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

In the Matter of the Accusation Against: Arnold Aldermann Weekes, M.D. Physician's & Surgeon's Certificate No. A 88042 Respondent.	Case No. 800-2015-017246

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 February 18, 2021.

IT IS SO ORDERED January 19, 2021.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson

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

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

In the Matter of the Accusation Against:

ARNOLD ALDERMANN WEEKES, M.D.

Physician's and Surgeon's Certificate No. A 88042

Respondent.

Agency Case No. 800-2015-017246

OAH No. 2019070429

PROPOSED DECISION

Administrative Law Judge Regina Brown, Office of Administrative Hearings, State of California, heard this matter via videoconference on October 12 through 15, 2020.

David M. Carr, Deputy Attorney General, represented complainant William Prasifka, Executive Director of the Medical Board of California, Department of Consumer Affairs.

Marvin Firestone, M.D., Attorney at Law, represented respondent Arnold Aldermann Weekes, M.D.

The record was held open to allow the parties to resubmit prehearing motions and oppositions thereto. Respondent timely filed his motion for more specific statement; motion to strike and motion in limine; and motion to compel evidence, which were marked for identification as Exhibits L, M and N, respectively. Complainant timely filed his opposition to respondent's motion for more specific statement; opposition to respondent's motion to strike and motion in limine; and opposition to respondent's motion to compel evidence, which were marked for identification as Exhibits 18, 19 and 20, respectively.

The record closed and the matter was submitted for decision on October 16, 2020.

FACTUAL FINDINGS

Jurisdictional Matters

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

2. On July 1, 2004, the Board issued Physician's and Surgeon's Certificate (Certificate) No. A 88042 to respondent Arnold Aldermann Weekes, M.D. Respondent's Certificate was in full force and effect at the times of the acts set forth below and will expire on July 31, 2022, unless renewed. Respondent has no prior disciplinary action.

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

Summary of Case

3. This case came to the Board's attention in 2015, after a complaint was filed expressing concerns about respondent's prescribing practices.[2] In 2015, a Controlled Substance Review and Evaluation System (CURES) report was pulled of respondent's prescriber history from November 2012 to November 2015 which identified three chronic pain patients, herein referred to as Patients One, Two and Three.[3] On May 9, 2017, Patient Three filed a complaint with the Board, after respondent had terminated her from his pain management practice because of her aberrant behavior, alleging that respondent had overprescribed pain medications. A Board investigator obtained the medical records of the patients, primarily covering a three-year period, and interviewed respondent on February 26, 2018. The Board's expert witness, after reviewing the medical records and other materials, issued two reports concluding that respondent departed from the standard of care in his treatment and recordkeeping for the three patients.

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[2] The evidence did not establish who filed the complaint, but the individual had taken over the care of some of respondent's patients. It does not appear that the Board initiated a full investigation at that time.

[3] The patients are referred to by numbers to protect their privacy. The medical records marked into evidence as Exhibits 2 through 10, 12 through 14, 16, B, E, F, G, H, and I, and other documents reflecting the identifies of Patient One, Patient Two, and Patient Three have been sealed under a Protective Order Sealing Confidential Records, dated October 2, 2020.

On October 4, 2018, complainant filed an Accusation alleging that between 2010 and 2017, respondent committed unprofessional conduct (repeated acts of negligence, gross negligence, and failure to maintain adequate and accurate medical records) in his treatment of Patients One, Two and Three. The Accusation alleges that respondent prescribed opioids, in combination with other dangerous drugs as defined in Business and Professions Code section 4022, without a proper evaluation of medical necessity and adequate clinical justification; without assessing the risks and benefits involved in prescribing such medications; without considering tapering the high dose opioid therapy; without effective monitoring and ongoing assessments of the treatment; and without maintaining adequate and accurate medical records which was a departure from the standard of care.[4] The Accusation also alleges that respondent departed from the standard of care in: (a) prescribing opiates to Patient One who had an untreated psychiatric comorbid condition, and (b) prescribing methadone to Patient Three without addressing the clinical implications of her abnormal electrocardiogram.

4. Respondent filed a notice of defense and this hearing followed.

5. Respondent disputes the allegations in the Accusation. He contends, among other things, that he prescribed opioids and other controlled substances after a proper evaluation of each patient; he advised each patient of the risks and benefits involved; and he managed their treatment within the standard of care at the time. At hearing, respondent provided additional evidence that had not been obtained by the Board during its investigation, including medical records and "Chronic Pain Management and Medication Agreement" forms signed by the patients. This

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[4] At hearing, the eighth cause of action alleging repeated negligent acts/gross negligence related to Patient Two was stricken from the Accusation.

additional evidence had not been reviewed by the Board's expert before he issued his report.

Complainant acknowledges that respondent has made meaningful and adequate changes to his pain management practices, but when there is uncertainty about patient safety, the Board is required to act, such as in this case. Respondent acknowledges that his patients' medical records did not always contain sufficient information regarding his care and treatment. Consequently, cause for discipline was established for respondent's failure to maintain adequate and accurate records, but cause for discipline was not established for gross negligence and/or repeated negligent acts for each patient, and the recommended discipline is a public reprimand.

Respondent's Education, Training and Medical Practice

6. Respondent earned his medical doctorate from Temple University School of Medicine in 1999. From 2001 to 2004, respondent completed a residency training in anesthesiology at the University of Medicine and Dentistry of New Jersey. He completed a one-year fellowship in pain management at the University of California San Francisco (UCSF) in 2005. He is board-certified in anesthesiology and a member of the American Society of Anesthesiologists.

For nine months in 2006, respondent was the attending pain management specialist at Saint Clare's Hospital in New Jersey, and the attending anesthesiologist and pain management specialist at Wyckoff Heights Medical Center in New York. From December 2006 to January 2008, respondent was the attending anesthesiologist and pain management specialist at Washington Adventist Hospital in Maryland. He was an attending locum tenens anesthesiologist from February to April 2008.

7. In March 2008, respondent became an attending anesthesiologist at Sutter Delta/Sutter East Bay Medical Group (Sutter) in Antioch, California. In 2010, the Chief Executive Officer of Sutter learned about respondent's fellowship in pain management at UCSF and encouraged respondent to establish a pain management specialty (pain management center). Initially, respondent split his time equally between anesthesiology and the pain management center. In 2014, respondent began working full-time in the pain management center.

8. In 2018, respondent closed the pain management center and resumed his position as a full-time anesthesiologist. Today, respondent treats no patients for chronic pain and he does not prescribe any pain medications.

Expert Witnesses' Experience and Testimony

9. The experts who testified at hearing were familiar with the standard of care applicable to physicians such as respondent, who prescribe opioids and other controlled substances on a long-term basis to treat chronic pain. Each expert reviewed the available medical records and documents, including the transcript from the Board's interview with respondent on February 26, 2018. They each offered differing opinions as to whether respondent committed unprofessional conduct in connection with his treatment of Patients One, Two and Three.

DAVID J. COPENHAVER, M.D.

10. Board expert David J. Copenhaver, M.D., is board-certified in anesthesiology and pain medicine. He graduated from University of California, Los Angeles School of Medicine in 2005, and completed his residency/fellowship in anesthesiology at Columbia University in 2009. In 2010, Dr. Copenhaver completed a

one-year fellowship in interventional pain medicine at University of California Davis (UC Davis).

11. Dr. Copenhaver has held a number of academic positions at UC Davis since 2010, including: Assistant Professor of Anesthesiology and Pain Medicine (2010), Director of Cancer Pain Management and Supportive Care (2012-present), Director of Pain Medicine Tele-Health ECHO (2013-present), Associate Professor of Anesthesiology and Pain Medicine (2017-present), and Associate Director of the Center for Advanced Pain Relief (2017-present). In 2018, he was appointed as Chief of the Division of Pain Medicine at UC Davis.

Dr. Copenhaver has published 13 articles in peer-reviewed journals, and has written 10 book chapters. He has given numerous presentations to physicians on chronic pain and opioid treatment. He has provided training on pain care to primary care clinicians across the state. He provides patient care between 70 to 90 percent of the time and serves as an administrator managing 10 faculty members and 50 employees for the remainder of the time. He has provided expert testimony in civil court proceedings. Dr. Copenhaver began performing expert reviews for the Board in 2017. This is his first time testifying in an administrative hearing.

12. Dr. Copenhaver prepared two written reports on the applicable standards of care and his findings regarding respondent's treatment and care of Patients One, Two and Three, and his documentation thereof. Dr. Copenhaver testified at hearing consistent with his reports, including a review of each patients' chart notes.

WILLIAM G. BROSE, M.D.

13. William G. Brose, M.D., is licensed to practice medicine in California, and is board-certified in anesthesiology, with added qualifications in pain management

and pain medicine. He graduated from the University of Kansas School of Medicine in 1984. He completed an internship in anesthesiology at Santa Clara Valley Medical Center in 1985, and a residency in anesthesiology at Stanford University School of Medicine (Stanford) in 1986. Dr. Brose completed a one-year fellowship in obstetric anesthesia in 1987, and the following year was a chief resident in anesthesia at Stanford. From 1988 to 1989, he served as a Physician Specialist at Stanford, and also completed a clinical research fellowship in anesthesia in South Australia.

14. Dr. Brose has held a number of academic positions at Stanford since 1989 including: Director of Pain Management Service (1989-1996); Associate Professor of Anesthesia (1995-1997); Adjunct Associate Professor of Anesthesia (1997-2011); and, Adjunct Clinical Professor of Anesthesia (2011-present). He has also held numerous clinical positions over the years: President of Alpha Omega Pain Medicine Associates, Inc. (1998-2018); Chief Executive Officer (CEO) of HELP, Holdings, Inc. and HELP Pain Medical Network (2010-2018); and, CEO of American Health Medical Group (2014-2018). He has trained over 100 fellowship-trained pain management physicians.

Dr. Brose has been awarded research grants, has published over 25 articles in peer-reviewed journals, and has written seven book chapters on pain management. He has given numerous presentations to physicians on chronic pain and opioid treatment. He is a qualified medical examiner in the workers' compensation system. Dr. Brose has provided expert testimony in civil court proceedings and five administrative hearings before the Board. He is enrolled as an expert reviewer for the Board, but has not yet evaluated a case or testified on behalf of the Board.

15. Dr. Brose prepared a written report regarding the applicable standards of care and his findings regarding respondent's treatment and care of Patients One, Two

and Three, and his documentation thereof. He testified at hearing consistent with his report and his review of the patients' chart notes.

STANDARD OF CARE FOR PRESCRIBING CONTROLLED SUBSTANCES

16. The experts agreed that the standard of care refers to the level of skill, knowledge and care that would be exercised by a reasonably prudent physician of similar background under similar circumstances. The experts disagreed as to what the standard of care required at the time respondent prescribed opioids and other controlled substances to his patients on a long-term basis.

17. Dr. Copenhaver based his opinions on federal materials, including the Centers for Disease Control and Prevention's (CDC) 2016 Guidelines for Prescribing Opioids for Chronic Pain[5] and the Board's "Guidelines for Prescribing Controlled Substances for Pain" (guidelines) as revised in 2007 and reflected in Business and Professions Code section 2241.5. Additionally, Dr. Copenhaver relied on the clinician's guide, "Responsible Opioid Prescribing – A Clinician's Guide, Second Edition 2012," (Clinician's guide) authored by Scott Fishman, M.D., which was supported by 30 states within the Federation of State Medical Boards to develop a model policy, and has been embraced by the Board in developing its guidelines. According to Dr. Copenhaver,

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[5] The federal materials included, but were not limited to: (a) CDC Grand Rounds: Prescription Drug Overdoses -a U.S. Epidemic *Weekly* January 13, 2012 / 61 (01); 10-13; (b) CDC. Policy impact: prescription painkiller overdoses. Atlanta, GA: US Department of Health and Human Services, CDC; 2011; and (c) CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016. Recommendations and Reports / March 18, 2016 / 65(1):1-19.

pain management clinicians should have been aware of the Clinician's guide in 2013 to 2017, because it was distributed to clinicians throughout the state.

18. According to Dr. Copenhaver, historically ongoing surveillance only of pain management treatment was considered safe practicing. Now, however, the standard of care requires a pain management practitioner to incorporate strategies from the CDC's guideline, the Board's guidelines and the Clinician's guide when treating patients. Dr. Copenhaver agreed that the academic setting, where he practices, is the ideal case model for implementing these guidelines into the practice of pain medicine management.

19. Dr. Copenhaver opined that the standard of care requires a risk benefit analysis to guide the treater's rationale to continue or discontinue opioid therapy. The standard of care also requires a surveillance of opioid therapy with documentation of the 4A's: analgesia (pain relief of patient); activity (patient's daily living and function), adverse effects (side effects of the drug), and potential aberrancy (overuse beyond prescribed amount or distributing to others). This documentation should be noted for every visit in a patient's medical record. Dr. Copenhaver explained that a departure from the standard of care may be simple or extreme. Generally, if there is no risk benefit analysis and there is minimal or no evaluation of the 4A's by the treater, it is an extreme departure from the standard of care.

20. The experts disagreed on whether the Board's guidelines and the 4A's must be strictly adhered to. Dr. Copenhaver opined that the Board's guidelines inform the standard of care, have been adopted by the pain management practitioner's community and are used to educate and train other pain management specialists and for board certification in pain management. Dr. Copenhaver acknowledges that the 4A's are not expressly delineated as such in the Board's guidelines. However, the

underpinnings of the 4A's are contained in the Board's guidelines that require that a practitioner have a treatment plan, account for pain relief; describe the patient's physical and psychosocial function; determine if there are any inconsistences with the patient adhering to the plan; and address adverse effects which are inherent in taking the patient's history.

21. In providing his opinions, Dr. Brose first discussed the evolution and progressive changes of the practice standards in long-term pain management. From the mid-1980s, there was a pro-opioid prescribing culture that shifted in 2011 with a national awareness of highly publicized opioid-related deaths. By 2013, there was an anti-controlled substance paradigm with more social and regulatory clinical pressures for the treatment of pain. Dr. Brose describes the federal and state guidelines which have developed over the years as "best practices," and he states that the adoption of such best practices into the operation of a treater's clinic takes time.

22. Dr. Brose agreed that the Board's guidelines form the basis for the standard of care for pain management practitioners. However, according to Dr. Brose, the guidelines are not a mandate and do not define the boundaries of the standard of care which is on a spectrum. Moreover, the guidelines are to be reviewed and analyzed by practitioners before they are integrated and assimilated into their practices. Dr. Brose also posited that there was a five-year timeframe for the guidelines to be incorporated into the standard of care for practitioners in the field based on the distribution of information, an initial analysis of the guidelines, applicability of the recommendations, and agreement among clinicians. Dr. Brose posited that with the administrative support and structure in a highly reputable academic practice, such as at UC Davis, the practitioners are able to experience a more rapid adoption of published literature into the practice of pain medicine, and as such, Dr. Copenhaver

may be less able to appreciate the standard of care that occurs in the broader pain treatment community.

23. Dr. Brose agreed with Dr. Copenhaver that the 4A's have clinical utility as an acronym and are commonly applied in the practices of some clinicians, but the 4A's are not exclusive and the Board's guidelines do not specify that a treater must use the 4A's to meet the standard of care in developing a treatment plan. Dr. Brose has observed the 4A's used in approximately 30 percent of the treaters' records he reviews. For example, documentation of analgesia on therapy with functional analysis is the type of documentation missing in the reporting of a majority of providers during the relevant time period, and as such the 4A's represent a goal rather than a standard. Dr. Brose suggested that if the 4A's notation is not included in a treater's note, the assessment itself can still be sufficient and within the standard of care.

24. Dr. Brose opined that an analysis of whether a clinician has met the standard of care requires a structured review incorporating the Board's guidelines. The structured review includes an "interpretation and analysis of documentation provided to determine awareness of opioid risk related concerns and implementation of steps to mitigate risk." The structured reviewed involves the following factors: (1) pain specific diagnosis; (2) informed consent with risk benefit discussion; (3) review of pain treatment alternatives; (4) clinical risk assessment using fixed length fixed format validated questionnaires (e.g.); (5) CURES review; (6) treatment planning with functional goal setting; (7) monitoring with risk adjusted visit or prescription frequency and functional assessment; (8) Urine Drug Test (UDT); (9) Morphine Equivalent Dose (MED) calculation; and (10) concurrent sedative use (by the patient).

25. According to Dr. Copenhaver, the standard of care also requires tapered withdrawal from opioids for pain medication therapy in order to have fewer side

effects. Dr. Copenhaver acknowledged that accelerated withdrawal may provoke certain behaviors such as suicidal ideation, fear, and anxiety. On the other hand, Dr. Brose opined that the CDC and Board guidelines only provide suggestions on tapering, and they do not provide details on how tapering should occur which has caused misapplication and resulted in a dramatic reduction in the access of pain medications for patients.

26. The experts disagreed about the standard of care regarding methadone prescribing and its relationship to QT prolongation for cardiac patients.[6] According to Dr. Copenhaver, the standard of care dictates that if the QTc reaches 500 ms, either methadone should be suspended or at least a risk benefit analysis must be made because of the elevated risk of arrhythmia. On the other hand, Dr. Brose noted the controversy within the community of pain treaters which was not resolved until 2014, when the American Pain Society and the Heart Rhythm Society created a guideline for methadone use that addressed the use of EKG. Resolving the controversy started "the clock on the adoption and integration by the reasonably prudent specialist within the pain community," which according to Dr. Brose takes approximately five years.

27. Overall, Dr. Copenhaver posited that respondent failed to meet the standard of care in that he prescribed and continued opioid therapy without a

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[6] The QT interval is a measurement made on an electrocardiogram used to assess electrical properties of the heart. An abnormally long QT interval is associated with an increased risk of developing abnormal heart rhythms and sudden cardiac death. The QTc is the measurements in milliseconds. Methadone may cause an enhanced risk of cardiac arrhythmia which can be detected by the QTC intervals on EKG results.

documented risk benefit analysis to guide his rationale to continue or discontinue therapy for the three patients. Also, respondent failed to document his surveillance of the 4A's for each patient. According to Dr. Copenhaver, respondent's failings amounted to extreme departures from the standard of care.

28. Overall, Dr. Brose posited that respondent met the standard of care in that he prescribed and continued opioid therapy with documented risk benefit analysis and discussions with the patients to guide his rationale to continue or discontinue their pain management therapy. Also, according to Dr. Brose, respondent was within the group of informed opioid prescribers and he showed, "partial adoption and implementation of published recommendations for the improved safe and treatment of these three patients during the time of the information reviewed." Dr. Brose concluded that:

> The care reviewed is consistent with the prevailing standard of care during the periods of treatment described. While his treatment timeline as shown in these records does overlap with the adoption of the voluntary guidelines by the [Board] and the publication of the guidelines by the CDC in 2016, his management is consistent with the standard of care. Moreover, these cases and the current [Board] accusation reveal the dynamic influences associated with misinterpretation of the guidelines. With the opportunity to review these treatment plans now in retrospect there is clear opportunity for increased scrutiny and more frequent measurement monitoring and analysis that may have led to earlier detection of risk but these opportunities should not

be confused with a deviation from the standard of care. That standard includes the specific care and treatment offered by Dr. Weekes during the time in question.

As discussed below, Dr. Brose's opinions were more persuasive then the opinions of Dr. Copenhaver.

STANDARD OF CARE FOR MEDICAL RECORD KEEPING

29. The standard of care requires providers to maintain adequate and accurate documentation of the care and treatment provided to a patient in order to provide other providers with sufficient information so that they can adequately treat the patient.

30. The experts' opinions diverged as to the extent of detail necessary to meet the standard of care for medical record keeping. Dr. Copenhaver opined that a patient's chart should include notes for each encounter and, among other things, include: a functional assessment of the efficacy of therapy, a risk/benefit analysis, a proper surveillance of increased dosages and changes in medications, and relevant discussions with patients. Dr. Brose concluded that a patient's medical record could meet the standard of care even if it is missing the above listed items. Dr. Copenhaver's opinion was more persuasive than Dr. Brose's opinion.

Respondent's Testimony Regarding His General Prescribing Practices

31. Respondent credibly testified that he complied with the standard of care when he treated Patients One, Two and Three with controlled substances. He always discussed the risks and limitations of pain medication therapy with every patient. He took a history, performed a physical examination, discussed treatment options and the

risks and benefits of treatment, and discussed the side effects and benefits of the opioids and other controlled substances. Respondent assessed each patients' medical issues and evaluated the medical necessity of treatment with controlled substances and he considered alternatives to using controlled substances, such as physical therapy, steroid injections, and weaning. He developed a plan for each patient after extensive conversations with the patient. Patients were tested randomly by an outside independent testing agency to check for aberrancy.

32. Respondent testified that he routinely spent over 30 minutes with each patient and it would take up to an hour for an initial visit. His follow-up appointments usually lasted 15 minutes. His work hours were 8:30 a.m. to 6:30 p.m., five days a week and he was on call for emergencies, such as responding to his patients in the emergency room. At the time, respondent was the only pain management physician for his medical group in the area. Respondent he did not have a physician's assistant and wrote out all prescriptions himself, which was time consuming.

33. Respondent explained that he did not regularly check CURES for each patient because before 2018, Sutter's EPIC system did not automatically provide access to CURES for every patient and precluded anyone except the prescriber from reviewing the CURES report.

34. Respondent located additional medical records for Patient One, Patient Two and Patient Three in Sutter's computerized record keeping system, EPIC, which contains all patient data, examination findings, referrals, telephone calls, and other pertinent information, and were either not subpoenaed by the Board or were not produced by the Sutter custodian of records. These additional medical records included chronic pain management and medication agreement (pain management

agreement) forms signed by the patients. These documents were not reviewed by the experts prior to issuing their written reports.

35. Respondent testified that annually each patient signed a pain management agreement which included information regarding the risks and benefits of pain medication therapy, required the patient to agree to safely store the medications, and required the patient to agree to strict accountability, and not to obtain opioids from another provider. The pain management agreement also stated that a prescription would not be filled early, unless the physician or patient would be out of town when the refill was due. Failure to adhere to the agreement could result in cessation of therapy and termination of care.

36. Angel R. Jenkins was the sole medical assistant in the pain management center from August 2014 through December 2017, who ran the office and handled the phones. Jenkins wrote a letter attesting to her observations of respondent in his practice and described respondent as understanding and very compassionate, but he was also stern while making everyone feel welcomed and valued.

Patient One

37. In August 2010, Patient One, a skilled laborer with a history of chronic lower back pain from a work-related injury, was referred to respondent. Patient One had already been prescribed Norco[7] by his primary care provider. Respondent ordered

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[7] Norco is a combination of hydrocodone (an opioid pain medication) and acetaminophen.

short acting oxycodone[8] because Norco had not helped Patient One's pain. An MRI, taken in October 2010, revealed degenerative changes in Patient One's lumbar spine and irritation of the spinal nerve roots as the pain generator. Respondent reviewed the MRI findings with the patient and discussed treatment options. Respondent offered to perform a spinal injection; however, the patient was afraid of needles and opted for physical therapy. Respondent did not document Patient One's fear of needles in the chart because he did not think it was unusual.

38. Respondent continued with Patient One's pain medication regimen and saw him regularly over the next three years and increased his dosage of oxycodone which was moderately effective for the pain. Respondent explained to Patient One that pain medications would not reduce the swelling and suggested a steroid injection. Respondent explained the risks of surgery. Patient One wanted to be unconscious because of his anxiety, but respondent explained to the patient that the procedure would take place with conscious sedation.

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[8] Oxycodone is a semisynthetic narcotic analgesic similar to morphine. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1), of the Health and Safety Code. Oxycodone can produce drug dependence of the morphine type and has the potential for being abused.

39. On October 7, 2013, respondent administered a spinal injection to Patient One utilizing Versed and 200 mcg of fentanyl[9] titrated to effect,[10] intravenously for pain control and conscious sedation. According to respondent, Patient One was not opiate naïve, so his dosage of fentanyl was higher than an opiate naïve patient. Respondent's chart entries described the procedure.

40. At hearing, respondent explained that he had been trained at UCSF to administer fentanyl to patients so that they could tolerate the uncomfortable positioning of the procedure and the insertion of the needle. According to respondent, conscious sedation is tailored to each patient and no one size fits all. Respondent had not been trained, (as Dr. Copenhaver opines below), to use local anesthesia only during this type of procedure.

41. Patient One continued with his pain medication regimen. He fell and injured his arm and reinjured his back. In an office visit on June 12, 2014, Patient One stated that he was being seen by a workers' compensation doctor, but no additional pain medications were given to him. At an office visit on September 30, 2014, Patient One informed respondent that his workers' compensation physician had taken over his pain management for his arm only. Respondent spoke at length with the patient about

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[9] Fentanyl is a potent narcotic analgesic. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c)(8), of the Health and Safety Code. A dose of 0.1 mg is approximately equivalent to 10 mg of morphine.

[10] Titrating to effect is to start off with a low dose and incrementally increase until treater sees the desired effect for pain management and anesthesia.

notifying respondent about any changes in terms of his pain medication regimen and that he could be discharged from the practice. The patient agreed to comply in the future and wanted respondent to continue as his sole pain management provider. Respondent conferred with the patient's workers' compensation physician before doing so.

42. In November 2014, respondent prescribed[11] morphine sulfate,[12] to address the additional pain ascribed to Patient One's recent injury. Respondent discussed the risks and benefits of the medication. Respondent recommended physical therapy, but Patient One's insurance carrier denied coverage. Respondent also suggested a reimaging of Patient One's lumbar spine due to exacerbated pain symptoms. Respondent continued the pain medication regimen.

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[11] The Accusation alleges that on April 4, 2014, respondent also prescribed carisoprodol (a muscle-relaxant and sedative, and a schedule IV controlled substance and a dangerous drug) and respondent's chart notes did not document a clinical basis for the additional prescription. However, the evidence did not establish that respondent prescribed carisoprodol for this patient.

[12] Morphine sulfate is a potent opiate used for relief of moderate to severe pain. Morphine is a dangerous drug as defined in Business and Professions Code section 4022, a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(l) of the Health and Safety Code. Morphine can produce drug dependence and carries the substantial risk of respiratory suppression.

43. At an August 20, 2015 office visit, respondent also prescribed baclofen[13] for Patient One to address his muscle spams, which still occurred even though he was already taking another muscle relaxant. Respondent discussed with Patient One the rationale for the change in medication and the risks and benefits of taking baclofen, which he wrote in a progress note.[14]

44. Patient One had surgery on his right shoulder in March 2016. After again conferring with Patient One's workers' compensation physician, respondent assumed the responsibility of solely treating Patient One for his back pain as well as the pain associated with his right shoulder and wrist. Patient One had occasional flare ups of pain and continued with his pain management regimen. In January 2017, respondent again referred the patient to physical therapy, prescribed a TENS unit and administered a Toradol (non-steroidal, anti-inflammatory) injection.

45. At an office visit on May 17, 2017, Patient One expressed having suicidal ideation. Initially, Patient One agreed to go to the emergency room for an evaluation; however, he recanted and left the office without a prescription refill, when he learned that law enforcement would escort him to the emergency room pursuant to Welfare and Institutions Code section 5150. When officers responded, they were unable to locate Patient One. Respondent gave a statement to the law enforcement officers and

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[13] Baclofen is a muscle relaxant and antispasmodic. It is a dangerous drug within the meaning of Business and Professions Code section 4022. The effects of baclofen may be additive to those of alcohol and other central nervous system depressants.

[14] This later discovered document was not reviewed by the experts prior to issuing their written opinions.

documented the events in a progress note[15]. Later that day, respondent called Patient One and the patient denied that he would harm himself because he had too much to live for, including his son.

46. On May 24, 2017, Patient One called respondent and said that he was feeling much better and denied any current suicidal ideation. Patient One came by the office and agreed to seek mental health treatment. Respondent believed that Patient One was stable and he was convinced that the patient was not in imminent danger of hurting himself. Respondent continued the pain medication regimen because Patient One had been a reliable patient over the prior three years. Respondent treated Patient One until he closed the pain management center in 2018 and referred the patient to another pain management physician.

47. Respondent testified that he performed the proper examination, assessments, advisements and monitoring in connection with his treatment of Patient One, consistent with his prescribing practices. Respondent reiterated that he discussed the risks and benefits frequently with Patient One over the years, but he did not usually document the discussions with the patient because it was "so basic and common" for each visit especially when the patient was stable and there was no change in the pain medication regimen. Patient One had signed pain management agreements evidencing his consent and acknowledgement of the risks and benefits of pain medication treatment. Respondent also discussed tapering Patient One off the pain medications as an option, but he continued the prescription because the

[15] Dr. Copenhaver did not have this documentation prior to issuing his report.

medications allowed the patient to function and continue to work and respondent saw no signs of aberrancy.

BOARD'S EXPERT (PATIENT ONE)

48. Regarding Patient One, Dr. Copenhaver opined that respondent failed to comply with the standard of care applicable to prescribing controlled substances, including not assessing the risks and benefits of morphine and oxycodone, which was an extreme departure from the standard of care for long-term opioid therapy. Dr. Copenhaver explained that a change in dosage and addition of a new opioid is a change of risk and requires a risk assessment and a treater must inform the patient in a shared decision-making process which should be reflected in the patient's chart.

49. Dr. Copenhaver also opined that administering the spinal injection was a departure from the standard of care because respondent did not document his evaluation of the increased risk with the excessive dose of fentanyl for sedation. According to Dr. Copenhaver, the use of fentanyl was an undue risk. Dr. Copenhaver testified that he has performed over 1000 similar procedures without the use of fentanyl and only uses 1-2 mg. of Versed, to reduce anxiety and as a local anesthetic for pain, which is a safe prudent standard by using less intravenous medications as possible because of the undue risk. Dr. Copenhaver acknowledged that some pain medicine professionals still use fentanyl for conscious sedation during this procedure.

50. Dr. Copenhaver noted that Patient One expressed suicidal ideation and, without the patient having a psychological evaluation, he would have expected respondent to reassess the pain treatment strategy. An untreated psychiatric comorbid condition influences opioid therapy and is a relevant risk factor for unintended overdose death. According to Dr. Copenhaver, when respondent continued Patient

One's pain management regimen, respondent should have included his rationale in the chart and his failure to do so was an extreme departure from the standard of care.

51. Dr. Copenhaver opined that respondent's documentation was inadequate to reflect the care that he provided to Patient One and that these deficiencies constituted a departure from the standard of care.

RESPONDENT'S EXPERT (PATIENT ONE)

52. Dr. Brose opined that respondent's treatment of Patient One was within the standard of care at the time, and that he performed appropriate assessments, monitoring, and review of aberrancy. Dr. Brose concluded that respondent's appropriate pattern of prescribing opioids met the standard of care as required during the five-year time period of assimilating and integrating the Board's guidelines. In particular, respondent confirmed diagnostic testing of the patient's pain generators, discussed with the patient and provided the risk-benefit analysis of pain management therapy, reviewed CURES, used urine drug testing, and clearly documented prescription quantities and doses. Although not clearly documented in the chart, treatment planning with goal setting and monitoring was inferred.

53. Dr. Brose opined that when Patient One became respondent's patient he was already receiving pain medication therapy, so a level of informed consent was assumed. Dr. Brose also stated that when a doctor accepts a pain management patient, he cannot just discontinue all prior care because this poses a threat in the continuation of care. In addition, the pain management agreements signed by Patient One included the risks and benefits analysis, the communications with the patient, and the justification to continue treatment. Dr. Brose also opined that is was commonplace and within the standard of care to omit documenting a discussion of risk and benefits

because the pain management agreement substituted for documentation of medical advice in a chart.

54. Dr. Brose opined that adding morphine to Patient One's pain medication regimen was within the standard of care. It was a common practice at the time, although it has become less common over the years.

55. Dr. Brose opined that respondent appropriately assessed Patient One for the spinal injection by evaluating the imaging studies. Dr. Brose concluded that respondent met the standard of care for using fentanyl for the conscious sedation where the intent was to dull the patient's senses to accomplish the injection. Use of fentanyl is a judgment call based on a patient's circumstances. Also, 200 mcg of fentanyl was commonly used for conscious sedation in 2015. Dr. Brose is aware of Sutter's documentation standards, and Patient One's sedation process would have been documented in the nursing notes or anesthesia records.

Dr. Brose disagreed that the procedure could have been accomplished without fentanyl. He believes that Dr. Copenhaver did not take into account that Patient One was not opioid naïve, his fear about needles and his anxiety, which was information that respondent had. Therefore, it was reasonable for respondent to administer fentanyl during the procedure and there was no harm to the patient.

56. Initially, in his report, Dr. Brose had concerns about respondent's clinical management regarding Patient One's psychological concerns. However, after reviewing additional medical records that documented respondent's compliance with Sutter's procedure, Dr. Brose opined that respondent had ruled out an active psychiatric condition for Patient One and his notes were adequate to show his effective monitoring and assessment of Patient One. It was reasonable for respondent

to accept the patient's explanation and resume the pain management plan and there was no harm to the patient.

57. Dr. Brose opined that respondent's notes met the prevailing standard of care. However, Dr. Brose acknowledged that respondent's notes were missing his clinical risk assessment, goal setting and monitoring, a functional assessment of the patient, MED calculation and determination of concurrent sedative use.

ULTIMATE FINDINGS (PATIENT ONE)

58. Both Dr. Copenhaver's and Dr. Brose's opinions are well-reasoned regarding Patient One. However, Dr. Brose's opinions are more persuasive and supported by the evidence, including respondent's credible testimony relating to his care and treatment plan for Patient One and the late-discovered medical records which were not considered by Dr. Copenhaver. Therefore, respondent acted within the standard of care when he administered the spinal injection and used fentanyl, in his monitoring and assessments for opioid therapy including adding morphine to Patient One's pain medication regimen. Respondent acted within the standard of care when he decided to continue to treat Patient One after his suicidal ideations. Accordingly, the evidence did not establish that respondent committed repeated and extreme departures from the standard of care in his pain medication regimen for Patient One.

59. Dr. Copenhaver's conclusion that respondent failed to maintain adequate medical records for Patient One is more persuasive than the opinions offered by Dr. Brose. It is clear that necessary elements of respondent's assessment and treatment were not documented in the patient's chart, thereby making it difficult for others to understand what actions he took and why for Patient One's pain medication

treatment. Therefore, it is found that respondent's record keeping with respect to Patient One was inadequate and inaccurate.

Patient Two

60. In February 2010, Patient Two had an initial consultation with respondent for a complaint of low back pain, as she had been diagnosed with lumbar degenerative changes. She was already taking methadone[16] and hydrocodone[17] for pain control. Respondent's chart entries detailed a comprehensive physical examination and history for Patient Two. Respondent noted his plan for epidural steroid injections, administration of a non-steroidal anti-inflammatory, and follow-up visits.

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[16] Methadone hydrochloride is a synthetic narcotic analgesic. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine.

[17] Hydrocodone bitartrate (tradename Vicodin) is a semisynthetic narcotic analgesic, a dangerous drug as defined in Business and Professions Code section 4022 and a schedule III controlled substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety Code. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety agents, or other central nervous system depressants (including alcohol) concomitantly with Vicodin may exhibit central nervous system depression.

61. Respondent re-filled Patient Two's prescriptions for methadone and hydrocodone. Respondent continued to treat Patient Two over the next few years.

62. Respondent had formal visits on January 21, 2011, and November 28, 2011, January 8, 2012, February 17, 2012, and February 8, 2013, where respondent documented that he had extensive and lengthy conversations with the patient on education, counseling and maintaining her pain medication regimen. He also discussed alternatives including using a TENS unit, physical therapy, and the benefits of exercise and losing weight. He also considered ordering an updated MRI. Respondent treated Patient Two's back pain with a variety of medical procedures, including facet injections and subsequent radio frequency nerve ablation. Patient Two's drug regimen included methadone, hydromorphone,[18] carisoprodol, and diazepam.[19]

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[18] Hydromorphone hydrochloride is a narcotic analgesic; it is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression.

[19] Diazepam is a psychotropic drug for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule IV controlled substance

63. During this time period, respondent also had informal visits for Patient Two when she experienced dire financial straits, including a period of homelessness, and could not afford medical coverage. Respondent continued the pain medication regimen. Respondent would rarely note the visits or prescription refills in her chart. At some point, she regained her medical coverage and the formal office visits resumed. Jenkins, respondent's medical assistant, attested that she was aware that Patient Two lost her medical insurance and was unable to self-pay for her visits, and respondent continued to be supportive and provide her with medical care and well-being checks and continued her pain medications because of the side effects of withdrawal and the increased pain that the patient would be in.

64. During an office visit on July 10, 2013, respondent re-visited Patient Two's lumbar spine pathology with her. In an office visit on August 1, 2013, respondent discussed opiate dependence with the patient. He sought to stabilize her pain control, increase her level of function generally, and then gradually wean her down from her current level of narcotic use. However, her pain continued to be well controlled on the pain medication regimen.

65. On August 6, 2015, Patient Two was discharged for violating the pain management agreement because her drug screen was negative for methadone suggesting that she was diverting her medication which is a violation. Additionally, the drug screen tested positive for unprescribed morphine. Respondent gave Patient Two

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as defined by section 11057 of the Health and Safety Code. Diazepam can produce psychological and physical dependence and it should be prescribed with caution.

a month's prescription for hydromorphone and referred her to her primary care physician for further pain treatment.

66. Respondent testified that he performed the proper examination, assessments, advisements and monitoring in connection with his treatment of Patient Two. According to respondent, it was difficult to manage Patient Two's pain. Patient Two, a domestic abuse victim, was impoverished and periodically stayed in a shelter with her young son. Respondent did not want to abandon her when she lost her medical coverage, so he would see her in an unofficial capacity. Respondent understands that it was "not an ideal situation," and he tried to do the best that he could for his patient. During his investigative interview, respondent expressed remorse and suggested that he developed more extensive procedures and processes thereafter.

67. Respondent did not consistently note in Patient Two's chart that he considered and discussed with her the risks and benefits of the continued high dose opioid therapy, his assessment of the analgesic effect of the drugs he was prescribing, and her level of functioning while taking these medications in combination. However, respondent pointed out that Patient Two had signed pain management agreements evidencing her consent and acknowledgement of the risks and benefits of pain medication treatment. Respondent also discussed tapering Patient Two off the pain medications on several occasions, but decided to maintain her pain management regimen because it allowed the patient to function and continue to work.

BOARD'S EXPERT (PATIENT TWO)

68. Dr. Copenhaver opined that respondent departed from the standard of care in his assessment and monitoring when he prescribed pain medications over a

number of years, because he had no clinical basis to justify opioid therapy with the use of methadone which posed an undue risk to Patient Two; there was no evidence of a risk/benefit analysis of the high dose opioid therapy; he failed to assess the analgesic effect of the drugs he was prescribing; and he failed to note signs of aberrant use of these drugs. He found that respondent's deficiencies constituted an extreme departure from the standard of care.

69. Dr. Copenhaver opined that respondent's documentation was inadequate to reflect the care that he provided to Patient Two and that these deficiencies constituted a departure from the standard of care.

RESPONDENT'S EXPERT (PATIENT TWO)

70. Dr. Brose opined that respondent's treatment of Patient Two was within the standard of care at the time, and that he performed appropriate assessments, monitoring, and review of aberrancy which eventually led to the patient's termination from therapy. Dr. Brose concluded that respondent's appropriate pattern of prescribing opioids met the standard of care as required during the five-year time period of assimilating and integrating the Board's guidelines. In particular, respondent confirmed diagnostic testing of the patient's pain generators, discussed with the patient and provided the risk-benefit analysis of pain management therapy, reviewed pain treatment alternative, reviewed CURES, used urine drug testing, and clearly documented prescription quantities and doses. Dr. Brose also opined that when Patient Two became respondent's patient she was already receiving pain medication therapy, so a level of informed consent was assumed. In addition, the pain management agreements signed by Patient Two included the risks and benefits analysis, the communications with the patient, and the justification to continue treatment.

71. Dr. Brose described respondent's treatment of Patient Two as altruistic, although poorly documented "compassionate prescriptions", as respondent was "motivated by a desire to provide oversight and monitoring of her care including the opioid use while not having her to issue a bill."

72. Dr. Brose opined that respondent's notes met the prevailing standard of care. However, Dr. Brose acknowledged that respondent's notes were missing a clinical risk assessment, a functional assessment, MED calculation and determination of concurrent sedative use.

ULTIMATE FINDINGS (PATIENT TWO)

73. Both Dr. Copenhaver's and Dr. Brose's opinions are well-reasoned regarding Patient Two. However, Dr. Brose's opinions are more persuasive and supported by the evidence, including respondent's credible testimony relating to his care and treatment plan for Patient Two and the later discovered medical records which were not considered by Dr. Copenhaver. Therefore, respondent acted within the standard of care in his monitoring and assessments over the course of years of opioid therapy for Patient Two. Accordingly, the evidence did not establish that respondent committed repeated and extreme departures from the standard of care in his treatment of Patient Two.

74. Dr. Copenhaver's conclusion that respondent failed to maintain adequate medical records for Patient Two is more persuasive than the opinions offered by Dr. Brose. It is clear that necessary elements of respondent's assessment and treatment were not documented, making it difficult to determine whether he met the standard of care and making it difficult for other providers to understand the objective of

treatment. Therefore, it is found that respondent's record keeping with respect to Patient Two was inadequate and inaccurate.

Patient Three

75. Prior to seeking treatment with respondent, Patient Three had gastric bypass surgery and was already taking hydromorphone and methadone. Patient Three was under the care of a cardiologist. Respondent had access to her EKG results through EPIC.

76. On November 11, 2014, Patient Three sought treatment with respondent, for chronic right knee pain and abdominal pain. Respondent determined that because the hydromorphone and methadone passed through Patient Three's system too quickly because of the gastric bypass surgery, fast acting methadone and Dilaudid would work better for her pain. Respondent assessed the risks and benefits of high-dose opioid therapy and he considered tapering the doses of the prescribed opiates. However, he did not indicate his assessments in the chart or indicate that he evaluated her EKG results before prescribing the methadone. Respondent discussed possible joint replacement surgery with the patient. Respondent maintained her pain medication regimen at monthly intervals thereafter.

77. In early 2016, Patient Three underwent a total knee replacement. She had had a cardiac evaluation prior to the procedure. Respondent was called to the hospital to consult regarding Patient Three's post-surgery pain. He discussed the risks of increasing her dose of methadone. He reviewed her EKG which had a 472 QTc. He did not determine this to be a prolonged QT interval because Patient Three had already been on methadone for years and her average was 466 QTc. Respondent also

consulted with Patient Three's cardiologist. Respondent did not note his assessments in the chart.

78. At an office visit on February 4, 2016, respondent increased the daily methadone dose from 45 mg to 90 mg in response to Patient Three's complaints of increased pain post-surgery. He completed a review of systems which is part of pain medication assessment of how well the patient is tolerating the medication. His plan was no change in the pain medication regimen and to see if patient could make it through physical therapy for her knee replacement. She had also recently lost her brother which caused her stress and impacted her chronic pain. His view was to only change one variable at a time. He felt that she would make better progress in physical therapy if she did not have a reduction in medication at the same time. He did not initiate tapering because it is difficult to wean a patient who is relying on medication to get through the day. Respondent continued her pain medication regimen. Respondent did not chart his rationale for doubling the methadone prescription, that he evaluated her EKG result subsequent to that increase, or his plan for surveillance of the higher dose opioid therapy.

79. On November 1, 2016, Patient Three's treating internist, Dr. Memon-Syed, diagnosed her as suffering from major depressive disorder and began prescribing an anti-depressant. Respondent was aware of this prescription through EPIC. On January 17, 2017, Patient Three was also hospitalized for treatment of a depressive disorder.

80. During an office visit on January 17, 2017, respondent documented a discussion with Patient Three regarding her early and excessive consumption of the opiates and warned her that continued overuse of her medications could result in respondent termination from his practice. She agreed to abide by the terms of the

pain management agreement. Respondent refilled her prescriptions. Respondent did not chart that he had assessed her ongoing pain medication regimen in light of her diagnosed of major depressive disorder and that he discussed tapering with the patient.

81. An EKG administered to Patient Three on January 19, 2017, revealed a 506 QTC. However, respondent did not consider this to be a prolonged QTC given the patient's baseline; furthermore, a subsequent EKG revealed that the 506 QTC had not persisted. Respondent did not indicate in the chart his reasoning for not suspending or reducing the methadone prescription in light of the EKG results. By February 2017, Patient Three was feeling upbeat and they again discussed weaning, but respondent decided to maintain the pain medication regimen.

82. In April 2017, Patient Three reported new pain in her left hip. Respondent continued the pain medication regimen and did not consider weaning because of this new development. The patient requested an early refill of her pain medications because of travel which is acceptable under the pain management agreement.

83. At an office visit on May 9, 2017, respondent noted that Patient Three had again taken her opioid medications in higher doses and frequency than as prescribed. She had also sought pain medications in the emergency room. Respondent was made aware because he had an agreement with the emergency room to be contacted to prevent medication misuse by his patients. Respondent told the ER not to give Patient Three any pain medications and directed her to come to his office. This was her second occurrence of violating the pain management agreement. Respondent believed that Patient Three had a problem with addiction and discussed tapering. He persuaded Patient Three to agree to inpatient drug treatment and provided a referral for such treatment, and in exchange he would continue to treat her. Respondent did

not refill her prescriptions for hydromorphone and methadone, but he did prescribe a palliative drug to address any possible withdrawal symptoms. Patient Three did not return to respondent for further treatment. Respondent learned that Patient Three again returned to the emergency room seeking pain medication which were not given. She filed a complaint with the Board.

84. Respondent testified that he performed the proper examination, assessments, advisements and monitoring in connection with his treatment of Patient Three, consistent with his prescribing practices.

BOARD'S EXPERT (PATIENT THREE)

85. Dr. Copenhaver concluded that respondent did not document a formal risk stratification analysis, proper surveillance, risk benefit analysis or evaluation and assessment of cardiac risks on his visits with Patient Three, and was outside the standard of care with respect to due diligence required for responsible opioid prescribing. Dr. Copenhaver agreed that respondent was justified to stop opioid therapy for Patient Three's aberrant behavior. Overall, Dr. Copenhaver believed that if respondent had performed a risk benefit analysis when he started treating Patient Three, then he would have tapered her immediately. Furthermore, upon the presentation of her depressive disorder and her inability to self-modulate her behavior, respondent should have stopped her pain medication therapy. Finally, Dr. Copenhaver opined that respondent failed to adequately monitor the possible cardiac effects of methadone on Patient Three. Furthermore, Dr. Copenhaver opined that respondent should have ordered his own EKGs and not relied on the cardiologist-ordered EKGs.

86. Overall, Dr. Copenhaver opined that respondent's documentation was inadequate to reflect the care that he provided to Patient Three and that these deficiencies constituted a departure from the standard of care.

RESPONDENT'S EXPERT (PATIENT THREE)

87. Dr. Brose opined that respondent's treatment of Patient Three was within the standard of care at the time, and that he performed appropriate assessments, monitoring, and review of aberrancy which eventually led to the patient's termination from the therapy. Dr. Brose concluded that respondent's appropriate pattern of prescribing opioids met the standard of care as required during the five-year time period of assimilating and integrating the Board's guidelines. In particular, respondent confirmed diagnostic testing of the patient's pain generators, discussed with the patient and provided the risk-benefit analysis of pain management therapy, reviewed pain treatment alternatives, reviewed CURES, reviewed EKGs, reviewed EPIC, used urine drug testing, and clearly documented prescription quantities and doses.

88. Dr. Brose also opined that when Patient Three became respondent's patient she was already receiving pain medication therapy, so it is assumed that there is already a level of informed consent. In addition, the pain management agreements that she signed included the risks and benefits analysis and the justification to continue treatment.

89. Dr. Brose concluded that it was reasonable for respondent to defer to Patient Three's cardiologist as he had access to those records through EPIC. Dr. Brose disagreed that Patient Three's escalation in QT interval required a change in her methadone therapy because of her baseline. Dr. Brose also concluded that

respondent's discussion of potential tapering with Patient Three and his decision not to taper was based on his clinical decision-making which met the standard of care.

90. Dr. Brose opined that respondent's record keeping for Patient Three met the prevailing standard of care. However, Dr. Brose acknowledged that respondent's notes were missing clinical risk assessments, functional assessments, MED calculations and a determination of concurrent sedative use.

ULTIMATE FINDINGS (PATIENT THREE)

91. Both Dr. Copenhaver's and Dr. Brose's opinions are well-reasoned regarding Patient Three. However, Dr. Brose's opinions are more persuasive and supported by the evidence, including respondent's credible testimony relating to his care and treatment plan for Patient Three and the late-discovered medical records which were not considered by Dr. Copenhaver. Therefore, respondent acted within the standard of care in his monitoring and assessment for opioid therapy for Patient Three's and addressing the clinical implications of prescribing methadone given Patient Three QT interval results. Accordingly, the evidence did not establish that respondent committed repeated and extreme departures from the standard of care in his pain medication regimen for Patient Three.

92. Dr. Copenhaver's conclusion that respondent failed to maintain accurate and adequate medical records is more persuasive than the opinions offered by Dr. Brose. It is clear that necessary elements of respondent's assessment and treatment were not documented, making it difficult to determine whether he met the standard of care and for other providers to understand the objective of treatment. Therefore, it is found that respondent's record keeping with respect to Patient Three was inadequate and inaccurate.

Additional Evidence Pertaining to Rehabilitation/Mitigation

93. In January 2019, respondent completed a course in "Prescribing Practices and Management of Chronic Pain and Substance Use Disorder." Respondent acknowledged that with the knowledge and experience he has now he would have completed his medical documentation differently.

94. The following individuals testified and submitted reference letters on behalf of respondent:

a. Benjamin Busfield, M.D., has worked with respondent for approximately 11 years. Over the years, Dr. Busfield had become one of respondent's largest referral sources for patient pain management, including Patient Three. Dr. Busfield has found respondent's long-term pain management of his patients to be valuable, thoughtful, appropriate, evidence-based, safe, and compassionate. Dr. Busfield observed respondent to be one of the few pain management physicians to personally see his patients because he did not have a physician's assistant. Dr. Busfield was aware that respondent dictated his own notes, and he would often work until 7:00 p.m., to spend sufficient time with each patient. According to Dr. Busfield, respondent had a difficult job as the only pain management doctor in an underserved area, and they "were thrown into the fire with the opioid crisis and it is not [their] fault."

b. Henry Liu, M.D., Sutter's Medical Director of Anesthesia Services, has known respondent for 10 years, initially as colleagues before respondent transitioned to the pain management center. Dr. Liu has served as respondent's direct supervisor in anesthesia for the last two years. Dr. Liu has never witnessed any behavior, judgment or decision by respondent that has failed to meet the standard of care or was not in the best interest of the patient They have collaborated on numerous occasions such as

for peer review and provider professional conduct issues. Dr. Liu values respondent's integrity, honesty, ethical decision-making abilities, knowledge, experience, and aptitude which is recognized by his peers and hospital staff. Respondent is careful, meticulous, takes his time, never has a rushed approach with patients, and is an invaluable asset to their community hospital in Antioch. Dr. Liu was surprised by the Accusation because the allegations are inconsistent with his experience with respondent.

c. Sabri Sen, M.D., has been a colleague of respondent for over 10 years. Dr. Sen has worked with respondent in the operating room where he administered anesthesia for her surgical patient., He also previously cared for her chronic pain patients. She has personally observed respondent spend extra time with patients, working to 7:00 p.m. Dr. Sen states that respondent's treatment of her patients has been well thought out, appropriate, safe, and compassionate. She has found respondent to be diligent, highly communicative, and she will continue to entrust the care of her patients to respondent.

d. Orthopedic surgeon Scott Seibert, M.D., has known respondent since 2013. Dr. Seibert referred patients to respondent for pain management. Dr. Seibert has found respondent to be responsible and ethical. Dr. Seibert has observed respondent frequently demonstrate patience and attention to challenging chronic pain patients. Dr. Seibert has relied on respondent's assistance with management of post-operative patients in the hospital and respondent was thorough and attentive as a consulting physician. Dr. Seibert has noted no negligence on respondent's part or any other concerning behavior. Dr. Seibert holds respondent in high regard as a physician and a colleague and he believes that the Board should find in respondent's favor.

e. Christopher Solis, M.D., FACS, Sutter's Chair of the Department of Surgery, has known respondent for eight years. For the last four years, he has assessed respondent's performance. Dr. Solis has had no issues with respondent's care of patients. Respondent has not had any cases brought to peer review. Because of this Accusation, during respondent's last privilege reappointment cycle, respondent completed a six-month Focused Professional Performance Evaluation with no negative findings. Dr. Solis attributes this to respondent's "overall personal goal to be a patient advocate, his drive to continuously improve his knowledge base and skill set with continued learning and self-assessment, and his overall passion for providing anesthesia." Dr. Solis has observed respondent hold patients' hands and talk to them with a calm soothing voice and heard respondent give "tough love" talks to patients when they need it. Dr. Solis described respondent as an excellent physician and he believes the community is better because of respondent. Dr. Solis has no reservations with respondent caring for his patients or providing anesthesia to his family members.

Dr. Solis considers the "practice of medicine is not an exact science and every day we are trying to become better at it, we do the best we can with the skill set based on what science says and our experience." Dr. Solis and respondent have had many discussions about their difficult cases analyzing what they could have done differently or better which is a sign of a true physician who constantly challenges their own performance with the intent of improving and growing. Dr. Solis is disappointed with the Accusation brought against respondent.

f. Internist Fatima Memon Syed, M.D., has known respondent since 2009. They shared mutual patients at Sutter with respondent providing long term pain management. Their offices were located next to each other. Dr. Syed stated that respondent followed the standard protocols for pain management patients and she

was aware that he required routine drug testing on his patients to ensure they were following his treatment guidelines and protocols. Dr. Syed described respondent as well respected as a colleague, always available to answer questions, one who cares about the well-being of his patients, always on time, communicates well with patients, and a strong advocate for his patients. According to Dr. Syed, respondent is "a family-oriented man with very righteous values in life."

95. Respondent is married with two children, ages 11 and 8.

96. Respondent's testimony at hearing was candid and credible.

LEGAL CONCLUSIONS

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

2. Unprofessional conduct is grounds for discipline of a physician's Certificate pursuant to Business and Professions Code sections 2227,[20] 2234, and 2266. Pursuant to Business and Professions Code section 2234, a licensee may be subject to discipline for committing unprofessional conduct, which includes violating the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), committing gross negligence (Bus. &

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

Prof. Code, § 2234, subd. (b)), committing repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)),[21] and failing to maintain adequate and accurate patient records (Bus. & Prof. Code, § 2266).

First, Second, Third, Fourth, Fifth, Seventh, Tenth, Eleventh and Twelfth Causes for Discipline (Gross Negligence)

3. By reason of the matters set forth in the Factual Findings above, complainant failed to establish by clear and convincing evidence that respondent's conduct departed from the standard of care to constitute gross negligence in connection with his treatment of Patient One (Factual Findings 16-28, 31-50, 52-56, 58), Patient Two (Factual Findings 16-28, 31-36, 60-68, 70-71, 73), and Patient Three (Factual Findings 16-28, 31-36, 75-85, 87-89, 91). Therefore, cause does not exist to discipline respondent's Certificate for unprofessional conduct pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b).

First, Second, Third, Fourth, Fifth, Seventh, Tenth, Eleventh and Twelfth Causes for Discipline (Repeated Negligent Acts)

4. By reason of the matters set forth in the Factual Findings above, complainant failed to establish by clear and convincing evidence that respondent's conduct departed from the standard of care to constitute repeated negligent acts in connection with his treatment of Patient One (Factual Findings 16-28, 31-50, 52-56, 58), Patient Two (Factual Findings 16-28, 31-36, 60-68, 70-71, 73), and Patient Three

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

(Factual Findings 16-28, 31-36, 75-85, 87-89, 91). Therefore, cause does not exist to discipline respondent's certificate for unprofessional conduct pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c).

Sixth, Ninth, and Thirteenth Causes for Discipline (Failure to Maintain Adequate and Accurate Records)

5. By reason of the matters set forth in the Factual Findings above, clear and convincing evidence established that respondent failed to maintain adequate and accurate records of his treatment of Patient One (Factual Findings 16-57, 59), Patient Two (Factual Findings 16-36, 60-72, 74), and Patient Three (Factual Findings 16-36, 75-90, 92). Cause therefore exists to discipline respondent's certificate for unprofessional conduct pursuant to Business and Professions Code section 2266.

Disciplinary Determination

6. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (12th ed., 2016),[22] recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's misconduct under Business and Professions Code section 2266. In closing argument, complainant suggested that if there is strong evidence that respondent's pain management practices have significantly altered and he has acknowledged the charges, the minimum penalty of probation may not be

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

necessary. (Respondent's suggestion that the Accusation be dismissed is inapposite to the instant discussion and is therefore not addressed.)

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

It is determined that a public reprimand, pursuant to Business and Professions Code section 2227, subdivision (a), is the appropriate discipline in the instant case. The facts in the instant case warrant a deviation from the Disciplinary Guidelines for several reasons: First, while respondent's documentation on multiple occasions was wholly inadequate, the evidence failed to support the more serious allegations, by clear and convincing evidence, that respondent was grossly negligent and repeatedly negligent. Second, respondent acknowledged that his chart documentation was lacking, and he has taken measures to modify his prescribing practices to conform with the evolving standard of care by voluntarily taking a prescribing course. Third, respondent closed the pain management center and no longer prescribes pain medications. Applicant has had a long and successful career as an anesthesiologist and has no disciplinary history. His professional integrity, generosity and expertise are highly regarded by physicians who are familiar with his work and know him well. Against this background, the protection of the public does not warrant the imposition of probationary terms on respondent. In conjunction with his public reprimand, respondent will be required to complete a course in medical record keeping.

ORDER

Physician's and Surgeon's Certificate No. A 88042, issued to respondent Arnold Aldermann Weekes, M.D., is publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). Respondent shall enroll in a course in medical record keeping, approved by the Board, within 60 days from the effective date of this decision, and shall provide proof of his completion of the course no later than six months after his initial enrollment. This course shall be at respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of certificates.

DATE: November 16, 2020

Regina Brown

REGINA BROWN
Administrative Law Judge
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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO October 4 20 18
BY K. Vong ANALYST

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

In the Matter of the Accusation Against: **Arnold Aldermann Weekes, M.D.** 4053 Lone Tree Way, Suite 200 Antioch, CA 94531-6210 Physician's and Surgeon's Certificate No. A 88042, Respondent.	Case No. 800-2015-017246 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 1, 2004, the Board issued Physician's and Surgeon's Certificate Number A 88042 to Arnold Aldermann Weekes, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the allegations herein and will expire on July 31, 2020, unless renewed.

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 unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2001.1 of the Code provides that the Board's highest priority shall be public protection.

6. 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."

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 practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) 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 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 4022 of the Code defines "dangerous drug" to include any drug unsafe for self-use and includes all drugs which can only be lawfully dispensed by prescription.

10. The incidents alleged herein occurred in California.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

11. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that his care and treatment of Patient One[1] included departures from the standard of care constituting gross negligence or, in conjunction with the other departures alleged herein, constitutes repeated negligent acts. The circumstances are as follows:

[1] To maintain patient confidentiality, the subject patients discussed herein are identified as Patient One, Patient Two, and Patient Three. The patients' full names will be provided to Respondent in discovery.

12. Patient One was a returning patient at the pain management clinic where Respondent was employed when he was seen by Respondent on August 6, 2013. The patient presented with a history of chronic lower back pain, for which Respondent had been prescribing a daily dose of up to 12 mg. tablets of Oxycodone.[2] Respondent's chart notes for this visit state that the patient's pain medication was moderately effective, but that Patient One was also requesting spinal injections for pain relief. Respondent planned to order the spinal injection, pending approval by Patient One's health plan. Nothing in the Respondent's notes for this visit provide a rationale for such injections, nor is there a documented clinical basis from the patient's medical history or diagnostic imaging to support spinal injections for pain. Respondent's chart entries for the patient's physical examination provides no information as to specific pain generators. Respondent continued prescribing Oxycodone for Patient One, without charting any assessment of the risks weighed with the benefits of employing opioids to treat Patient One's chronic pain.

13. On or about October 7, 2013, Respondent administered the planned injections in Patient One's lumbar spine, at the L5-S1 level, utilizing 200 mcg of fentanyl[3] intravenously for anesthesia/sedation. While Respondent's chart entries describe the procedure, there is no documented clinical basis from the physical examination, history, or diagnostic imaging warranting spinal injections.

14. Patient One's medical record indicates the next office visit with Respondent occurred on June 12, 2014. Respondent had refilled Patient One's prescription for Oxycodone at least five times between the October 7, 2013, procedure and the June 12, 2014, office visit. On or about

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[2] Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxycodone can produce drug dependence of the morphine type and has the potential for being abused. Patients taking Oxycodone are at risk of potentially fatal respiratory depression, particularly when used in combination with other central nervous system-affecting drugs.

[3] Fentanyl is a potent narcotic analgesic. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c)(8), of the Health and Safety Code. A dose of 0.1 mg is approximately equi-analgesic to 10 mg of morphine.

April 4, 2014, Respondent had added Carisoprodol[4] to the Oxycodone he was prescribing for Patient One. Respondent's chart notes for the next office visit do not document a clinical basis for this additional prescription, nor is there any indication of Respondent's monitoring and consideration of the analgesic effect of the prescribed medications, the patient's level of functioning while undergoing opioid therapy, any adverse effects, or any signs of aberrant use of the medications. There is no indication that Respondent accessed CURES, the state's controlled substance records system, at any time to learn whether Patient One was being concurrently prescribed medications by any other provider, at this office visit opportunity or at the next noted visit on September 30, 2014.

15. At the office visit on November 4, 2014, Respondent added a daily dose of 45 mg of morphine sulfate[5] to the Carisoprodol and Oxycodone he was prescribing to Patient One, reportedly to address the additional pain Patient One ascribed to a wrist injury sustained in a fall. There is no indication that Respondent considered the risks and benefits of adding morphine sulfate to Patient One's drug regimen, most particularly the cumulative morphine equivalency dosing of the morphine sulfate and Oxycodone. The medical record indicates that Respondent continued to order refills of this combination of drugs to Patient One until the next office visit, more than nine months later, on August 20, 2015. At the August 20, 2015, office visit, Respondent substituted baclofen[6] for the Carisoprodol he had been giving Patient One; he continued to prescribe the morphine sulfate and Oxycodone. There is no indication in the medical record that Respondent discussed the risks and benefits of baclofen with Patient One, nor

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[4] Carisoprodol is a muscle-relaxant and sedative. It is a schedule IV controlled substance and a dangerous drug as defined in section 4022. The effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be additive; appropriate caution should be exercised with patients who take more than one of these agents concurrently.

[5] Morphine sulfate is a potent opiate used for relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022, a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Morphine can produce drug dependence and carries the substantial risk of respiratory suppression.

[6] Baclofen is a muscle relaxant and antispasmodic. It is a dangerous drug within the meaning of Business and Professions Code section 4022. The effects of baclofen may be additive to those of alcohol and other central nervous system depressants.

is there a substantive rationale or clinical basis presented within the record for Respondent's change in medication.

16. Respondent saw Patient One at seven subsequent office visits over the next 21 months; Respondent continued to prescribe opiates and the muscle relaxant for Patient One over this period. In his chart entries for the office visit on May 17, 2017, Respondent notes: "Today, the patient states that he has been having suicidal ideation and has gone so far as to point a gun at his own head." Although Respondent stated that Patient One agreed to go to the emergency room for an evaluation, Patient One left the office when he learned that law enforcement and paramedics would escort him to the emergency room; officers summoned for that duty were unable to locate Patient One.

17. Patient One presented to Respondent's office six weeks later, on June 20, 2017, and denied any continued suicidal ideation; he told Respondent that he had been "looking for counseling." Patient One also told Respondent he was taking his pain medications as prescribed and stated he was suffering no ill effects on those drugs. Respondent did not refer Patient One for an evaluation at this visit, nor did he reduce the level of opiates he continued to prescribe to Patient One. Patient One was encouraged to seek mental health treatment and was given a three months supply of his prescribed drugs.

18. Respondent has subjected his license to disciplinary action for unprofessional conduct in that his failure to clinically assess the basis for administering spinal injections to Patient One was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

19. The allegations of paragraphs 12 through 17 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his failure to effectively monitor and assess Patient One's condition and response to opioid therapy was a departure from the standard of care constituting gross negligence in violation of section

2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

20. The allegations of paragraphs 12 through 17 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his use of 200 mcg of fentanyl intravenously for anesthesia/sedation for spinal injections was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

21. The allegations of paragraphs 12 through 17 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his addition of morphine sulfate to the Oxycodone he was prescribing for Patient One without adequate clinical justification based on assessment of the risks and benefits of prescribing that drug was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

FIFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

22. The allegations of paragraphs 12 through 17 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his continued prescribing of high-dose opiates to a patient with an evident untreated psychiatric comorbid condition was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

23. The allegations of paragraphs 12 through 17 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action in that his failure to maintain adequate and accurate records relating to his provision of services to Patient One constitutes unprofessional conduct under section 2266.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

24. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that his care and treatment of Patient Two included departures from the standard of care constituting gross negligence or, in conjunction with the other departures alleged herein, constitute repeated negligent acts. The circumstances are as follows:

25. The medical records for Patient Two indicate an initial consult visit with Respondent for a complaint of low back pain on February 2, 2010. Respondent's chart entries for this first visit detailed a comprehensive physical examination and discussion of the patient's history. The record indicates Respondent's understanding that Patient Two was then taking methadone[7] and hydrocodone,[8] which reportedly controlled Patient Two's pain. There is no indication in the medical record that Respondent considered or discussed with Patient Two the risks and benefits of opioid therapy. Respondent noted his plan for epidural steroid injections, administration of a non-steroidal anti-inflammatory, and follow-up visits. Respondent re-filled Patient Two's prescriptions for methadone and hydrocodone at this initial visit.

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[7] Methadone hydrochloride is a synthetic narcotic analgesic. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine.

[8] Hydrocodone bitartrate is a semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022 and a schedule III controlled substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety Code. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety agents, or other central nervous system depressants (including alcohol) concomitantly with Vicodin may exhibit central nervous system depression.

26. In his interview with Board investigators, Respondent stated that he saw and treated Patient Two over the next few years on an informal basis, rarely noting the visits or prescription refills because he was aware that Patient Two and her family were in dire financial straits, including a period of homelessness. During this period, Respondent reportedly treated Patient Two's back pain with a variety of medical procedures, including facet injections and subsequent radio frequency nerve ablation.

27. Respondent re-visited Patient Two's lumbar spine pathology in a discussion noted in the medical record of an office visit on July 10, 2013. Respondent continued her drug regimen, which at this time included methadone, hydromorphone,[9] carisoprodol, and diazepam.[10] There is no indication in the medical record for this encounter that Respondent considered or discussed with Patient Two the risks and benefits of the continued high dose opioid therapy, nor is there any evidence in the record that Respondent attempted to assess the analgesic effect of the drugs he was prescribing, Patient Two's level of functioning while taking these medications in combination, or signs of aberrant use of these drugs.

28. The medical record for the August 1, 2013, office visit reflects Respondent's awareness of the amount and combination of prescription drugs he was prescribing to Patient Two: "I did also discuss with the patient her opiate dependence. She is on a lot of medication presently, which I am uncertain if it is serving her well. We will attempt to stabilize her pain control, increase her level of function generally and then eventually hope to gradually wean her down from her current level of narcotic use." At this visit, in addition to the diazepam and carisoprodol, Respondent prescribed daily doses of 96 mg of hydromorphone and 180 mg of methadone, a calculated morphine equivalency dose of 924 mg.

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[9] Hydromorphone hydrochloride is a narcotic analgesic; it is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression.

[10] Diazepam is a psychotropic drug for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Diazepam can produce psychological and physical dependence and it should be prescribed with caution.

29. Rather than taper the dose of opiates he was prescribing to Patient Two--as he had suggested in his August 1, 2013, office visit notes--Respondent continued to re-fill Patient Two's hydromorphone and methadone prescriptions at the same dosing level for the next two years. In his chart notes of the August 6, 2015, office visit, Respondent informed Patient Two that he was terminating her from his practice after reviewing the results of a recently-administered drug screen, which showed extremely low quantitative presence of the prescribed methadone: "Clearly she is not taking this medication." Additionally, Patient Two's test revealed the presence of morphine, which was not being prescribed for Patient Two. Respondent admitted to Board investigators that he had not administered any drug screens to Patient Two over the course of his prescribing to her for the preceding five years; he stated that Patient Two could not afford to pay for such testing. Respondent issued a month's prescription for the hydromorphone which the drug screen indicated Patient Two had been taking and referred her to the physician identified in her medical insurance record as her primary care physician, a provider Patient Two told Respondent she had never met.

30. Respondent is subject to disciplinary action for unprofessional conduct in that his failure to effectively monitor and assess Patient Two's condition and response to opioid therapy over the course of years of prescribing multiple opioids to her was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

EIGHTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

31. The allegations of paragraphs 25 through 29 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his years of currently prescribing multiple opiates to Patient Two without adequate clinical justification based on assessment of the risks and benefits of that opioid therapy was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a

departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

32. The allegations of paragraphs 25 through 29 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action in that his failure to maintain adequate and accurate records relating to his provision of services to Patient Two constitutes unprofessional conduct under section 2266.

TENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

33. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) in that his care and treatment of Patient Three included departures from the standard of care constituting gross negligence or, in conjunction with the other departures alleged herein, constitutes repeated negligent acts. The circumstances are as follows:

34. Patient Three first saw Respondent on November 11, 2014, for treatment of chronic right knee pain and abdominal pain subsequent to gastric bypass surgery. At this time of this first office visit, Patient Three was being prescribed a daily dose of 96 mg of hydromorphone and 45 mg of methadone by prior treating physicians. There is no mention in Respondent's notes for this office visit that he evaluated the results of a recent electrocardiogram in light of the methadone dose he was prescribing for Patient Three. There is no indication in Respondent's medical records of this first visit that he assessed the risks and benefits of high-dose opioid therapy for Patient Three, or that he considered tapering the doses of either opiate medication. Respondent prescribed the same doses of both medications at this first visit, and authorized refills of those opiates at monthly intervals thereafter.

35. In early 2016 Patient Three underwent a total knee replacement. At the office visit on February 4, 2016, Respondent maintained the daily hydromorphone dose and increased the daily methadone dose from 45 mg to 90 mg in response to Patient Three's complaints of increased pain post-surgery. There is no significant clinical rationale presented in Respondent's

chart notes for this visit to justify doubling the amount of methadone he prescribed Patient Three and no evaluation of electrocardiogram test results subsequent to that increase, nor is there a discussion of Respondent's plan for effective surveillance of the new, higher dose opioid therapy he was administering to Patient Three. Respondent continued to refill both medications at this new daily dose level for the next 15 months.

36. On November 1, 2016, Patient Three's treating internist diagnosed her as suffering from major depressive disorder and began prescribing an anti-depressant. The records of this diagnosis and treatment were part of the patient's medical record to which Respondent had immediate and continuing access. Respondent's chart entries for the office visit of January 17, 2017, note that Patient Three was recently hospitalized for treatment of her mood disorder. Respondent charted a discussion with Patient Three regarding her early and excessive consumption of the opiates he prescribed for her and warned that continued overuse of her medications could result in Respondent's terminating his care of Patient Three. Respondent re-filled the patient's prescriptions for both hydromorphone and methadone, at the continuing high dose he initiated eleven months prior.

37. An electrocardiogram administered to Patient Three on January 19, 2017, revealed an abnormally extended QT interval, a possible consequence of methadone. Respondent had access to this test result but his chart notes for subsequent visits do not reveal consideration of suspending the methadone prescription or reducing the dose in light of the enhanced risk of cardiac arrhythmia presented by the electrocardiogram results. Respondent re-filled Patient Three's prescription for hydromorphone and for methadone in each of the following 4 months.

38. At the office visit on May 9, 2017, Respondent noted that Patient Three had again taken her opioid medications in higher doses and frequency than prescribed. Respondent stated that he persuaded Patient Three to agree to inpatient drug treatment and provided a referral for such treatment. Respondent informed Patient Three he would continue to treat her if she undertook the recommended inpatient drug treatment. Respondent did not refill her prescriptions for hydromorphone and methadone but did prescribe palliative drug therapy to address possible withdrawal symptoms. Patient Three did not return to Respondent for further treatment.

39. Respondent is subject to disciplinary action for unprofessional conduct in that his failure to discuss the risks and benefits of opioid drug therapy and failure to consider tapering the initial high dose opioid therapy Patient Three was receiving at the time of their first contact was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

ELEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

40. The allegations of paragraphs 34 through 38 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his failure to effectively monitor and assess Patient Three's response to opioid therapy over the course of years of prescribing multiple opioids to her was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

TWELFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts/Gross Negligence)

41. The allegations of paragraphs 34 through 38 are incorporated by reference as if set out in full. Respondent is subject to disciplinary action for unprofessional conduct in that his failure to address the clinical implications of Patient Three's abnormal January 19, 2017, electrocardiogram when prescribing methadone to her was a departure from the standard of care constituting gross negligence in violation of section 2234(b), or was a departure from the standard of care which, in conjunction with the other departures alleged herein, constitutes repeated negligent acts in violation of section 2234(c).

THIRTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

42. The allegations of paragraphs 34 through 38 above are incorporated by reference as if set out in full. Respondent is subject to disciplinary action in that his failure to maintain adequate

and accurate records relating to his provision of services to Patient Three constitutes unprofessional conduct under section 2266.

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 88042, issued to Arnold Aldermann Weekes, M.D.;

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

3. Ordering Arnold Aldermann Weekes, 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: October 4, 2018

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

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