.

e. Respondent failed to maintain adequate and accurate records.

Patient C:

f. Respondent failed to be in substantial compliance with appropriate controlled substance prescribing practices, including that he prescribed controlled substances without any indication that non-controlled substances or other modalities of treatment had been attempted first, failed to make appropriate referrals, failed to warn Patient C of the risks of combining benzodiazepines and opioids, failed to conduct and/or document physical and other exams to justify the high doses of controlled substances Patient C was receiving, and failed to follow-up on the inconsistent drug screen test, among others.

g. Respondent failed to ensure proper treatment for a patient with a history of psychotic symptoms.

Patient D:

h. Respondent failed to maintain adequate and accurate records for his care and treatment of Patient D.

i. Respondent failed to appropriately evaluate and manage Patient D's reported ADD/ADHD.

Patient E:

j. Respondent failed to maintain adequate and accurate records for his care and treatment of Patient E.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

103. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 35907 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records relating to the provision of services to Patient A, Patient B, Patient C, Patient D, and Patient E. The circumstances are set

forth in paragraphs 36 through 99, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

104. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 35907 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession as more particularly alleged herein:

105. Paragraphs 36 through 103, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

106. Respondent treated two family members with controlled substances on multiple occasions in non-emergent circumstances.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 35907, issued to Respondent Royce Lewis Hutain, M.D.;

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

3. Ordering Respondent Royce Lewis Hutain, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: FEB 11 2020

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