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

In the Matter of the Accusation Against: Assad Ullah Darawal, M.D. Physician's and Surgeon's Certificate No. A 51602 Respondent.	Case No. 800-2017-030626

DECISION

The attached Stipulated Settlement and Disciplinary Order After Reconsideration is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 4, 2021.

IT IS SO ORDERED: February 2, 2021.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, MD

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

XAVIER BECERRA
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **ASSAD ULLAH DARAWAL, M.D.** **81-893 Dr Carreon Blvd # 1** **Indio, CA 92201** **Physician's and Surgeon's Certificate No. A 51602** Respondent.	Case No. 800-2017-030626 OAH No. 2020040198 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER AFTER RECONSIDERATION**

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

PARTIES

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

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

2. Respondent Assad Ullah Darawal, M.D. (Respondent) is represented in this proceeding by Raymond J. McMahon, Esq. of Doyle Shafer McMahon, whose address is 5440 Trabuco Road, Irvine, CA 926202.

3. On or about February 8, 1993, the Board issued Physician's and Surgeon's Certificate No. A 51602 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-030626, and will expire on November 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030626 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 13, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2017-030626 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030626. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-030626, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-030626, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 51602 to disciplinary action.

9. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-030626 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 51602 issued to Respondent Assad Ullah Darawal, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. **CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES**. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished. Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation

2. **EDUCATION COURSE**. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 25 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge in the area of pain management and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's

expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 50 hours of CME of which 25 hours were in satisfaction of this condition.

3. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **MEDICAL RECORD KEEPING COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The

medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. **MONITORING - PRACTICE**. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all

times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. **NOTIFICATION**. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to

Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. **OBEY ALL LAWS**. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

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

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

10. **GENERAL PROBATION REQUIREMENTS**.

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

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

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

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

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE**. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model

Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing

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

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

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

application shall be treated as a petition for reinstatement of a revoked certificate.

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

17. **FUTURE ADMISSIONS CLAUSE**. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-030626 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/1/2021

ASSAD ULLAH DARAWAL, M.D.
Respondent

I have read and fully discussed with Respondent Assad Ullah Darawal, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve of its form and content.

DATED: January 4, 2021

RAYMOND J. MCMAHON
Attorney for Respondent

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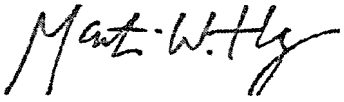
ENDORSEMENT

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

DATED: January 4, 2021

Respectfully submitted,

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



MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030626

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 13 2020
BY: Anna Logan ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2017-030626
Assad Ullah Darawal, M.D. **81-893 DR CARREON BLVD # 1** **INDIO CA 92201** **Physician's and Surgeon's Certificate No. A 51602,** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about February 8, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number A 51602 to Assad Ullah Darawal, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2020, unless renewed.

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JURISDICTION

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

4. Section 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.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

...

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

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6. Section 2266 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, D, and E, as more particularly alleged hereinafter:

PATIENT A[1]

9. On or about September 14, 2015, Respondent had his first visit with Patient A, a then-34-year-old male, who reported his occupation as a student, his main presenting problem as "back problems," and indicated he was taking Norco and Xanax on his patient history form which was not consistent with his CURES report which indicated he had not filled any prescriptions for controlled substances for the prior five and one-half months and his last prescriptions on March 30, 2015, were for hydrocodone 5/325 mg (twice a day) and tramadol HCL 50 mg. Respondent's medical records fail to document whether Respondent considered any other any non-opioid treatment options prior to him prescribing Norco to treat the complaint of back pain. Respondent did not check the Controlled Substances Utilization and Evaluation System (CURES) at any time for Patient A.[2] According to Respondent, he requested prior medical records from Patient A but they were never provided and he made no attempt to follow up in order to verify Patient A's prior treatment. The medical record for the initial visit failed to document any specific exams for Patient A's complaints. Respondent did, however, order an MRI of the lumbar spine which was reported on October 26, 2015, and noted degenerative spondylosis with end point changes and narrowing at L5-S1 with all other levels noted to be within normal limits.[3] Respondent

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[1] The patients referenced in this Accusation are designated as "Patient A," Patient B," "Patient C," "Patient D," and "Patient E," in order to maintain and protect their privacy.

[2] California's Controlled Substance Utilization Review and Evaluation System (CURES) is a prescription drug monitoring program which tracks Schedule II, III and IV controlled substance prescriptions that are dispensed in California. Respondent indicated in his subject interview before a Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit ("HQIU") Investigator that he "didn't look at CURES for any of the patients." (Transcript, at p. 80.)

[3] The MRI's impression section stated, "IMPRESSION: L5-S1 intervertebral disc space narrowing and endplate changes Schmorl's nodes and dessication with disc osteophyte central left

prescribed Norco[4] (hydrocodone/acetaminophen [APAP]) 10/325 mg (#90) 1 tab t.i.d. (three times a day); and Xanax (alprazolam)[5] 2 mg (#90) 1 tab t.i.d.

10. During the remainder of 2015, Respondent had four more visits with Patient A which took place on October 24, November 12, December 8, and December 11, 2015. During this time, Patient A's problems were generally documented in the electronic medical records (EMR's) assessment/plan section as including, but not limited to, back issues mild intermittent asthma and opioid dependence. On November 12, opioid dependence was added to the assessment but there was no plan documented for treating Patient A's opioid dependency.[6] On December 8, Patient A presented for "cough" but no further details were documented. On December 11, Patient A presented for cough and back pain with a respiratory rate of 15 with no further new details documented. According to the CURES report for Patient A, the following prescriptions for

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paracentral with mild subarticular and left lower neural foraminal narrowing."

[4] Hydrocodone APAP (Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

[5] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[6] Respondent claimed during his subject interview that he had a later discussion with Patient A about "taper[ing] you down gradually from this medication." Respondent was asked "Now, is that – that conversation that you had with him regarding that, documented anywhere in these notes, either in the EMR or what you wrote by hand on the paper portion of the chart?" Respondent replied that it was done "verbally." (Transcript, at pp. 66-67.)

controlled substances were filled for Patient A for the remainder of 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-14-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
10-14-2015	Alprazolam	2 mg	90	30	Respondent
11-12-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
11-12-2015	Alprazolam	2 mg	90	30	Respondent
12-08-2015	Promethazine Codeine Syrup[7]	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
12-11-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent
12-11-2015	Alprazolam	2 mg	90	30	Respondent

11. During the period of on or about January 1, 2016, through December 31, 2016, Patient A had thirteen visits with Respondent or his nurse practitioner which took place on January 11, February 11, March 11, April 8, May 6, June 6, July 5, August 3, September 2 (nurse practitioner), September 30 (nurse practitioner), October 28 (nurse practitioner), November 28 (nurse practitioner) and December 28, 2016 (nurse practitioner). During this time, Patient A's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, back issues, mild intermittent asthma, opioid dependence (dropped from assessment without explanation on February 11), obesity (added on March 11), bilateral knee pain (added on March 11, noted on handwritten note, but not documented on EMR), generalized anxiety disorder (added on June 6), constipation (added on September 30), and chest wall trauma related to falling off a bike on October 28, 2016. On February 11, bronchitis was added to the assessment but there was no supportive documentation for the bronchitis assessment. On September 2, Respondent's

[7] Promethazine phenylephrine codeine syrup (Robitussin®), a narcotic analgesic, with codeine, is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the temporary relief of coughs and upper respiratory symptoms, including nasal congestion, associated with allergy or the common cold. The Federal Drug Administration has issued a black box warning for promethazine phenylephrine codeine syrups which warns about, among other things, that concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death and to avoid the use of opioid cough medications in patients taking benzodiazepines, other CNS depressants, or alcohol.

nurse practitioner documented the "common and serious side effects" of the medication that was prescribed.[8] On October 28, Respondent documented Patient A's "[complaint of] chest wall pain after falling off motor bike" without documenting targeted chest wall symptoms or a targeted examination. On November 28, chest wall pain/trauma was removed from the assessment although it was still presented in the history of present illness (HPI). According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-11-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
01-11-2016	Alprazolam	2 mg	90	30	Respondent
02-11-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
02-11-2016	Alprazolam	2 mg	90	30	Respondent
03-11-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
03-11-2016	Alprazolam	2 mg	90	30	Respondent
04-09-2016	Hydrocodone/APAP	10/325 mg	90	20	Respondent
04-09-2016	Alprazolam	2 mg	90	30	Respondent
05-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
05-06-2016	Alprazolam	2 mg	90	30	Respondent
06-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent

[8] This was the only specific documentation of any type of informed consent discussion with Patient A. The Medical Board of California's Guidelines for Prescribing Controlled Substances of Pain (November 2014) provides that "Patient consent typically addresses: the potential risks and anticipated benefits of long-term opioid therapy; potential side effects (both short and long term) of the medication, such as nausea, opioid- induced constipation, decreased libido, sexual dysfunction, hypogonadism with secondary osteoporosis [citation omitted] and cognitive impairment; the likelihood that some medications will cause tolerance and physical dependence to develop; the risk of drug interactions and over-sedation; the risk of respiratory depression; the risk of impaired motor skills (affecting driving and other tasks); the risk of opioid misuse, dependence, addiction and overdose; and the limited evidence as to the benefit of long-term opioid therapy." (MBC Guidelines (2014), at p. 11; see also, p. 19 [discussing that medical records should document "instructions to the patient, including discussion of the risks and benefits with the patient and any significant others.")

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-06-2016	Alprazolam	2 mg	90	30	Respondent
07-05-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
07-05-2016	Alprazolam	2 mg	90	30	Respondent
08-03-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
08-03-2016	Alprazolam	2 mg	90	30	Respondent
09-02-2016	Hydrocodone/APAP	10/325 mg	90	15	N.P.[9]
09-02-2016	Alprazolam	2 mg	90	30	N.P.
09-30-2016	Hydrocodone/APAP	10/325 mg	90	20	N.P.
09-30-2016	Alprazolam	2 mg	90	30	N.P.
10-28-2016	Hydrocodone/APAP	10/325 mg	90	15	N.P.
10-28-2016	Alprazolam	2 mg	90	30	N.P.
11-28-2016	Hydrocodone/APAP	10/325 mg	90	20	N.P.
11-28-2016	Alprazolam	2 mg	90	30	N.P.
12-28-2016	Hydrocodone/APAP	10/325 mg	90	15	N.P.
12-28-2016	Alprazolam	2 mg	90	30	N.P.

12. During the period of on or about January 1, 2017, through December 31, 2017, Patient A had twelve visits with Respondent which took place on January 24, February 22, March 22, April 21, May 19, June 16, July 13, August 14, September 13, October 16, November 20, and December 20, 2017. During this time, Patient A's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, back issues, mild intermittent asthma, obesity, generalized anxiety disorder, constipation, and "crushing injury of right hand" (added on October 19). On May 19, Respondent's handwritten note and EMR of May 19, references a referral to psychiatry. On June 16, Respondent failed to document the psychiatric referral. Respondent's handwritten note of July 13, references a referral to pain management

[9] The "N.P." reference used in the tables in this Accusation refers to Respondent's nurse practitioner.

(that was not documented in the EMR). According to Respondent, Patient A did not follow through on the pain management or psychiatric referrals (with the failure to follow through on the referrals not being documented). On October 19, Respondent documented "crushing injury of right hand" without documenting any corresponding plan. According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-25-2017	Hydrocodone/APAP	10/325 mg	90	20	Respondent
01-25-2017	Alprazolam	2 mg	90	30	Respondent
02-22-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-22-2017	Alprazolam	2 mg	90	30	Respondent
03-22-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
03-22-2017	Alprazolam	2 mg	90	30	Respondent
04-23-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-23-2017	Alprazolam	2 mg	90	30	Respondent
05-20-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
05-20-2017	Alprazolam	2 mg	90	30	Respondent
06-16-2017	Hydrocodone/APAP	10/325 mg	90	20	Respondent
06-16-2017	Alprazolam	2 mg	90	30	Respondent
07-13-2017	Hydrocodone/APAP	10/325 mg	90	18	Respondent
07-13-2017	Alprazolam	2 mg	90	30	Respondent
08-14-2017	Hydrocodone/APAP	10/325 mg	60	23	Respondent
08-14-2017	Alprazolam	2 mg	90	30	Respondent
09-13-2017	Hydrocodone/APAP	10/325 mg	90	20	Respondent
09-13-2017	Alprazolam	2 mg	60	30	Respondent
10-19-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
10-19-2017	Alprazolam	2 mg	60	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-20-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
11-20-2017	Alprazolam	2 mg	60	30	Respondent
12-20-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
12-20-2017	Alprazolam	2 mg	60	30	Respondent

13. During the period of on or about January 1, 2018, to February 16, 2018, Patient A had two visits with Respondent which took place on February 13 and February 26, 2018. During this time, Patient A's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, back issues, mild intermittent asthma, obesity, generalized anxiety disorder, constipation, and complaint of wound in right hand (added on February 26, 2018). On February 13, Respondent's treatment plan included changes to Patient A's Xanax and Norco prescriptions without any specifics documented for the change. On February 26, Respondent documented references to pain management and a psychiatrist in his medical records. Respondent claimed that on February 26, that he also discussed with Patient A that he was going to have to taper off his medications, but that conversation was not documented in Respondent's medical records. According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-13-2018	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-13-2018	Alprazolam	2 mg	60	30	Respondent

14. In general, during the course of treatment for Patient A for 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's[10] often appeared to have been copied and pasted and, at times, did not

[10] Respondent maintained handwritten notes and EMR's for each patient. The handwritten notes were on a pre-printed form used for each visit that contained sections for entering, among other things, the date of the patient encounter, allergies, chief complaints, presenting medications, physical examination, review of systems, assessment/plan, labs, additional impression, health education, referrals, and the time for the next visit. During his subject interview, Respondent was asked "which of these would you say is the most accurate and

reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.

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

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

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complete record of the encounter?" Respondent answered that you had to consider "both together, have to be together, because ... sometimes we have something in the paper that's not in computer. And sometimes, it could be in the computer not [but] not in the paper..." (Transcript, at pp. 43-44.)

PATIENT B

16. On or about February 13, 2014, Respondent had his first visit with Patient B, a then-62-year-old male, who reported his main presenting problem as knee pain. Respondent did not check CURES at the time of this initial visit which would have shown that Respondent had not filled a prescription for controlled substances for approximately nine months and his last prescription was for hydrocodone/APAP 10/325 mg (six a day) that had been prescribed by a physician assistant. A "Narcotic Release" document was signed by Patient B and Respondent on September 25, 2014.[11] Respondent's nurse practitioner prescribed an initial prescription of hydrocodone/APAP 10/325 mg (four a day) which amounted to a morphine equivalency dose[12] of 40 mg per day on February 17 and March 27. Thereafter, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 170 milligrams per day and different benzodiazepines. According to the CURES report for Patient B, the following prescriptions for controlled substances were filled for patient B during the remainder of 2014:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-17-2014	Hydrocodone/APAP	10/325 mg	90	22	N.P.
03-27-2014	Hydrocodone/APAP	10/325 mg	90	22	N.P.
08-13-2014	Oxycodone HCL[13]	10 mg	120	20	Respondent

[11] The "Narcotic Release" memorialized that Patient B and Respondent "agree[d] to the following rules of taking any narcotic medication[:] (1) Patient to fill medication on due date only[;] (2) Patient has been informed of the side effects and risk of taking a narcotic[;] (3) Patient has tried and failed other pain medications[;] (4) if Patient abuse [sic] this contract patient will be referred to pain management or released from practice[;] and (5) Patient has been informed pain medications may be come addictive if not taken properly." There were no written pain management agreements for any of the other patients identified herein.

[12] Morphine equivalency dose (MED) is a value assigned to opioids to represent their relative potencies. MED is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the prescribed opioid. Daily MED is the sum total of all opioids, with conversion factors applied, that are being taken within a 24-hour period, which is used to determine if a patient is at risk of addiction, respiratory depression, or other delirious effects associated with opioids. The process of converting opioid doses to an overall morphine equivalency dose can be accomplished by using a MED calculator or a morphine equivalency table, also known as an opioid conversation chart.

[13] Oxycodone HCL (OxyContin®), an opioid narcotic, is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
08-13-2014	Methadone HCL[14]	10 mg	60	30	Respondent
08-26-2014	Temazepam[15]	15 mg	30	30	Respondent
09-10-2014	Methadone HCL	10 mg	60	30	Respondent
09-25-2014	Temazepam	15 mg	30	30	Respondent
09-26-2014	Oxycodone HCL	10 mg	120	20	N.P.
10-09-2014	Methadone HCL	10 mg	60	30	Respondent
10-23-2014	Temazepam	15 mg	30	30	N.P.
10-23-2014	Alprazolam	0.5 mg	30	30	N.P.
11-04-2014	Oxycodone HCL	10 mg	120	20	N.P.
11-04-2014	Methadone HCL	10 mg	60	30	Respondent
11-24-2014	Diazepam[16]	10 mg	30	30	Respondent

indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

[14] Methadone (methadone hydrochloride), an opioid narcotic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it can be used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified methadone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for methadone which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of methadone with benzodiazepines or other central nervous system (CNS) depressants.

[15] Temazepam (Restoril®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as temazapam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) The FDA has issued a black box warning indicating that concomitant use of temazapam with opioids "may result in profound sedation, respiratory depression, coma, and death."

[16] Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-28-2014	Oxycodone HCL	10 mg	120	20	N.P.
12-03-2014	Methadone HCL	10 mg	60	30	Respondent
12-24-2014	Oxycodone HCL	10/325 mg	120	20	Respondent

17. During the period of on or about January 1, 2015, through December 31, 2015, Patient B had twelve visits with Respondent which took place on January 15, February 12, May 12, June 12, July 10, July 13, August 7, September 28, October 12, October 20, November 20, and December 18, 2015. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, opioid dependence, habitual drug user (added on September 28 with no specifics), knee pain, insomnia, major depressive disorder, back pain, and acute bronchitis. On January 1, acute bronchitis was documented in the assessment without further explanation. On May 12, Respondent documented in his EMR that he "referred to pain management." On June 12, the plan included requesting a cane and scooter to assist with activities of daily living (ADL) with the power scooter being denied by insurance and, instead, there was referral to physical therapy. On July 10, Patient B had a positive urine drug screen for methadone (being prescribed by Respondent), methamphetamine, and opiates (being prescribed by Respondent).[17] On December 11, an X-ray of Patient B's bilateral knees revealed moderate to advanced arthritic disease in both knees, essentially unchanged from his previous study. During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day and different benzodiazepines. According to the CURES report for

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(d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for short-term relief of anxiety. Concomitant use of diazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) The FDA has issued a black box warning indicating that concomitant use of diazepam with opioids "may result in profound sedation, respiratory depression, coma, and death."

[17] The urine drug screen was conducted while Patient B was at JFK Memorial Hospital. A copy of the urine drug screen result was contained within the certified medical records provided by Respondent for Patient B. Respondent's EMR for Patient B for July 13, 2015, documented "all hospital records reviewed."

patient B, the following prescriptions for controlled substances were filled for patient B during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2015	Methadone HCL	10 mg	60	30	Respondent
01-15-2015	Diazepam	10 mg	30	30	Respondent
01-23-2015	Oxycodone HCL	10 mg	120	30	N.P.
02-02-2015	Methadone HCL	10 mg	60	30	Respondent
02-12-2015	Diazepam	10 mg	30	30	Respondent
02-23-2015	Oxycodone HCL	10 mg	120	20	Respondent
03-02-2015	Methadone HCL	10 mg	60	30	Respondent
03-09-2015	Diazepam	10 mg	30	30	N.P.
03-23-2015	Oxycodone/APAP	10/325 mg	120	20	N.P.
04-03-2015	Methadone HCL	10 mg	60	30	Respondent
04-08-2015	Diazepam	10 mg	30	30	Other - S.H.
05-01-2015	Methadone HCL	10 mg	60	30	Other - S.H.
05-12-2015	Oxycodone HCL	10 mg	120	30	Respondent
05-12-2015	Diazepam	5 mg	30	30	Respondent
05-28-2015	Methadone HCL	10 mg	60	30	Respondent
06-12-2015	Diazepam	5 mg	30	30	Respondent
06-12-2015	Oxycodone HCL	10 mg	120	30	Respondent
06-26-2015	Methadone HCL	10 mg	60	30	Respondent
07-13-2015	Oxycodone HCL	10 mg	120	30	Respondent
07-13-2015	Diazepam	5 mg	30	30	Respondent
07-24-2015	Methadone HCL	10 mg	60	30	Respondent
08-07-2015	Oxycodone HCL	10 mg	120	30	Respondent
08-07-2015	Diazepam	5 mg	30	30	Respondent
09-17-2015	Temazapam	15 mg	15	15	Other - Dr. K.M.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
09-23-2015	Oxycodone/APAP	5/325 mg	30	5	Other - Dr. K.M.
09-28-2015	Lorazepam[18]	2 mg	30	30	Respondent
10-20-2015	Methadone HCL	10 mg	60	30	Respondent
10-29-2015	Lorazepam	2 mg	30	30	Respondent
11-20-2015	Methadone HCL	10 mg	60	30	Respondent
11-30-2015	Lorazepam	2 mg	30	30	N.P.
12-18-2015	Methadone HCL	10 mg	60	30	Respondent
12-27-2015	Lorazepam	2 mg	30	30	Respondent

18. During the period of on or about January 1, 2016, through December 31, 2016, Respondent Patient B had sixteen visits with Respondent or his nurse practitioner (N.P.) which took place on January 26, February 24, March 17, March 23, April 13, May 12, May 20, June 6, June 15, June 22, June 26, July 13, August 12 (nurse practitioner), September 9 (nurse practitioner), November 4, and December 2, 2016. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, opioid dependence, knee pain, insomnia, major depressive disorder, back pain, acute bronchitis and chronic kidney disease. On February 18, there was another X-ray of Patient B's bilateral knees which revealed severe osteoarthritis without significant progression since the prior X-ray of December 11, 2015. On February 24, there were only two medications documented but no reasoning provided. On March 17, there was documentation of "fatigue" and Patient B being "shaky" without any further details. On March 23, the EMR documented changes of "current meds" of Lorazepam and methadone with the addition of Norco without further

[18] Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of lorazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as lorazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) The FDA has issued a black box warning indicating that concomitant use of lorazepam with opioids "may result in profound sedation, respiratory depression, coma, and death."

details. On June 6, Patient B had a right knee injection. On June 12, Respondent sought authorization for a physical therapy referral (which was authorized on June 19). On June 15, Respondent's EMR documented a change in Lorazepam and methadone, as well as the addition of Oxycodone, without any further details or explanation. On June 22, Patient B was given an additional prescription of Percocet "due to his pain meds getting stolen, one time deal." Respondent's certified medical records contained a CURES report for Patient B, dated June 28, 2016, accessed by M.C., Respondent's nurse practitioner, which revealed that another physician, Dr. M.M., had issued a prescription for Lorazepam (#10) 1 mg and Methadone (#20) 10 mg on January 19, 2016.[19] There was no documentation of Patient B being counseled about receiving controlled substances from another prescriber. On December 2, Patient B presented for knee pain and referral to an eye doctor with no further details pertaining to the basis for the ophthalmology referral made by Respondent. During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day concurrently with a benzodiazepine. According to the CURES report for patient B, the following prescriptions for controlled substances were filled for Patient B during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-19-2016	Methadone HCL	10 mg	20	10	Other - Dr. M.M.
01-19-2016	Lorazepam	1 mg	10	10	Other - Dr. M.M.
01-26-2016	Methadone HCL	10 mg	60	30	Respondent
01-26-2016	Lorazepam	2 mg	30	30	Respondent
02-24-2016	Hydrocodone/APAP	10/325 mg	60	10	Respondent
02-24-2016	Lorazepam	2 mg	30	30	Respondent
02-24-2016	Methadone HCL	10 mg	60	30	Respondent
03-23-2016	Lorazepam	2 mg	30	30	Respondent

[19] Respondent's EMR for June 28, 2016, states, in pertinent part, "Patient is here due to feeling weak and chills [and] [patient] requesting his methadone and oxycodone he was advised he was not [due] he then said he did not want to see doctor we advise[d] [patient] to keep his [appointment] when he was scheduled for his rx [prescription]."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
03-23-2016	Hydrocodone/APAP	10/325 mg	60	10	Respondent
03-23-2016	Methadone HCL	10 mg	60	30	Respondent
04-13-2016	Oxycodone HCL	10 mg	120	20	Respondent
04-21-2016	Lorazepam	2 mg	30	30	Respondent
04-21-2016	Methadone HCL	10 mg	60	30	Respondent
05-12-2016	Oxycodone HCL	10 mg	120	30	Respondent
05-20-2016	Lorazepam	2 mg	30	30	Respondent
05-20-2016	Methadone HCL	10 mg	60	30	Respondent
06-15-2016	Oxycodone HCL	10 mg	120	30	Respondent
06-16-2016	Lorazepam	2 mg	30	30	Respondent
06-16-2016	Methadone HCL	10 mg	60	30	Respondent
06-22-2016	Oxycodone/APAP	10/325 mg	60	10	Respondent
07-13-2016	Lorazepam	2 mg	30	30	Respondent
07-13-2016	Oxycodone HCL	10 mg	120	30	Respondent
07-13-2016	Methadone HCL	10 mg	60	30	Respondent
08-12-2016	Methadone HCL	10 mg	60	30	Respondent
08-12-2016	Oxycodone HCL	10 mg	120	30	N.P.
08-12-2016	Lorazepam	2 mg	30	30	N.P.
08-17-2016	Hydrocodone/APAP	10/325 mg	40	10	Other – Dr. S.M.
09-09-2016	Methadone HCL	10 mg	60	30	N.P.
09-09-2016	Oxycodone HCL	10 mg	120	30	N.P.
09-09-2016	Lorazepam	1 mg	30	30	N.P.
10-06-2016	Methadone HCL	10 mg	60	30	Respondent
10-06-2016	Lorazepam	2 mg	30	30	Respondent
10-06-2016	Oxycodone HCL	10 mg	120	30	Respondent
11-04-2016	Methadone HCL	10 mg	60	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-04-2016	Lorazepam	1 mg	30	30	Respondent
11-04-2016	Oxycodone HCL	10 mg	120	30	Respondent
12-02-2016	Methadone HCL	10 mg	60	30	Respondent
12-02-2016	Lorazepam	1 mg	30	30	Respondent
12-02-2016	Oxycodone HCL	10 mg	120	30	Respondent
12-26-2016	Hydrocodone/APAP	10/325 mg	60	15	Other – Dr. S.M.

19. During the period of on or about January 1, 2017, through December 31, 2017, Patient B had fourteen visits with Respondent which took place on January 3, February 2, February 9, March 2, March 26, April 26, May 26, June 23, July 21, August 21, September 20, October 19, November 17 and December 18, 2017. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, opioid dependence, knee pain, insomnia, major depressive disorder, back pain, acute bronchitis and chronic kidney disease. On March 2, referrals were made for colonoscopy and bone density scan without any mention of the referrals in the EMR. On March 28, the EMR included addition of a new hypertensive regimen without explanation. On June 16, Patient B's urine drug screen was positive for amphetamines, benzodiazepines (which were being prescribed), cannabis, methamphetamine, and opiates (which were being prescribed). On June 23, Patient B presented for "hospital follow up" without any documentation of the reason for the hospitalization. On July 13, Respondent sought authorization for a referral to pain management (which was approved on July 19). On August 21, changes to Patient B's Lorazepam, Methadone and Oxycodone were documented but no clear explanation was provided in the plan. Respondent sought authorization for a referral to orthopedics around August 21 (which was authorized on August 22). During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day in combination with a benzodiazepine (Lorazepam) and a sleep aid (zolpidem tartrate [Ambien].). According to the CURES report for Patient B, the following prescriptions for controlled substances were filled

for patient B during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-03-2017	Oxycodone HCL	10 mg	120	30	Respondent
01-03-2017	Lorazepam	1 mg	30	30	Respondent
01-03-2017	Methadone HCL	10 mg	60	30	Respondent
02-02-2017	Lorazepam	1 mg	30	30	Respondent
02-02-2017	Methadone HCL	10 mg	60	30	Respondent
02-02-2017	Oxycodone HCL	10 mg	120	30	Respondent
03-02-2017	Oxycodone HCL	10 mg	120	30	Respondent
03-02-2017	Lorazepam	1 mg	30	30	Respondent
03-02-2017	Methadone HCL	10 mg	60	30	Respondent
03-14-2017	Zolpidem Tartrate[20]	10 mg	30	30	Other – Dr. S.M.
03-14-2017	Hydrocodone/APAP	10/325 mg	60	21	Other – Dr. S.M.
03-29-2017	Lorazepam	1 mg	30	30	Respondent
03-29-2017	Oxycodone HCL	10 mg	120	30	Respondent
03-29-2017	Methadone HCL	10 mg	60	30	Respondent
04-24-2017	Zolpidem Tartrate	10 mg	30	30	Respondent
04-26-2017	Methadone HCL	10 mg	60	30	Respondent
04-26-2017	Lorazepam	1 mg	30	30	Respondent
04-26-2017	Oxycodone HCL	10 mg	120	30	Respondent
05-26-2017	Lorazepam	1 mg	30	30	Respondent
05-26-2017	Oxycodone HCL	10 mg	120	30	Respondent
05-26-2017	Methadone HCL	10 mg	60	30	Respondent
06-26-2017	Oxycodone HCL	10 mg	120	30	Respondent

[20] Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-26-2017	Methadone HCL	10 mg	60	30	Respondent
06-26-2017	Lorazepam	1 mg	30	30	Respondent
07-21-2017	Oxycodone HCL	10 mg	120	30	Respondent
07-21-2017	Lorazepam	1 mg	30	30	Respondent
07-21-2017	Methadone HCL	10 mg	60	30	Respondent
08-21-2017	Oxycodone HCL	10 mg	120	30	Respondent
08-21-2017	Lorazepam	1 mg	30	30	Respondent
08-21-2017	Methadone HCL	10 mg	60	30	Respondent
09-20-2017	Lorazepam	1 mg	30	30	Respondent
09-20-2017	Methadone HCL	10 mg	60	30	Respondent
09-20-2017	Oxycodone HCL	10 mg	120	30	Respondent
10-19-2017	Lorazepam	1 mg	30	30	Respondent
10-19-2017	Oxycodone HCL	10 mg	120	30	Respondent
10-19-2017	Methadone HCL	10 mg	60	30	Respondent
11-17-2017	Methadone HCL	10 mg	60	30	Respondent
11-17-2017	Lorazepam	1 mg	30	30	Respondent
11-17-2017	Oxycodone HCL	10 mg	120	30	Respondent
12-18-2017	Methadone HCL	10 mg	60	30	Respondent
12-18-2017	Oxycodone HCL	10 mg	120	30	Respondent
12-18-2017	Lorazepam	1 mg	30	30	Respondent

20. During the period of on or about January 1, 2018, through May 14, 2018, Patient B had five visits with Respondent which took place on January 18, February 15, March 14, April 14, and May 14, 2018. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, continuous opioid dependence, bilateral knee pain, recurrent major depressive episodes, back pain, and chronic kidney disease. On February 15, the EMR documented a change of the aspirin

dosage from 81 mg to 325 mg without any clear explanation with Omeprazole (generally used to reduce acid in the stomach) being prescribed without any reason provided. Respondent also sought authorization for a referral to an orthopedist on February 15 (which was authorized on February 23). On March 14, Respondent's EMR documented that "pain management" was "ordered/advised." Respondent claimed that for "three or four months, I was telling [Patient B] that you need to find [another] physician eventually [and] [o]ne day we're going to give you medication [for] the last time," but, as Respondent acknowledged, the conversation was not documented in his medical records. Respondent further claimed on Patient B's last visit of May 14, he spoke to Patient B about the need to taper his medications and "we told him what to taper" but this conversation, as Respondent acknowledged, also was not documented in the medical records. During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day concurrently with a benzodiazepine. According to the CURES report for Patient B, the following prescriptions for controlled substances were filled for Patient B during this time and up until May 14, 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-18-2018	Oxycodone HCL	10 mg	120	30	Respondent
01-18-2018	Lorazepam	1 mg	30	30	Respondent
01-18-2018	Methadone HCL	10 mg	60	30	Respondent
02-15-2018	Methadone HCL	10 mg	60	30	Respondent
02-15-2018	Oxycodone HCL	10 mg	120	30	Respondent
02-15-2018	Lorazepam	1 mg	30	30	Respondent
03-14-2018	Oxycodone HCL	10 mg	120	30	Respondent
03-14-2018	Lorazepam	1 mg	30	30	Respondent
03-14-2018	Methadone HCL	10 mg	60	30	Respondent
04-13-2018	Methadone HCL	10 mg	60	30	Respondent
04-13-2018	Oxycodone HCL	10 mg	120	30	Respondent
04-13-2018	Lorazepam	1 mg	30	30	Respondent

21. In general, during the course of treatment for Patient B during 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.[21]

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

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely

[21] Respondent acknowledged during his subject interview that there were issues with the medication list in his EMR's not matching what was actually being prescribed to Patient B. (Transcript, at p. 87.)

manner which increased the risk of harm to the patient including, but not limited to, the risk of respiratory depression.

PATIENT C

23. On or about February 5, 2015, Respondent had his first visit with Patient C, a then-30-year-old female. According to Respondent's medical record for this visit, Patient C had a history of spina bifida, renal failure, arthritis, gout and anxiety; her current medications were listed on her history form as Cyclosporine 100 mg/mL (one tab twice a day), Prednisone 5 mg (every 6 hours); and her chief complaints were back problems and anxiety. Respondent did not check CURES at the time of this initial visit and there was no documentation, or other indication, of him checking CURES at any other time during his care and treatment of Patient C. As part of this visit, Respondent prescribed Patient C Alprazolam (zolpidem tartrate) 0.25 mg and hydrocodone/APAP 5/325 mg (#60). According to the CURES report for patient C, she filled prescriptions for Alprazolam (zolpidem tartrate) 0.25 mg (#60) (30 day supply) and hydrocodone/APAP 5/325 mg (#60) (10 day supply) on February 5, 2015.

24. During the period of on or about February 6, 2015, through December 31, 2015, Patient C had nine visits with Respondent which took place on March 6, April 2, May 4, June 4, July 8, August 5, September 4, October 5 and December 4, 2015. During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-05-2015	Alprazolam	0.25 mg	60	30	Respondent
02-05-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
03-05-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
03-05-2015	Alprazolam	0.25 mg	60	30	Respondent
03-28-2015	Hydrocodone/APAP	5/325 mg	12	3	Other – C.P.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-03-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
04-03-2015	Alprazolam	0.25 mg	60	30	Respondent
05-05-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
05-05-2015	Alprazolam	0.25 mg	60	30	Respondent
06-04-2015	Alprazolam	0.25 mg	60	30	Respondent
06-04-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
07-08-2015	Hydrocodone/APAP	10/325 mg	90	20	Respondent
08-05-2015	Alprazolam	0.25 mg	60	30	Respondent
08-05-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-04-2015	Alprazolam	0.25 mg	60	30	Respondent
09-04-2015	Hydrocodone/APAP	10/325 mg	90	22	Respondent
10-05-2015	Alprazolam	0.25 mg	60	30	Respondent
10-05-2015	Hydrocodone/APAP	10/325 mg	90	22	Respondent
11-05-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent
11-05-2015	Alprazolam	0.25 mg	60	30	Respondent
12-04-2015	Alprazolam	0.25 mg	60	30	Respondent
12-04-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent

25. During the period of on or about January 1, 2016, through December 31, 2016, Patient C had twelve visits with Respondent or his nurse practitioner which took place on January 5, February 5, March 8, April 7, May 8, June 6, July 6, August 5, September 2 (nurse practitioner), September 30 (nurse practitioner), October 31 and December 30, 2016 (nurse practitioner). During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. On July 6, changes were documented to the "current meds" for Xanax and hydrocodone/APAP without a clear explanation. On August 5, "has skin rash all over body" was documented without any skin exam

being documented. According to the CURES report for patient C, the following prescriptions for controlled substances were filled for Patient C during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-05-2016	Alprazolam	0.25 mg	60	30	Respondent
01-05-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
02-05-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-05-2016	Alprazolam	0.25 mg	60	30	Respondent
03-08-2016	Alprazolam	0.25 mg	60	30	Respondent
03-08-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-07-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-07-2016	Alprazolam	0.25 mg	60	30	Respondent
04-11-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
05-06-2016	Alprazolam	0.25 mg	60	30	Respondent
06-06-2016	Alprazolam	0.25 mg	60	30	Respondent
06-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
07-06-2016	Alprazolam	0.25 mg	60	30	Respondent
07-06-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
08-05-2016	Alprazolam	0.25 mg	60	30	Respondent
08-05-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-02-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-02-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-02-2016	Alprazolam	0.25 mg	60	30	Respondent
09-30-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-30-2016	Alprazolam	0.25 mg	60	30	Respondent
10-31-2016	Hydrocodone/APAP	10/325 mg	30	5	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-31-2016	Alprazolam	0.25 mg	60	30	Respondent
10-31-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
12-30-2016	Alprazolam	0.25 mg	60	30	Respondent
12-30-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent

26. During the period of on or about January 1, 2017, through December 31, 2017, Patient C had twelve visits with Respondent which took place on January 27, February 27, March 27, April 27, May 26 June 28, July 26, August 24, September 25, October 25, November 27 and December 22, 2017. During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. On February 27, changes were documented to the "current meds" for Xanax and Hydrocodone/APAP without a clear explanation. On October 25, there were two EMR's for the date, one of which included a prescription for cyclosporine not listed on the other EMR. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-27-2017	Alprazolam	0.25 mg	60	30	Respondent
01-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-27-2017	Alprazolam	0.5 mg	60	30	Respondent
02-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
03-27-2017	Alprazolam	0.5 mg	60	30	Respondent
03-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-27-2017	Alprazolam	0.5 mg	60	30	Respondent
05-26-2017	Alprazolam	0.5 mg	60	30	Respondent
05-26-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-26-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
06-26-2017	Alprazolam	0.5 mg	60	30	Respondent
07-26-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
07-26-2017	Alprazolam	0.5 mg	60	30	Respondent
08-24-2017	Alprazolam	0.5 mg	60	30	Respondent
08-24-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
10-25-2017	Alprazolam	0.25 mg	60	30	Respondent
10-25-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
11-27-2017	Alprazolam	0.25 mg	60	30	Respondent
11-27-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
12-22-2017	Alprazolam	0.25 mg	60	30	Respondent
12-22-2017	Hydrocodone/APAP	10/325 mg	90	23	Respondent

27. During the period of on or about January 1, 2018, through December 31, 2018, Patient C had nine visits with Respondent which took place on January 22, February 22, May 29, June 15, July 9, August 9, September 3, October 15, and November 15, 2018. During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. On February 22, Respondent sought authorization for a referral to pain management (which was approved on March 2). On June 11, "patient has weakness of lower limbs" was documented without any documented chronicity. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-22-2018	Alprazolam	0.25 mg	60	30	Respondent
01-22-2018	Hydrocodone/APAP	10/325 mg	90	22	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-22-2018	Hydrocodone/APAP	10/325 mg	90	23	Respondent
02-22-2018	Alprazolam	0.25 mg	60	30	Respondent
02-28-2018	Hydrocodone/APAP	7.5/325 mg	50	12	Other – Dr. D.C.
03-21-2018	Alprazolam	0.25 mg	30	30	Other – Dr. D.C.
04-26-2018	Tramadol	50 mg	30	30	Respondent
05-24-2018	Hydrocodone/APAP	5/325 mg	90	30	Other – J.Z.
05-29-2018	Alprazolam	0.25 mg	60	30	Respondent
06-21-2018	Hydrocodone/APAP	5/325 mg	90	30	Other – J.B.
07-09-2018	Alprazolam	0.25 mg	60	30	Respondent
08-09-2018	Alprazolam	0.25 mg	60	30	Respondent
09-17-2018	Hydrocodone/APAP	5/325 mg	60	30	Other – J.B.
10-15-2018	Alprazolam	0.25 mg	60	30	Respondent
10-15-2018	Hydrocodone/APAP	5/325 mg	20	4	Other – Dr. J.D.
10-18-2015	Hydrocodone/APAP	5/325 mg	60	30	Other – Dr. D.R.
11-15-2018	Hydrocodone/APAP	5/325 mg	60	30	Other – Dr. D.R.
12-17-2018	Hydrocodone/APAP	5/325 mg	60	30	Other – J.B.

28. On or about January 18, 2019, Patient C had a visit with Respondent in which she complained of rash and pruritis (itchy skin) all over her body. The physical exam section of the EMR, however, documented "No rash or lesions." The patient was prescribed fluconazole, betamethasone dipropionate topical cream, and ketoconazole topical cream. Patient C requested, and was provided with, a dermatology referral.

29. In general, during the course of treatment for Patient C during 2015 through 2019, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.

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

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing timely tapering or antidote therapy which increased the risk of harm to the patient including, but not limited to, the risk of respiratory depression.

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PATIENT D

31. On or about April 16, 2015, Patient D had his first visit with Respondent's office and was seen by Respondent's nurse practitioner. On his personal history form, Patient D, a then-33-year-old male, indicated that he was not currently taking any medications, he had no allergies, and he did not check any boxes for his medical history, such as back pain – recurrent, foot pain, etc. Respondent's nurse practitioner's EMR, however, indicated that Patient D had right hip pain for approximately 1.5 years, "[r]eports that he has been seen on multiple occasions for pain" and "reports severe panic attacks when around a lot of people." According to Respondent, prior medical records were requested, not received, and there was no follow up. CURES was not checked at the time of this initial visit and there was no documentation, or other indication, of Respondent or his nurse practitioner checking CURES at any other time during the care and treatment of Patient D. If CURES would have been checked, Respondent or his nurse practitioner would have seen limited and sporadic prescriptions for hydrocodone/APAP 5/325 mg (generally 4 to 5 per day) and one prescription for hydrocodone 10/325 mg (4 a day)[22] for an MED of approximately 20 to 40 mgs per day; and no prior prescriptions for benzodiazepines. The documented physical exam noted "right hip pain with ROM [range of motion]." There was no written pain management agreement with Patient D and Respondent claimed "at that time it was verbal agreement." According to the EMR for this visit, labs were ordered, X-rays of the lumbar spine and right hip were ordered, and there was documentation in the EMR of "Mental Health (Dx [diagnosis] anxiety attacks)." Patient D was prescribed Percocet 10/325 mg 1 tablet every 6 hours, Xanax (alprazolam) 2 mg 1 tab daily, and Ultram (tramadol) 50 mg (#90) (three a day) (carried over on the EMR "meds" list until January 22, 2016 [but only filled by the patient on April 16, 2015].)

32. During the period of on or about April 17, 2015, through December 31, 2015, Patient D had nine additional visits with Respondent or his nurse practitioner which took place on May 1 (nurse practitioner), May 29 (nurse practitioner), June 29, July 27, August 24, September 21

[22] A CURES report that reached back to November 26, 2012, indicated prescriptions for Roxicet 5/325 mg (#16) on 10-28-2013; hydrocodone/APAP 10/325 mg (#20) on 05-11-2014; hydrocodone/APAP 10/325 mg (#15) on 06-12-2014; hydrocodone/APAP 5/325 mg (#15) on 06-12-2014; hydrocodone/APAP 5/325 mg (#12) on 10-23-2014; and hydrocodone/APAP 5/325 mg (#15) on 01-26-2015.

(nurse practitioner), October 19 (nurse practitioner), November 20 (nurse practitioner), and December 21, 2015 (nurse practitioner). During this time, Patient D's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), "hypnotic or anxiolytic dependence, continuous" (added on August 24), and opioid dependence (added on August 24 [but not indicated on EMR problem list].) On May 1, Respondent's nurse practitioner documented a review of records from Patient D's last ER visit with x-ray's indicating bilateral arthritis with patient declining to see orthopedics, pain management or mental health referral, and his failure to complete labs. X-rays of Patient D's lumbar spine and hips of May 1 were interpreted as showing "mild degenerative changes" (which was consistent with prior imaging done at Eisenhower Medical Center on June 12, 2014). Respondent's nurse practitioner documented a discussion of the "common and serious side effects" of the medication for five patient visits.[23] During this period of time, the MED ranged from 45 mg to 90 mg per day concurrently with a benzodiazepine. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-16-2015	Oxycodone HCL	10/325 mg	30	7	N.P.
04-16-2015	Tramadol[24]	50 mg	90	30	N.P.

[23] The relevant portion of the EMR stated, "Discussed the common and serious side effects of this medication and the need to alert me if experiencing these or having any concerns about a possible medication effect. Advised the patient to discuss possible side effects, contraindications, and interactions with their pharmacist. Educated on safety concerning driving or the operation of heavy equipment during use. All medications have been reviewed and refilled." (See EMR's for May 1, September 21, October 19, November 20, and December 21, 2015.)

[24] Tramadol Hydrochloride (Ultram®, Ultracet®), an opioid analgesic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The FDA-approved labeling under the Drug Abuse and Dependence section provides warns, among other things, that "[t]ramadol hydrochloride may induce psychic and physical dependence ... Dependence and abuse, including drug-seeking behavior and taking illicit actions to obtain the

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
05-01-2015	Oxycodone HCL	10/325 mg	60	15	N.P.
05-01-2015	Alprazolam	2 mg	30	30	N.P.
05-29-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
05-29-2015	Alprazolam	2 mg	30	30	N.P.
06-29-2015	Oxycodone HCL	10/325 mg	90	20	Respondent
06-29-2015	Alprazolam	2 mg	30	30	Respondent
07-27-2015	Oxycodone HCL	10/325 mg	90	20	Respondent
07-27-2015	Alprazolam	2 mg	30	30	Respondent
08-24-2015	Oxycodone HCL	10/325 mg	90	15	Respondent
08-24-2015	Alprazolam	2 mg	30	30	Respondent
09-21-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
09-21-2015	Alprazolam	2 mg	25	25	N.P.
10-19-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
10-19-2015	Alprazolam	2 mg	30	30	N.P.
11-20-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
11-20-2015	Alprazolam	2 mg	30	30	N.P.
12-22-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
12-22-2015	Alprazolam	2 mg	30	30	N.P.

33. During the period of on or about January 1, 2016, through December 31, 2016, Patient D had twelve visits with Respondent or his nurse practitioner which took place on January 22 (nurse practitioner), February 22, March 21, April 21, May 20, June 20, July 20, July 28, August 18 (nurse practitioner), September 19 (nurse practitioner), November 18 (nurse practitioner), and December 15, 2016. During this time, Patient D's problems were generally

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drug are not limited to those patients with prior history of opioid dependence. The risk in patients with substance abuse has been observed to be higher. Tramadol hydrochloride is associated with craving and tolerance development. Withdrawal symptoms may occur if tramadol hydrochloride is discontinued abruptly." According to the DEA, "[t]ramadol is most commonly abused by narcotic addicts, chronic pain patients, and health professionals."

documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), "hypnotic or anxiolytic dependence, continuous," and opioid dependence (removed without explanation on March 21). On January 22, it was documented that Patient D denied constipation but the plan included Movantik for constipation. On February 22, Respondent sought authorization for a referral to pain management (which was authorized on February 24) and changes were documented to the "current meds" for Xanax and Percocet without a clear explanation. On March 21, changes were documented to the "current meds" for Xanax and Percocet without a clear explanation of any change to the Percocet. On April 21, changes were documented to the "current meds" for Xanax and Percocet without a clear explanation. On August 2, Respondent requested authorization for referral to neurology with a listed diagnosis of "personal history of mental and behavioral disorders" (which was authorized on August 2). There is no indication that Patient D actually was seen by pain management or for a mental health evaluation during the course of his treatment with Respondent. According to Respondent, Patient D failed to follow through with the referrals. There was documentation of a discussion of the "common and serious side effects" of the medication at three patient visits (January 22, February 22 and August 18, 2016). During this period of time, Patient D was receiving an opiate (Oxycodone) at a MED as high as 90 milligrams per day concurrently with a benzodiazepine. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-22-2016	Alprazolam	2 mg	30	30	N.P.
01-22-2016	Oxycodone HCL	10/325 mg	90	30	N.P.
02-22-2016	Alprazolam	2 mg	30	30	Respondent
02-22-2016	Oxycodone HCL	10/325 mg	90	30	Respondent
03-21-2016	Alprazolam	2 mg	30	30	Respondent
03-21-2016	Oxycodone HCL	10/325 mg	90	15	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-21-2016	Alprazolam	2 mg	30	30	Respondent
04-21-2016	Oxycodone HCL	10/325 mg	90	23	Respondent
05-20-2016	Alprazolam	2 mg	30	30	Respondent
05-20-2016	Oxycodone HCL	10/325 mg	90	22	Respondent
06-20-2016	Alprazolam	2 mg	30	30	Respondent
06-20-2016	Oxycodone HCL	10/325 mg	90	20	Respondent
07-20-2016	Alprazolam	2 mg	60	30	Respondent
07-20-2016	Oxycodone HCL	10/325 mg	90	20	Respondent
08-18-2016	Alprazolam	2 mg	60	30	N.P.
08-18-2016	Oxycodone HCL	10/325 mg	90	15	N.P.
09-19-2016	Alprazolam	2 mg	60	30	N.P.
09-19-2016	Oxycodone HCL	10/325 mg	90	15	N.P.
10-14-2016	Alprazolam	2 mg	60	30	Respondent
10-17-2016	Oxycodone HCL	10/325 mg	90	22	N.P.
11-18-2016	Alprazolam	2 mg	60	30	N.P.
11-18-2016	Oxycodone HCL	10/325 mg	90	15	N.P.
12-15-2016	Alprazolam	2 mg	60	30	Respondent
12-15-2016	Oxycodone HCL	10/325 mg	90	22	Respondent

34. During the period of on or about January 1, 2017, through December 31, 2017, Patient D had three visits with Respondent which took place on January 16, February 16, and March 16, 2017. During this time, Patient D's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), and "hypnotic or anxiolytic dependence, continuous." On March 16, Respondent sought authorization for a referral to pain management (which was authorized on March 23). Respondent claimed that he also discussed weaning Patient D down or off of his narcotics but

admitted that his conversation was not documented in his medical records. During this period of time, Patient D was receiving an opiate (Oxycodone) at a MED as high as 90 milligrams per day concurrently with a benzodiazepine. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-16-2017	Alprazolam	2 mg	60	30	Respondent
01-16-2017	Oxycodone HCL	10/325 mg	90	15	Respondent
02-16-2017	Alprazolam	2 mg	60	30	Respondent
02-16-2017	Oxycodone HCL	10/325 mg	90	15	Respondent
03-16-2017	Alprazolam	0.5 mg	60	30	Respondent
03-16-2017	Oxycodone HCL	10/325 mg	90	18	Respondent

35. During the period of on or about January 1, 2018, through December 31, 2018, Patient D had nine visits with Respondent which took place on February 14, March 14, April 16, May 17, June 15, July 18, August 28, September 28, and November 12, 2018. During this time, Patient D's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), and "hypnotic or anxiolytic dependence, continuous." Respondent acknowledged that he did not check CURES upon Patient D's return from an approximate eleven month gap in treatment even though he was "suspicious at that time that he [Patient D] [was] probably abusing his medication" and may have been "a drug seeker." On February 14, the assessment documented continuation of treatment plan, however, Percocet was discontinued. On May 17, Ibuprofen was prescribed while Patient D was already on Naproxen.[25] On June 15, Patient D complained of a toothache for three days and patient was diagnosed with gingival abscesses and prescribed Clindamycin (used to treat bacterial infections), however, no abnormal oral exam was documented. According to the CURES report

[25] Ibuprofen and Naproxen are both non-steroidal anti-inflammatory drugs which are used to treat, among other things, pain and inflammation.

for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-14-2018	Alprazolam	0.5 mg	60	30	Respondent
03-14-2018	Alprazolam	0.5 mg	60	30	Respondent
04-16-2018	Alprazolam	0.5 mg	60	30	Respondent
05-17-2018	Alprazolam	0.5 mg	60	30	Respondent
06-15-2018	Alprazolam	0.5 mg	60	30	Respondent
08-28-018	Alprazolam	0.5 mg	60	30	Respondent
09-28-2018	Alprazolam	0.5 mg	60	30	Respondent
11-12-2018	Alprazolam	0.5 mg	60	30	Respondent

36. In general, during the course of treatment for Patient D during 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.[26]

37. Respondent committed gross negligence in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

[26] Respondent acknowledged during his subject interview that there were issues with his medical records not matching what was actually being prescribed to Patient D. (Transcript, at pp. 155-156.)

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing timely tapering or antidote therapy which increased the risk of harm to the patient including, but not limited to, the risk of respiratory depression.

PATIENT E

38. During the period of on or about January 1, 2015, through December 31, 2015, Patient E, a then-63-year-old male, had twelve visits with Respondent which took place on January 28, March 2, April 2, April 30, May 28, June 25, July 23, August 21, September 18, October 16, November 16, and December 16, 2015. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, opioid dependence, backache, and lumbar spondylosis. There was no documentation, or other indication, of Respondent checking CURES at any time during his care and treatment of Patient E. On December 16, Patient E requested medications due to an upcoming vacation. During this period of time, Patient E was receiving overlapping prescriptions of an opiate (hydrocodone/APAP), a benzodiazepine (Lorazepam), a sleep aid (zolpidem tartrate), and codeine cough syrup. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-05-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
01-28-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
02-12-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
03-02-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
03-23-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
04-02-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-02-2015	Hydrocodone/APAP	10/325 mg	150	30	Respondent
04-20-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
04-30-2015	Hydrocodone/APAP	10/325 mg	150	28	Respondent
05-15-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
05-28-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
06-10-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
06-25-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
07-08-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
07-23-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
07-23-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
08-12-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
08-21-2015	Lorazepam	0.5 mg	30	30	Respondent
08-24-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-18-2015	Hydrocodone/APAP	10/325 mg	150	15	Respondent
09-18-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-21-2015	Lorazepam	0.5 mg	30	30	Respondent
10-16-2015	Hydrocodone/APAP	10/325 mg	150	15	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-19-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
10-29-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
10-29-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
11-04-2015	Lorazepam	0.5	30	30	Respondent
11-16-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	6	Respondent
11-16-2015	Hydrocodone/APAP	10/325 mg	150	15	Respondent
11-30-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	6	Respondent
12-16-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
12-16-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
12-16-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent

39. During the period of on or about January 1, 2016, through December 31, 2016, Patient E had fifteen visits with Respondent which took place on January 18, February 18, March 17, April 15, May 13, June 13, July 11, July 26, August 11, September 12, September 26, October 10, November 10, December 13, and December 16, 2016. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, opioid dependence (removed after January 18), chronic cough, lumbar spondylosis, chronic back pain, chronic obstructive pulmonary disease (COPD) (added April 15), and being overweight. During this period of time, Patient E was receiving prescriptions for an opiate (hydrocodone/APAP), a benzodiazepine (Lorazepam), a sleep aid (zolpidem tartrate), and codeine cough syrup. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2016:

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Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
01-13-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
01-18-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
01-25-2016	Lorazepam	0.5	30	30	Respondent
01-25-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
02-18-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
02-18-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
03-04-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
03-17-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
03-17-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
03-29-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-05-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-15-2016	Hydrocodone/APAP	10/325 mg	150	20	Respondent
04-15-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-28-2016	Zolpidem Tartrate	5 mg	30	30	Respondent
04-28-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-13-2016	Hydrocodone/APAP	10/325 mg	150	20	Respondent
05-13-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-27-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
06-13-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-13-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
07-11-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
07-11-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
07-26-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
08-11-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
08-11-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
09-07-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-12-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
09-26-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
10-10-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
11-10-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
11-10-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
12-13-2016	Hydrocodone/APAP	10/325 mg	150	37	Respondent
12-16-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent

40. During the period of on or about January 1, 2017, through December 31, 2017, Patient E had twelve visits with Respondent which took place on January 12, February 16, March 16, April 18, May 18, June 19, July 19, August 18, September 18, October 19, November 20, and December 19, 2017. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, chronic cough, lumbar spondylosis, chronic back pain, COPD, and being overweight. On January 12, a change of "current meds" was documented for Norco (hydrocodone/APAP) but the prescription essentially remained the same. On February 21, a change of "current meds" was documented again for Norco (hydrocodone/APAP) but the

prescription essentially remained the same. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-12-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
01-12-2017	Hydrocodone/APAP	10/325 mg	150	37	Respondent
02-16-2017	Carisoprodol[27]	350 mg	90	30	Respondent
02-16-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
03-16-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
03-16-2017	Carisoprodol	350 mg	90	30	Respondent
03-21-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-18-2017	Hydrocodone/APAP	10/325 mg	150	38	Respondent
04-18-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	16	Respondent
04-18-2017	Carisoprodol	350 mg	90	30	Respondent
05-18-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-18-2017	Carisoprodol	350 mg	90	30	Respondent
05-18-2017	Hydrocodone/APAP	10/325 mg	150	38	Respondent
06-19-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
06-19-2017	Carisoprodol	350 mg	90	30	Respondent

[27] Carisoprodol (Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of acute and painful musculoskeletal conditions. Carisoprodol is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high." According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States. According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-19-2017	Hydrocodone/APAP	10/325 mg	150	38	Respondent
07-24-2017	Hydrocodone/APAP	10/325 mg	150	37	Respondent
08-25-2017	Hydrocodone/APAP	10/325 mg	150	20	Respondent
09-18-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-21-2017	Hydrocodone/APAP	10/325 mg	150	20	Respondent
10-19-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
10-19-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
11-20-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
11-20-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
12-19-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
12-19-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	06	Respondent

41. During the period of on or about January 1, 2018, through December 31, 2018, Patient E had thirteen visits with Respondent which took place on January 24, February 19, March 19, April 19, May 18, June 18, July 9, July 18, August 17, September 18, October 18, November 19, and December 13, 2018. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, chronic cough, lumbar spondylosis, chronic back pain, COPD, and being overweight. On January 18, the EMR documented "[Left] ear itchy" and prescribed Cortisporin-TC (used to treat outer ear infections caused by bacteria) one drop in each ear twice a day, however, the ear examination was documented as normal. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-18-2018	Hydrocodone/APAP	10/325 mg	150	20	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-24-2018	Carisoprodol	350 mg	90	30	Respondent
02-19-2018	Hydrocodone/APAP	10/325 mg	150	20	Respondent
02-19-2018	Carisoprodol	350 mg	90	30	Respondent
03-19-2018	Hydrocodone/APAP	10/325 mg	150	20	Respondent
04-04-2018	Carisoprodol	350 mg	90	30	Respondent
04-19-2018	Hydrocodone/APAP	10/325 mg	150	25	Respondent
05-04-2018	Carisoprodol	350 mg	90	30	Respondent
05-18-2018	Zolpidem Tartrate	5 mg	30	30	Respondent
05-18-2018	Hydrocodone/APAP	10/325 mg	150	25	Respondent
06-04-2018	Carisoprodol	350 mg	90	30	Respondent
06-16-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.[28]
06-18-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
06-27-2018	Zolpidem Tartrate	5 mg	30	30	Respondent
07-09-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
07-10-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
08-21-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
09-17-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
09-18-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
10-15-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
10-18-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
11-12-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.

[28] Dr. A.L., board certified in Physical Medication and Rehabilitation, was associated with a pain management practice. Respondent's medical records for Patient E contain copies of Dr. A.L.'s medical records for his visits with Patient E of November 12, 2018, November 14, 2018, December 10, 2018, and February 5, 2019. According to Dr. A.L.'s medical records, his diagnoses were radiculopathy, lumbar region; other spondylosis, lumbar region; cervicalgia and chronic instability of right knee.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
12-10-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.

42. In general, during the course of treatment for Patient E during 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed. [29]

43. Respondent committed gross negligence in his care and treatment of Patient E which included, but was not limited to, the following:

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant

[29] In discussing the problem with failing to reconcile the medication list and the medication list in the EMR's being inaccurate, at times, Respondent acknowledged "it did happen" and noted that "sometimes" there was a problem in failing to update the medication list when a medication or medications was discontinued." In his subject interview, Respondent, through his counsel, expressed his intent to take a medical record keeping course and agreed that such a course would be helpful in improving his practice. (Transcript, at pp. 165-166, 179.)

behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent failed to perform a proper diagnostic workup and failed to properly treat the patient's chronic cough.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

44. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged herein.

PATIENT A

45. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Paragraphs 8 through 15, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the

patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent and failed to utilize or document the use of a pain management agreement; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

PATIENT B

46. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Paragraphs 16 through 22, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

PATIENT C

47. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Paragraphs 23 through 30, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent and failed to utilize or document the use of a pain management agreement; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

PATIENT D

48. Respondent committed repeated negligent acts in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Paragraphs 31 through 37, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions

and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without utilizing or documenting the use of a pain management agreement; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

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PATIENT E

49. Respondent committed repeated negligent acts in his care and treatment of Patient E which included, but was not limited to, the following:

(a) Paragraphs 38 through 43, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent and failed to utilize or document the use of a pain management agreement;

(f) Respondent repeatedly prescribed opiates and benzodiazepines; concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression; and

(g) Respondent failed to perform a proper diagnostic workup and failed to properly treat the patient's chronic cough.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

50. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to Patient B, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 16 through 22, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

51. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 8 through 49, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 51602, issued to Respondent Assad Ullah Darawal, M.D.;

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

3. Ordering Respondent Assad Ullah Darawal, 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: JAN 1 3 2020

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

SD2019702500
Accusation (Word Clean Copy).docx

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

In the Matter of the Accusation Against: Assad Ullah Darawal, M.D. Physician's & Surgeon's Certificate No A 51602 Respondent.	MBC File No. 800-2017-030626

ORDER GRANTING RECONSIDERATION

The stipulated settlement and disciplinary order in the above captioned matter was adopted by the Board on December 4, 2020, and was to become effective on December 31, 2020. A Petition for Reconsideration under Government Code Section 11521 was filed in a timely manner by complainant.

The petition for reconsideration having been read and considered, the Board hereby orders reconsideration. The Board itself will reconsider the case based upon the entire record. The parties are invited to submit a Proposed Stipulation After Reconsideration. If such a proposed stipulation is submitted and adopted by the Board, then that will become the Board's decision, and no further written or oral argument will be requested.

If the Board votes to hold the proposed stipulation for discussion, both complainant and respondent will be afforded the opportunity to present written argument to the Board. You will be notified of the time for submitting written argument. In addition to written argument, oral argument may be scheduled if any party files with the Board, a written request for oral argument within 20 days from the date of notice of written argument. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place of oral arguments. The Board directs the parties attention to Title 16 of the California Code of Regulations, Sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Your right to argue any matter is not limited, however, no new evidence will be heard. The Board is particularly interested in the reconsideration of the penalty order.

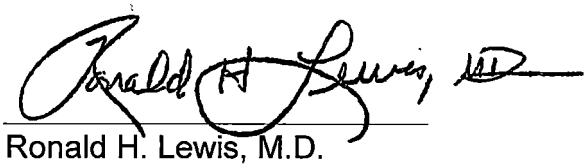
The decision with an effective date of December 31, 2020 is stayed. This stay shall remain in effect until the Board issues its decision after reconsideration.

The address for serving written argument on the Board is:

Andrea Geremia, Discipline Coordination Unit
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831

Please submit an original and 1 copy.

IT IS SO ORDERED: December 23, 2020



Ronald H. Lewis, M.D.
Panel A
Medical Board of California

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

In the Matter of the Accusation Against Assad Ullah Darawal, M.D. Physician's and Surgeon's Certificate No. A 51602 Respondent.	Case No. 800-2017-030626

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 31, 2020.

IT IS SO ORDERED: December 4, 2020.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
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Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **ASSAD ULLAH DARAWAL, M.D.** **81-893 Dr Carreon Blvd # 1** **Indio, CA 92201** **Physician's and Surgeon's Certificate No. A 51602** Respondent.	Case No. 800-2017-030626 OAH No. 2020040198 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

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2. Respondent Assad Ullah Darawal, M.D. (Respondent) is represented in this proceeding by Raymond J. McMahon, Esq. of Doyle Shafer McMahon, whose address is 5440 Trabuco Road, Irvine, CA 926202.

3. On or about February 8, 1993, the Board issued Physician's and Surgeon's Certificate No. A 51602 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-030626, and will expire on November 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030626 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 13, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2017-030626 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030626. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-030626, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-030626, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 51602 to disciplinary action.

9. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-030626 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 51602 issued to Respondent Assad Ullah Darawal, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. **CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES**. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished. Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation

2. **EDUCATION COURSE**. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge in the area of pain management and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's

expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 50 hours of CME of which 25 hours were in satisfaction of this condition.

3. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **MEDICAL RECORD KEEPING COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The

medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. **MONITORING - PRACTICE**. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all

times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. **OBEY ALL LAWS**. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

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

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

9. **GENERAL PROBATION REQUIREMENTS**.

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

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

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

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

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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10. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE**. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled

Substances; and Biological Fluid Testing

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

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

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

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

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16. **FUTURE ADMISSIONS CLAUSE**. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-030626 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10/13/2020

ASSAD ULLAH DARAWAL, M.D.
Respondent

I have read and fully discussed with Respondent Assad Ullah Darawal, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve of its form and content.

DATED: October 13, 2020

RAYMOND J. MCMAHON
Attorney for Respondent

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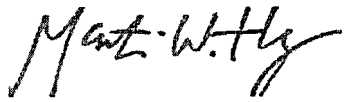
ENDORSEMENT

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

DATED: October 13, 2020

Respectfully submitted,

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



MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030626

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 13 2020
BY: Anna Logan ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2017-030626
Assad Ullah Darawal, M.D. **81-893 DR CARREON BLVD # 1** **INDIO CA 92201** **Physician's and Surgeon's Certificate No. A 51602,** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about February 8, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number A 51602 to Assad Ullah Darawal, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2020, unless renewed.

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JURISDICTION

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

4. Section 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.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

...

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

....

6. Section 2266 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

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

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, D, and E, as more particularly alleged hereinafter:

PATIENT A[1]

9. On or about September 14, 2015, Respondent had his first visit with Patient A, a then-34-year-old male, who reported his occupation as a student, his main presenting problem as "back problems," and indicated he was taking Norco and Xanax on his patient history form which was not consistent with his CURES report which indicated he had not filled any prescriptions for controlled substances for the prior five and one-half months and his last prescriptions on March 30, 2015, were for hydrocodone 5/325 mg (twice a day) and tramadol HCL 50 mg. Respondent's medical records fail to document whether Respondent considered any other any non-opioid treatment options prior to him prescribing Norco to treat the complaint of back pain. Respondent did not check the Controlled Substances Utilization and Evaluation System (CURES) at any time for Patient A.[2] According to Respondent, he requested prior medical records from Patient A but they were never provided and he made no attempt to follow up in order to verify Patient A's prior treatment. The medical record for the initial visit failed to document any specific exams for Patient A's complaints. Respondent did, however, order an MRI of the lumbar spine which was reported on October 26, 2015, and noted degenerative spondylosis with end point changes and narrowing at L5-S1 with all other levels noted to be within normal limits.[3] Respondent

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[1] The patients referenced in this Accusation are designated as "Patient A," Patient B," "Patient C," "Patient D," and "Patient E," in order to maintain and protect their privacy.

[2] California's Controlled Substance Utilization Review and Evaluation System (CURES) is a prescription drug monitoring program which tracks Schedule II, III and IV controlled substance prescriptions that are dispensed in California. Respondent indicated in his subject interview before a Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit ("HQIU") Investigator that he "didn't look at CURES for any of the patients." (Transcript, at p. 80.)

[3] The MRI's impression section stated, "IMPRESSION: L5-S1 intervertebral disc space narrowing and endplate changes Schmorl's nodes and dessication with disc osteophyte central left

prescribed Norco[4] (hydrocodone/acetaminophen [APAP]) 10/325 mg (#90) 1 tab t.i.d. (three times a day); and Xanax (alprazolam)[5] 2 mg (#90) 1 tab t.i.d.

10. During the remainder of 2015, Respondent had four more visits with Patient A which took place on October 24, November 12, December 8, and December 11, 2015. During this time, Patient A's problems were generally documented in the electronic medical records (EMR's) assessment/plan section as including, but not limited to, back issues mild intermittent asthma and opioid dependence. On November 12, opioid dependence was added to the assessment but there was no plan documented for treating Patient A's opioid dependency.[6] On December 8, Patient A presented for "cough" but no further details were documented. On December 11, Patient A presented for cough and back pain with a respiratory rate of 15 with no further new details documented. According to the CURES report for Patient A, the following prescriptions for

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paracentral with mild subarticular and left lower neural foraminal narrowing."

[4] Hydrocodone APAP (Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

[5] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[6] Respondent claimed during his subject interview that he had a later discussion with Patient A about "taper[ing] you down gradually from this medication." Respondent was asked "Now, is that – that conversation that you had with him regarding that, documented anywhere in these notes, either in the EMR or what you wrote by hand on the paper portion of the chart?" Respondent replied that it was done "verbally." (Transcript, at pp. 66-67.)

controlled substances were filled for Patient A for the remainder of 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-14-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
10-14-2015	Alprazolam	2 mg	90	30	Respondent
11-12-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
11-12-2015	Alprazolam	2 mg	90	30	Respondent
12-08-2015	Promethazine Codeine Syrup[7]	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
12-11-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent
12-11-2015	Alprazolam	2 mg	90	30	Respondent

11. During the period of on or about January 1, 2016, through December 31, 2016, Patient A had thirteen visits with Respondent or his nurse practitioner which took place on January 11, February 11, March 11, April 8, May 6, June 6, July 5, August 3, September 2 (nurse practitioner), September 30 (nurse practitioner), October 28 (nurse practitioner), November 28 (nurse practitioner) and December 28, 2016 (nurse practitioner). During this time, Patient A's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, back issues, mild intermittent asthma, opioid dependence (dropped from assessment without explanation on February 11), obesity (added on March 11), bilateral knee pain (added on March 11, noted on handwritten note, but not documented on EMR), generalized anxiety disorder (added on June 6), constipation (added on September 30), and chest wall trauma related to falling off a bike on October 28, 2016. On February 11, bronchitis was added to the assessment but there was no supportive documentation for the bronchitis assessment. On September 2, Respondent's

[7] Promethazine phenylephrine codeine syrup (Robitussin®), a narcotic analgesic, with codeine, is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the temporary relief of coughs and upper respiratory symptoms, including nasal congestion, associated with allergy or the common cold. The Federal Drug Administration has issued a black box warning for promethazine phenylephrine codeine syrups which warns about, among other things, that concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death and to avoid the use of opioid cough medications in patients taking benzodiazepines, other CNS depressants, or alcohol.

nurse practitioner documented the "common and serious side effects" of the medication that was prescribed.[8] On October 28, Respondent documented Patient A's "[complaint of] chest wall pain after falling off motor bike" without documenting targeted chest wall symptoms or a targeted examination. On November 28, chest wall pain/trauma was removed from the assessment although it was still presented in the history of present illness (HPI). According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-11-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
01-11-2016	Alprazolam	2 mg	90	30	Respondent
02-11-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
02-11-2016	Alprazolam	2 mg	90	30	Respondent
03-11-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
03-11-2016	Alprazolam	2 mg	90	30	Respondent
04-09-2016	Hydrocodone/APAP	10/325 mg	90	20	Respondent
04-09-2016	Alprazolam	2 mg	90	30	Respondent
05-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
05-06-2016	Alprazolam	2 mg	90	30	Respondent
06-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent

[8] This was the only specific documentation of any type of informed consent discussion with Patient A. The Medical Board of California's Guidelines for Prescribing Controlled Substances of Pain (November 2014) provides that "Patient consent typically addresses: the potential risks and anticipated benefits of long-term opioid therapy; potential side effects (both short and long term) of the medication, such as nausea, opioid- induced constipation, decreased libido, sexual dysfunction, hypogonadism with secondary osteoporosis [citation omitted] and cognitive impairment; the likelihood that some medications will cause tolerance and physical dependence to develop; the risk of drug interactions and over-sedation; the risk of respiratory depression; the risk of impaired motor skills (affecting driving and other tasks); the risk of opioid misuse, dependence, addiction and overdose; and the limited evidence as to the benefit of long-term opioid therapy." (MBC Guidelines (2014), at p. 11; see also, p. 19 [discussing that medical records should document "instructions to the patient, including discussion of the risks and benefits with the patient and any significant others.")

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-06-2016	Alprazolam	2 mg	90	30	Respondent
07-05-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
07-05-2016	Alprazolam	2 mg	90	30	Respondent
08-03-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
08-03-2016	Alprazolam	2 mg	90	30	Respondent
09-02-2016	Hydrocodone/APAP	10/325 mg	90	15	N.P.[9]
09-02-2016	Alprazolam	2 mg	90	30	N.P.
09-30-2016	Hydrocodone/APAP	10/325 mg	90	20	N.P.
09-30-2016	Alprazolam	2 mg	90	30	N.P.
10-28-2016	Hydrocodone/APAP	10/325 mg	90	15	N.P.
10-28-2016	Alprazolam	2 mg	90	30	N.P.
11-28-2016	Hydrocodone/APAP	10/325 mg	90	20	N.P.
11-28-2016	Alprazolam	2 mg	90	30	N.P.
12-28-2016	Hydrocodone/APAP	10/325 mg	90	15	N.P.
12-28-2016	Alprazolam	2 mg	90	30	N.P.

12. During the period of on or about January 1, 2017, through December 31, 2017, Patient A had twelve visits with Respondent which took place on January 24, February 22, March 22, April 21, May 19, June 16, July 13, August 14, September 13, October 16, November 20, and December 20, 2017. During this time, Patient A's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, back issues, mild intermittent asthma, obesity, generalized anxiety disorder, constipation, and "crushing injury of right hand" (added on October 19). On May 19, Respondent's handwritten note and EMR of May 19, references a referral to psychiatry. On June 16, Respondent failed to document the psychiatric referral. Respondent's handwritten note of July 13, references a referral to pain management

[9] The "N.P." reference used in the tables in this Accusation refers to Respondent's nurse practitioner.

(that was not documented in the EMR). According to Respondent, Patient A did not follow through on the pain management or psychiatric referrals (with the failure to follow through on the referrals not being documented). On October 19, Respondent documented "crushing injury of right hand" without documenting any corresponding plan. According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-25-2017	Hydrocodone/APAP	10/325 mg	90	20	Respondent
01-25-2017	Alprazolam	2 mg	90	30	Respondent
02-22-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-22-2017	Alprazolam	2 mg	90	30	Respondent
03-22-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
03-22-2017	Alprazolam	2 mg	90	30	Respondent
04-23-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-23-2017	Alprazolam	2 mg	90	30	Respondent
05-20-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
05-20-2017	Alprazolam	2 mg	90	30	Respondent
06-16-2017	Hydrocodone/APAP	10/325 mg	90	20	Respondent
06-16-2017	Alprazolam	2 mg	90	30	Respondent
07-13-2017	Hydrocodone/APAP	10/325 mg	90	18	Respondent
07-13-2017	Alprazolam	2 mg	90	30	Respondent
08-14-2017	Hydrocodone/APAP	10/325 mg	60	23	Respondent
08-14-2017	Alprazolam	2 mg	90	30	Respondent
09-13-2017	Hydrocodone/APAP	10/325 mg	90	20	Respondent
09-13-2017	Alprazolam	2 mg	60	30	Respondent
10-19-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
10-19-2017	Alprazolam	2 mg	60	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-20-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
11-20-2017	Alprazolam	2 mg	60	30	Respondent
12-20-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
12-20-2017	Alprazolam	2 mg	60	30	Respondent

13. During the period of on or about January 1, 2018, to February 16, 2018, Patient A had two visits with Respondent which took place on February 13 and February 26, 2018. During this time, Patient A's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, back issues, mild intermittent asthma, obesity, generalized anxiety disorder, constipation, and complaint of wound in right hand (added on February 26, 2018). On February 13, Respondent's treatment plan included changes to Patient A's Xanax and Norco prescriptions without any specifics documented for the change. On February 26, Respondent documented references to pain management and a psychiatrist in his medical records. Respondent claimed that on February 26, that he also discussed with Patient A that he was going to have to taper off his medications, but that conversation was not documented in Respondent's medical records. According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-13-2018	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-13-2018	Alprazolam	2 mg	60	30	Respondent

14. In general, during the course of treatment for Patient A for 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's[10] often appeared to have been copied and pasted and, at times, did not

[10] Respondent maintained handwritten notes and EMR's for each patient. The handwritten notes were on a pre-printed form used for each visit that contained sections for entering, among other things, the date of the patient encounter, allergies, chief complaints, presenting medications, physical examination, review of systems, assessment/plan, labs, additional impression, health education, referrals, and the time for the next visit. During his subject interview, Respondent was asked "which of these would you say is the most accurate and

reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.

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

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

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complete record of the encounter?" Respondent answered that you had to consider "both together, have to be together, because ... sometimes we have something in the paper that's not in computer. And sometimes, it could be in the computer not [but] not in the paper..." (Transcript, at pp. 43-44.)

PATIENT B

16. On or about February 13, 2014, Respondent had his first visit with Patient B, a then-62-year-old male, who reported his main presenting problem as knee pain. Respondent did not check CURES at the time of this initial visit which would have shown that Respondent had not filled a prescription for controlled substances for approximately nine months and his last prescription was for hydrocodone/APAP 10/325 mg (six a day) that had been prescribed by a physician assistant. A "Narcotic Release" document was signed by Patient B and Respondent on September 25, 2014.[11] Respondent's nurse practitioner prescribed an initial prescription of hydrocodone/APAP 10/325 mg (four a day) which amounted to a morphine equivalency dose[12] of 40 mg per day on February 17 and March 27. Thereafter, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 170 milligrams per day and different benzodiazepines. According to the CURES report for Patient B, the following prescriptions for controlled substances were filled for patient B during the remainder of 2014:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-17-2014	Hydrocodone/APAP	10/325 mg	90	22	N.P.
03-27-2014	Hydrocodone/APAP	10/325 mg	90	22	N.P.
08-13-2014	Oxycodone HCL[13]	10 mg	120	20	Respondent

[11] The "Narcotic Release" memorialized that Patient B and Respondent "agree[d] to the following rules of taking any narcotic medication[:] (1) Patient to fill medication on due date only[;] (2) Patient has been informed of the side effects and risk of taking a narcotic[;] (3) Patient has tried and failed other pain medications[;] (4) if Patient abuse [sic] this contract patient will be referred to pain management or released from practice[;] and (5) Patient has been informed pain medications may be come addictive if not taken properly." There were no written pain management agreements for any of the other patients identified herein.

[12] Morphine equivalency dose (MED) is a value assigned to opioids to represent their relative potencies. MED is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the prescribed opioid. Daily MED is the sum total of all opioids, with conversion factors applied, that are being taken within a 24-hour period, which is used to determine if a patient is at risk of addiction, respiratory depression, or other delirious effects associated with opioids. The process of converting opioid doses to an overall morphine equivalency dose can be accomplished by using a MED calculator or a morphine equivalency table, also known as an opioid conversation chart.

[13] Oxycodone HCL (OxyContin®), an opioid narcotic, is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
08-13-2014	Methadone HCL[14]	10 mg	60	30	Respondent
08-26-2014	Temazepam[15]	15 mg	30	30	Respondent
09-10-2014	Methadone HCL	10 mg	60	30	Respondent
09-25-2014	Temazepam	15 mg	30	30	Respondent
09-26-2014	Oxycodone HCL	10 mg	120	20	N.P.
10-09-2014	Methadone HCL	10 mg	60	30	Respondent
10-23-2014	Temazepam	15 mg	30	30	N.P.
10-23-2014	Alprazolam	0.5 mg	30	30	N.P.
11-04-2014	Oxycodone HCL	10 mg	120	20	N.P.
11-04-2014	Methadone HCL	10 mg	60	30	Respondent
11-24-2014	Diazepam[16]	10 mg	30	30	Respondent

indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

[14] Methadone (methadone hydrochloride), an opioid narcotic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it can be used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified methadone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for methadone which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of methadone with benzodiazepines or other central nervous system (CNS) depressants.

[15] Temazepam (Restoril®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as temazapam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) The FDA has issued a black box warning indicating that concomitant use of temazapam with opioids "may result in profound sedation, respiratory depression, coma, and death."

[16] Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-28-2014	Oxycodone HCL	10 mg	120	20	N.P.
12-03-2014	Methadone HCL	10 mg	60	30	Respondent
12-24-2014	Oxycodone HCL	10/325 mg	120	20	Respondent

17. During the period of on or about January 1, 2015, through December 31, 2015, Patient B had twelve visits with Respondent which took place on January 15, February 12, May 12, June 12, July 10, July 13, August 7, September 28, October 12, October 20, November 20, and December 18, 2015. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, opioid dependence, habitual drug user (added on September 28 with no specifics), knee pain, insomnia, major depressive disorder, back pain, and acute bronchitis. On January 1, acute bronchitis was documented in the assessment without further explanation. On May 12, Respondent documented in his EMR that he "referred to pain management." On June 12, the plan included requesting a cane and scooter to assist with activities of daily living (ADL) with the power scooter being denied by insurance and, instead, there was referral to physical therapy. On July 10, Patient B had a positive urine drug screen for methadone (being prescribed by Respondent), methamphetamine, and opiates (being prescribed by Respondent).[17] On December 11, an X-ray of Patient B's bilateral knees revealed moderate to advanced arthritic disease in both knees, essentially unchanged from his previous study. During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day and different benzodiazepines. According to the CURES report for

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(d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for short-term relief of anxiety. Concomitant use of diazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) The FDA has issued a black box warning indicating that concomitant use of diazepam with opioids "may result in profound sedation, respiratory depression, coma, and death."

[17] The urine drug screen was conducted while Patient B was at JFK Memorial Hospital. A copy of the urine drug screen result was contained within the certified medical records provided by Respondent for Patient B. Respondent's EMR for Patient B for July 13, 2015, documented "all hospital records reviewed."

patient B, the following prescriptions for controlled substances were filled for patient B during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2015	Methadone HCL	10 mg	60	30	Respondent
01-15-2015	Diazepam	10 mg	30	30	Respondent
01-23-2015	Oxycodone HCL	10 mg	120	30	N.P.
02-02-2015	Methadone HCL	10 mg	60	30	Respondent
02-12-2015	Diazepam	10 mg	30	30	Respondent
02-23-2015	Oxycodone HCL	10 mg	120	20	Respondent
03-02-2015	Methadone HCL	10 mg	60	30	Respondent
03-09-2015	Diazepam	10 mg	30	30	N.P.
03-23-2015	Oxycodone/APAP	10/325 mg	120	20	N.P.
04-03-2015	Methadone HCL	10 mg	60	30	Respondent
04-08-2015	Diazepam	10 mg	30	30	Other - S.H.
05-01-2015	Methadone HCL	10 mg	60	30	Other - S.H.
05-12-2015	Oxycodone HCL	10 mg	120	30	Respondent
05-12-2015	Diazepam	5 mg	30	30	Respondent
05-28-2015	Methadone HCL	10 mg	60	30	Respondent
06-12-2015	Diazepam	5 mg	30	30	Respondent
06-12-2015	Oxycodone HCL	10 mg	120	30	Respondent
06-26-2015	Methadone HCL	10 mg	60	30	Respondent
07-13-2015	Oxycodone HCL	10 mg	120	30	Respondent
07-13-2015	Diazepam	5 mg	30	30	Respondent
07-24-2015	Methadone HCL	10 mg	60	30	Respondent
08-07-2015	Oxycodone HCL	10 mg	120	30	Respondent
08-07-2015	Diazepam	5 mg	30	30	Respondent
09-17-2015	Temazapam	15 mg	15	15	Other - Dr. K.M.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
09-23-2015	Oxycodone/APAP	5/325 mg	30	5	Other - Dr. K.M.
09-28-2015	Lorazepam[18]	2 mg	30	30	Respondent
10-20-2015	Methadone HCL	10 mg	60	30	Respondent
10-29-2015	Lorazepam	2 mg	30	30	Respondent
11-20-2015	Methadone HCL	10 mg	60	30	Respondent
11-30-2015	Lorazepam	2 mg	30	30	N.P.
12-18-2015	Methadone HCL	10 mg	60	30	Respondent
12-27-2015	Lorazepam	2 mg	30	30	Respondent

18. During the period of on or about January 1, 2016, through December 31, 2016, Respondent Patient B had sixteen visits with Respondent or his nurse practitioner (N.P.) which took place on January 26, February 24, March 17, March 23, April 13, May 12, May 20, June 6, June 15, June 22, June 26, July 13, August 12 (nurse practitioner), September 9 (nurse practitioner), November 4, and December 2, 2016. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, opioid dependence, knee pain, insomnia, major depressive disorder, back pain, acute bronchitis and chronic kidney disease. On February 18, there was another X-ray of Patient B's bilateral knees which revealed severe osteoarthritis without significant progression since the prior X-ray of December 11, 2015. On February 24, there were only two medications documented but no reasoning provided. On March 17, there was documentation of "fatigue" and Patient B being "shaky" without any further details. On March 23, the EMR documented changes of "current meds" of Lorazepam and methadone with the addition of Norco without further

[18] Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of lorazepam with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as lorazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) The FDA has issued a black box warning indicating that concomitant use of lorazepam with opioids "may result in profound sedation, respiratory depression, coma, and death."

details. On June 6, Patient B had a right knee injection. On June 12, Respondent sought authorization for a physical therapy referral (which was authorized on June 19). On June 15, Respondent's EMR documented a change in Lorazepam and methadone, as well as the addition of Oxycodone, without any further details or explanation. On June 22, Patient B was given an additional prescription of Percocet "due to his pain meds getting stolen, one time deal." Respondent's certified medical records contained a CURES report for Patient B, dated June 28, 2016, accessed by M.C., Respondent's nurse practitioner, which revealed that another physician, Dr. M.M., had issued a prescription for Lorazepam (#10) 1 mg and Methadone (#20) 10 mg on January 19, 2016.[19] There was no documentation of Patient B being counseled about receiving controlled substances from another prescriber. On December 2, Patient B presented for knee pain and referral to an eye doctor with no further details pertaining to the basis for the ophthalmology referral made by Respondent. During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day concurrently with a benzodiazepine. According to the CURES report for patient B, the following prescriptions for controlled substances were filled for Patient B during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-19-2016	Methadone HCL	10 mg	20	10	Other - Dr. M.M.
01-19-2016	Lorazepam	1 mg	10	10	Other - Dr. M.M.
01-26-2016	Methadone HCL	10 mg	60	30	Respondent
01-26-2016	Lorazepam	2 mg	30	30	Respondent
02-24-2016	Hydrocodone/APAP	10/325 mg	60	10	Respondent
02-24-2016	Lorazepam	2 mg	30	30	Respondent
02-24-2016	Methadone HCL	10 mg	60	30	Respondent
03-23-2016	Lorazepam	2 mg	30	30	Respondent

[19] Respondent's EMR for June 28, 2016, states, in pertinent part, "Patient is here due to feeling weak and chills [and] [patient] requesting his methadone and oxycodone he was advised he was not [due] he then said he did not want to see doctor we advise[d] [patient] to keep his [appointment] when he was scheduled for his rx [prescription]."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
03-23-2016	Hydrocodone/APAP	10/325 mg	60	10	Respondent
03-23-2016	Methadone HCL	10 mg	60	30	Respondent
04-13-2016	Oxycodone HCL	10 mg	120	20	Respondent
04-21-2016	Lorazepam	2 mg	30	30	Respondent
04-21-2016	Methadone HCL	10 mg	60	30	Respondent
05-12-2016	Oxycodone HCL	10 mg	120	30	Respondent
05-20-2016	Lorazepam	2 mg	30	30	Respondent
05-20-2016	Methadone HCL	10 mg	60	30	Respondent
06-15-2016	Oxycodone HCL	10 mg	120	30	Respondent
06-16-2016	Lorazepam	2 mg	30	30	Respondent
06-16-2016	Methadone HCL	10 mg	60	30	Respondent
06-22-2016	Oxycodone/APAP	10/325 mg	60	10	Respondent
07-13-2016	Lorazepam	2 mg	30	30	Respondent
07-13-2016	Oxycodone HCL	10 mg	120	30	Respondent
07-13-2016	Methadone HCL	10 mg	60	30	Respondent
08-12-2016	Methadone HCL	10 mg	60	30	Respondent
08-12-2016	Oxycodone HCL	10 mg	120	30	N.P.
08-12-2016	Lorazepam	2 mg	30	30	N.P.
08-17-2016	Hydrocodone/APAP	10/325 mg	40	10	Other – Dr. S.M.
09-09-2016	Methadone HCL	10 mg	60	30	N.P.
09-09-2016	Oxycodone HCL	10 mg	120	30	N.P.
09-09-2016	Lorazepam	1 mg	30	30	N.P.
10-06-2016	Methadone HCL	10 mg	60	30	Respondent
10-06-2016	Lorazepam	2 mg	30	30	Respondent
10-06-2016	Oxycodone HCL	10 mg	120	30	Respondent
11-04-2016	Methadone HCL	10 mg	60	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-04-2016	Lorazepam	1 mg	30	30	Respondent
11-04-2016	Oxycodone HCL	10 mg	120	30	Respondent
12-02-2016	Methadone HCL	10 mg	60	30	Respondent
12-02-2016	Lorazepam	1 mg	30	30	Respondent
12-02-2016	Oxycodone HCL	10 mg	120	30	Respondent
12-26-2016	Hydrocodone/APAP	10/325 mg	60	15	Other – Dr. S.M.

19. During the period of on or about January 1, 2017, through December 31, 2017, Patient B had fourteen visits with Respondent which took place on January 3, February 2, February 9, March 2, March 26, April 26, May 26, June 23, July 21, August 21, September 20, October 19, November 17 and December 18, 2017. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, opioid dependence, knee pain, insomnia, major depressive disorder, back pain, acute bronchitis and chronic kidney disease. On March 2, referrals were made for colonoscopy and bone density scan without any mention of the referrals in the EMR. On March 28, the EMR included addition of a new hypertensive regimen without explanation. On June 16, Patient B's urine drug screen was positive for amphetamines, benzodiazepines (which were being prescribed), cannabis, methamphetamine, and opiates (which were being prescribed). On June 23, Patient B presented for "hospital follow up" without any documentation of the reason for the hospitalization. On July 13, Respondent sought authorization for a referral to pain management (which was approved on July 19). On August 21, changes to Patient B's Lorazepam, Methadone and Oxycodone were documented but no clear explanation was provided in the plan. Respondent sought authorization for a referral to orthopedics around August 21 (which was authorized on August 22). During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day in combination with a benzodiazepine (Lorazepam) and a sleep aid (zolpidem tartrate [Ambien].). According to the CURES report for Patient B, the following prescriptions for controlled substances were filled

for patient B during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-03-2017	Oxycodone HCL	10 mg	120	30	Respondent
01-03-2017	Lorazepam	1 mg	30	30	Respondent
01-03-2017	Methadone HCL	10 mg	60	30	Respondent
02-02-2017	Lorazepam	1 mg	30	30	Respondent
02-02-2017	Methadone HCL	10 mg	60	30	Respondent
02-02-2017	Oxycodone HCL	10 mg	120	30	Respondent
03-02-2017	Oxycodone HCL	10 mg	120	30	Respondent
03-02-2017	Lorazepam	1 mg	30	30	Respondent
03-02-2017	Methadone HCL	10 mg	60	30	Respondent
03-14-2017	Zolpidem Tartrate[20]	10 mg	30	30	Other – Dr. S.M.
03-14-2017	Hydrocodone/APAP	10/325 mg	60	21	Other – Dr. S.M.
03-29-2017	Lorazepam	1 mg	30	30	Respondent
03-29-2017	Oxycodone HCL	10 mg	120	30	Respondent
03-29-2017	Methadone HCL	10 mg	60	30	Respondent
04-24-2017	Zolpidem Tartrate	10 mg	30	30	Respondent
04-26-2017	Methadone HCL	10 mg	60	30	Respondent
04-26-2017	Lorazepam	1 mg	30	30	Respondent
04-26-2017	Oxycodone HCL	10 mg	120	30	Respondent
05-26-2017	Lorazepam	1 mg	30	30	Respondent
05-26-2017	Oxycodone HCL	10 mg	120	30	Respondent
05-26-2017	Methadone HCL	10 mg	60	30	Respondent
06-26-2017	Oxycodone HCL	10 mg	120	30	Respondent

[20] Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-26-2017	Methadone HCL	10 mg	60	30	Respondent
06-26-2017	Lorazepam	1 mg	30	30	Respondent
07-21-2017	Oxycodone HCL	10 mg	120	30	Respondent
07-21-2017	Lorazepam	1 mg	30	30	Respondent
07-21-2017	Methadone HCL	10 mg	60	30	Respondent
08-21-2017	Oxycodone HCL	10 mg	120	30	Respondent
08-21-2017	Lorazepam	1 mg	30	30	Respondent
08-21-2017	Methadone HCL	10 mg	60	30	Respondent
09-20-2017	Lorazepam	1 mg	30	30	Respondent
09-20-2017	Methadone HCL	10 mg	60	30	Respondent
09-20-2017	Oxycodone HCL	10 mg	120	30	Respondent
10-19-2017	Lorazepam	1 mg	30	30	Respondent
10-19-2017	Oxycodone HCL	10 mg	120	30	Respondent
10-19-2017	Methadone HCL	10 mg	60	30	Respondent
11-17-2017	Methadone HCL	10 mg	60	30	Respondent
11-17-2017	Lorazepam	1 mg	30	30	Respondent
11-17-2017	Oxycodone HCL	10 mg	120	30	Respondent
12-18-2017	Methadone HCL	10 mg	60	30	Respondent
12-18-2017	Oxycodone HCL	10 mg	120	30	Respondent
12-18-2017	Lorazepam	1 mg	30	30	Respondent

20. During the period of on or about January 1, 2018, through May 14, 2018, Patient B had five visits with Respondent which took place on January 18, February 15, March 14, April 14, and May 14, 2018. During this time, Patient B's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, chronic pain syndrome, continuous opioid dependence, bilateral knee pain, recurrent major depressive episodes, back pain, and chronic kidney disease. On February 15, the EMR documented a change of the aspirin

dosage from 81 mg to 325 mg without any clear explanation with Omeprazole (generally used to reduce acid in the stomach) being prescribed without any reason provided. Respondent also sought authorization for a referral to an orthopedist on February 15 (which was authorized on February 23). On March 14, Respondent's EMR documented that "pain management" was "ordered/advised." Respondent claimed that for "three or four months, I was telling [Patient B] that you need to find [another] physician eventually [and] [o]ne day we're going to give you medication [for] the last time," but, as Respondent acknowledged, the conversation was not documented in his medical records. Respondent further claimed on Patient B's last visit of May 14, he spoke to Patient B about the need to taper his medications and "we told him what to taper" but this conversation, as Respondent acknowledged, also was not documented in the medical records. During this period of time, Patient B was receiving overlapping opiate prescriptions with morphine equivalency doses that were as high as 140 milligrams per day concurrently with a benzodiazepine. According to the CURES report for Patient B, the following prescriptions for controlled substances were filled for Patient B during this time and up until May 14, 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-18-2018	Oxycodone HCL	10 mg	120	30	Respondent
01-18-2018	Lorazepam	1 mg	30	30	Respondent
01-18-2018	Methadone HCL	10 mg	60	30	Respondent
02-15-2018	Methadone HCL	10 mg	60	30	Respondent
02-15-2018	Oxycodone HCL	10 mg	120	30	Respondent
02-15-2018	Lorazepam	1 mg	30	30	Respondent
03-14-2018	Oxycodone HCL	10 mg	120	30	Respondent
03-14-2018	Lorazepam	1 mg	30	30	Respondent
03-14-2018	Methadone HCL	10 mg	60	30	Respondent
04-13-2018	Methadone HCL	10 mg	60	30	Respondent
04-13-2018	Oxycodone HCL	10 mg	120	30	Respondent
04-13-2018	Lorazepam	1 mg	30	30	Respondent

21. In general, during the course of treatment for Patient B during 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.[21]

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

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely

[21] Respondent acknowledged during his subject interview that there were issues with the medication list in his EMR's not matching what was actually being prescribed to Patient B. (Transcript, at p. 87.)

manner which increased the risk of harm to the patient including, but not limited to, the risk of respiratory depression.

PATIENT C

23. On or about February 5, 2015, Respondent had his first visit with Patient C, a then-30-year-old female. According to Respondent's medical record for this visit, Patient C had a history of spina bifida, renal failure, arthritis, gout and anxiety; her current medications were listed on her history form as Cyclosporine 100 mg/mL (one tab twice a day), Prednisone 5 mg (every 6 hours); and her chief complaints were back problems and anxiety. Respondent did not check CURES at the time of this initial visit and there was no documentation, or other indication, of him checking CURES at any other time during his care and treatment of Patient C. As part of this visit, Respondent prescribed Patient C Alprazolam (zolpidem tartrate) 0.25 mg and hydrocodone/APAP 5/325 mg (#60). According to the CURES report for patient C, she filled prescriptions for Alprazolam (zolpidem tartrate) 0.25 mg (#60) (30 day supply) and hydrocodone/APAP 5/325 mg (#60) (10 day supply) on February 5, 2015.

24. During the period of on or about February 6, 2015, through December 31, 2015, Patient C had nine visits with Respondent which took place on March 6, April 2, May 4, June 4, July 8, August 5, September 4, October 5 and December 4, 2015. During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-05-2015	Alprazolam	0.25 mg	60	30	Respondent
02-05-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
03-05-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
03-05-2015	Alprazolam	0.25 mg	60	30	Respondent
03-28-2015	Hydrocodone/APAP	5/325 mg	12	3	Other – C.P.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-03-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
04-03-2015	Alprazolam	0.25 mg	60	30	Respondent
05-05-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
05-05-2015	Alprazolam	0.25 mg	60	30	Respondent
06-04-2015	Alprazolam	0.25 mg	60	30	Respondent
06-04-2015	Hydrocodone/APAP	5/325 mg	60	10	Respondent
07-08-2015	Hydrocodone/APAP	10/325 mg	90	20	Respondent
08-05-2015	Alprazolam	0.25 mg	60	30	Respondent
08-05-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-04-2015	Alprazolam	0.25 mg	60	30	Respondent
09-04-2015	Hydrocodone/APAP	10/325 mg	90	22	Respondent
10-05-2015	Alprazolam	0.25 mg	60	30	Respondent
10-05-2015	Hydrocodone/APAP	10/325 mg	90	22	Respondent
11-05-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent
11-05-2015	Alprazolam	0.25 mg	60	30	Respondent
12-04-2015	Alprazolam	0.25 mg	60	30	Respondent
12-04-2015	Hydrocodone/APAP	10/325 mg	90	15	Respondent

25. During the period of on or about January 1, 2016, through December 31, 2016, Patient C had twelve visits with Respondent or his nurse practitioner which took place on January 5, February 5, March 8, April 7, May 8, June 6, July 6, August 5, September 2 (nurse practitioner), September 30 (nurse practitioner), October 31 and December 30, 2016 (nurse practitioner). During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. On July 6, changes were documented to the "current meds" for Xanax and hydrocodone/APAP without a clear explanation. On August 5, "has skin rash all over body" was documented without any skin exam

being documented. According to the CURES report for patient C, the following prescriptions for controlled substances were filled for Patient C during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-05-2016	Alprazolam	0.25 mg	60	30	Respondent
01-05-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
02-05-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-05-2016	Alprazolam	0.25 mg	60	30	Respondent
03-08-2016	Alprazolam	0.25 mg	60	30	Respondent
03-08-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-07-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-07-2016	Alprazolam	0.25 mg	60	30	Respondent
04-11-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
05-06-2016	Alprazolam	0.25 mg	60	30	Respondent
06-06-2016	Alprazolam	0.25 mg	60	30	Respondent
06-06-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
07-06-2016	Alprazolam	0.25 mg	60	30	Respondent
07-06-2016	Hydrocodone/APAP	10/325 mg	90	22	Respondent
08-05-2016	Alprazolam	0.25 mg	60	30	Respondent
08-05-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-02-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-02-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-02-2016	Alprazolam	0.25 mg	60	30	Respondent
09-30-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
09-30-2016	Alprazolam	0.25 mg	60	30	Respondent
10-31-2016	Hydrocodone/APAP	10/325 mg	30	5	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-31-2016	Alprazolam	0.25 mg	60	30	Respondent
10-31-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent
12-30-2016	Alprazolam	0.25 mg	60	30	Respondent
12-30-2016	Hydrocodone/APAP	10/325 mg	90	15	Respondent

26. During the period of on or about January 1, 2017, through December 31, 2017, Patient C had twelve visits with Respondent which took place on January 27, February 27, March 27, April 27, May 26 June 28, July 26, August 24, September 25, October 25, November 27 and December 22, 2017. During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. On February 27, changes were documented to the "current meds" for Xanax and Hydrocodone/APAP without a clear explanation. On October 25, there were two EMR's for the date, one of which included a prescription for cyclosporine not listed on the other EMR. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-27-2017	Alprazolam	0.25 mg	60	30	Respondent
01-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
02-27-2017	Alprazolam	0.5 mg	60	30	Respondent
02-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
03-27-2017	Alprazolam	0.5 mg	60	30	Respondent
03-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-27-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent
04-27-2017	Alprazolam	0.5 mg	60	30	Respondent
05-26-2017	Alprazolam	0.5 mg	60	30	Respondent
05-26-2017	Hydrocodone/APAP	10/325 mg	90	15	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-26-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
06-26-2017	Alprazolam	0.5 mg	60	30	Respondent
07-26-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
07-26-2017	Alprazolam	0.5 mg	60	30	Respondent
08-24-2017	Alprazolam	0.5 mg	60	30	Respondent
08-24-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
10-25-2017	Alprazolam	0.25 mg	60	30	Respondent
10-25-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
11-27-2017	Alprazolam	0.25 mg	60	30	Respondent
11-27-2017	Hydrocodone/APAP	10/325 mg	90	22	Respondent
12-22-2017	Alprazolam	0.25 mg	60	30	Respondent
12-22-2017	Hydrocodone/APAP	10/325 mg	90	23	Respondent

27. During the period of on or about January 1, 2018, through December 31, 2018, Patient C had nine visits with Respondent which took place on January 22, February 22, May 29, June 15, July 9, August 9, September 3, October 15, and November 15, 2018. During this time, Patient C's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, renal failure, spina bifida, generalized anxiety disorder, gouty nephropathy, chronic pain, and obesity. On February 22, Respondent sought authorization for a referral to pain management (which was approved on March 2). On June 11, "patient has weakness of lower limbs" was documented without any documented chronicity. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-22-2018	Alprazolam	0.25 mg	60	30	Respondent
01-22-2018	Hydrocodone/APAP	10/325 mg	90	22	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-22-2018	Hydrocodone/APAP	10/325 mg	90	23	Respondent
02-22-2018	Alprazolam	0.25 mg	60	30	Respondent
02-28-2018	Hydrocodone/APAP	7.5/325 mg	50	12	Other – Dr. D.C.
03-21-2018	Alprazolam	0.25 mg	30	30	Other – Dr. D.C.
04-26-2018	Tramadol	50 mg	30	30	Respondent
05-24-2018	Hydrocodone/APAP	5/325 mg	90	30	Other – J.Z.
05-29-2018	Alprazolam	0.25 mg	60	30	Respondent
06-21-2018	Hydrocodone/APAP	5/325 mg	90	30	Other – J.B.
07-09-2018	Alprazolam	0.25 mg	60	30	Respondent
08-09-2018	Alprazolam	0.25 mg	60	30	Respondent
09-17-2018	Hydrocodone/APAP	5/325 mg	60	30	Other – J.B.
10-15-2018	Alprazolam	0.25 mg	60	30	Respondent
10-15-2018	Hydrocodone/APAP	5/325 mg	20	4	Other – Dr. J.D.
10-18-2015	Hydrocodone/APAP	5/325 mg	60	30	Other – Dr. D.R.
11-15-2018	Hydrocodone/APAP	5/325 mg	60	30	Other – Dr. D.R.
12-17-2018	Hydrocodone/APAP	5/325 mg	60	30	Other – J.B.

28. On or about January 18, 2019, Patient C had a visit with Respondent in which she complained of rash and pruritis (itchy skin) all over her body. The physical exam section of the EMR, however, documented "No rash or lesions." The patient was prescribed fluconazole, betamethasone dipropionate topical cream, and ketoconazole topical cream. Patient C requested, and was provided with, a dermatology referral.

29. In general, during the course of treatment for Patient C during 2015 through 2019, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.

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

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing timely tapering or antidote therapy which increased the risk of harm to the patient including, but not limited to, the risk of respiratory depression.

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PATIENT D

31. On or about April 16, 2015, Patient D had his first visit with Respondent's office and was seen by Respondent's nurse practitioner. On his personal history form, Patient D, a then-33-year-old male, indicated that he was not currently taking any medications, he had no allergies, and he did not check any boxes for his medical history, such as back pain – recurrent, foot pain, etc. Respondent's nurse practitioner's EMR, however, indicated that Patient D had right hip pain for approximately 1.5 years, "[r]eports that he has been seen on multiple occasions for pain" and "reports severe panic attacks when around a lot of people." According to Respondent, prior medical records were requested, not received, and there was no follow up. CURES was not checked at the time of this initial visit and there was no documentation, or other indication, of Respondent or his nurse practitioner checking CURES at any other time during the care and treatment of Patient D. If CURES would have been checked, Respondent or his nurse practitioner would have seen limited and sporadic prescriptions for hydrocodone/APAP 5/325 mg (generally 4 to 5 per day) and one prescription for hydrocodone 10/325 mg (4 a day)[22] for an MED of approximately 20 to 40 mgs per day; and no prior prescriptions for benzodiazepines. The documented physical exam noted "right hip pain with ROM [range of motion]." There was no written pain management agreement with Patient D and Respondent claimed "at that time it was verbal agreement." According to the EMR for this visit, labs were ordered, X-rays of the lumbar spine and right hip were ordered, and there was documentation in the EMR of "Mental Health (Dx [diagnosis] anxiety attacks)." Patient D was prescribed Percocet 10/325 mg 1 tablet every 6 hours, Xanax (alprazolam) 2 mg 1 tab daily, and Ultram (tramadol) 50 mg (#90) (three a day) (carried over on the EMR "meds" list until January 22, 2016 [but only filled by the patient on April 16, 2015].)

32. During the period of on or about April 17, 2015, through December 31, 2015, Patient D had nine additional visits with Respondent or his nurse practitioner which took place on May 1 (nurse practitioner), May 29 (nurse practitioner), June 29, July 27, August 24, September 21

[22] A CURES report that reached back to November 26, 2012, indicated prescriptions for Roxicet 5/325 mg (#16) on 10-28-2013; hydrocodone/APAP 10/325 mg (#20) on 05-11-2014; hydrocodone/APAP 10/325 mg (#15) on 06-12-2014; hydrocodone/APAP 5/325 mg (#15) on 06-12-2014; hydrocodone/APAP 5/325 mg (#12) on 10-23-2014; and hydrocodone/APAP 5/325 mg (#15) on 01-26-2015.

(nurse practitioner), October 19 (nurse practitioner), November 20 (nurse practitioner), and December 21, 2015 (nurse practitioner). During this time, Patient D's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), "hypnotic or anxiolytic dependence, continuous" (added on August 24), and opioid dependence (added on August 24 [but not indicated on EMR problem list].) On May 1, Respondent's nurse practitioner documented a review of records from Patient D's last ER visit with x-ray's indicating bilateral arthritis with patient declining to see orthopedics, pain management or mental health referral, and his failure to complete labs. X-rays of Patient D's lumbar spine and hips of May 1 were interpreted as showing "mild degenerative changes" (which was consistent with prior imaging done at Eisenhower Medical Center on June 12, 2014). Respondent's nurse practitioner documented a discussion of the "common and serious side effects" of the medication for five patient visits.[23] During this period of time, the MED ranged from 45 mg to 90 mg per day concurrently with a benzodiazepine. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-16-2015	Oxycodone HCL	10/325 mg	30	7	N.P.
04-16-2015	Tramadol[24]	50 mg	90	30	N.P.

[23] The relevant portion of the EMR stated, "Discussed the common and serious side effects of this medication and the need to alert me if experiencing these or having any concerns about a possible medication effect. Advised the patient to discuss possible side effects, contraindications, and interactions with their pharmacist. Educated on safety concerning driving or the operation of heavy equipment during use. All medications have been reviewed and refilled." (See EMR's for May 1, September 21, October 19, November 20, and December 21, 2015.).

[24] Tramadol Hydrochloride (Ultram®, Ultracet®), an opioid analgesic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The FDA-approved labeling under the Drug Abuse and Dependence section provides warns, among other things, that "[t]ramadol hydrochloride may induce psychic and physical dependence ... Dependence and abuse, including drug-seeking behavior and taking illicit actions to obtain the

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
05-01-2015	Oxycodone HCL	10/325 mg	60	15	N.P.
05-01-2015	Alprazolam	2 mg	30	30	N.P.
05-29-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
05-29-2015	Alprazolam	2 mg	30	30	N.P.
06-29-2015	Oxycodone HCL	10/325 mg	90	20	Respondent
06-29-2015	Alprazolam	2 mg	30	30	Respondent
07-27-2015	Oxycodone HCL	10/325 mg	90	20	Respondent
07-27-2015	Alprazolam	2 mg	30	30	Respondent
08-24-2015	Oxycodone HCL	10/325 mg	90	15	Respondent
08-24-2015	Alprazolam	2 mg	30	30	Respondent
09-21-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
09-21-2015	Alprazolam	2 mg	25	25	N.P.
10-19-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
10-19-2015	Alprazolam	2 mg	30	30	N.P.
11-20-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
11-20-2015	Alprazolam	2 mg	30	30	N.P.
12-22-2015	Oxycodone HCL	10/325 mg	90	30	N.P.
12-22-2015	Alprazolam	2 mg	30	30	N.P.

33. During the period of on or about January 1, 2016, through December 31, 2016, Patient D had twelve visits with Respondent or his nurse practitioner which took place on January 22 (nurse practitioner), February 22, March 21, April 21, May 20, June 20, July 20, July 28, August 18 (nurse practitioner), September 19 (nurse practitioner), November 18 (nurse practitioner), and December 15, 2016. During this time, Patient D's problems were generally

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drug are not limited to those patients with prior history of opioid dependence. The risk in patients with substance abuse has been observed to be higher. Tramadol hydrochloride is associated with craving and tolerance development. Withdrawal symptoms may occur if tramadol hydrochloride is discontinued abruptly." According to the DEA, "[t]ramadol is most commonly abused by narcotic addicts, chronic pain patients, and health professionals."

documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), "hypnotic or anxiolytic dependence, continuous," and opioid dependence (removed without explanation on March 21). On January 22, it was documented that Patient D denied constipation but the plan included Movantik for constipation. On February 22, Respondent sought authorization for a referral to pain management (which was authorized on February 24) and changes were documented to the "current meds" for Xanax and Percocet without a clear explanation. On March 21, changes were documented to the "current meds" for Xanax and Percocet without a clear explanation of any change to the Percocet. On April 21, changes were documented to the "current meds" for Xanax and Percocet without a clear explanation. On August 2, Respondent requested authorization for referral to neurology with a listed diagnosis of "personal history of mental and behavioral disorders" (which was authorized on August 2). There is no indication that Patient D actually was seen by pain management or for a mental health evaluation during the course of his treatment with Respondent. According to Respondent, Patient D failed to follow through with the referrals. There was documentation of a discussion of the "common and serious side effects" of the medication at three patient visits (January 22, February 22 and August 18, 2016). During this period of time, Patient D was receiving an opiate (Oxycodone) at a MED as high as 90 milligrams per day concurrently with a benzodiazepine. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-22-2016	Alprazolam	2 mg	30	30	N.P.
01-22-2016	Oxycodone HCL	10/325 mg	90	30	N.P.
02-22-2016	Alprazolam	2 mg	30	30	Respondent
02-22-2016	Oxycodone HCL	10/325 mg	90	30	Respondent
03-21-2016	Alprazolam	2 mg	30	30	Respondent
03-21-2016	Oxycodone HCL	10/325 mg	90	15	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-21-2016	Alprazolam	2 mg	30	30	Respondent
04-21-2016	Oxycodone HCL	10/325 mg	90	23	Respondent
05-20-2016	Alprazolam	2 mg	30	30	Respondent
05-20-2016	Oxycodone HCL	10/325 mg	90	22	Respondent
06-20-2016	Alprazolam	2 mg	30	30	Respondent
06-20-2016	Oxycodone HCL	10/325 mg	90	20	Respondent
07-20-2016	Alprazolam	2 mg	60	30	Respondent
07-20-2016	Oxycodone HCL	10/325 mg	90	20	Respondent
08-18-2016	Alprazolam	2 mg	60	30	N.P.
08-18-2016	Oxycodone HCL	10/325 mg	90	15	N.P.
09-19-2016	Alprazolam	2 mg	60	30	N.P.
09-19-2016	Oxycodone HCL	10/325 mg	90	15	N.P.
10-14-2016	Alprazolam	2 mg	60	30	Respondent
10-17-2016	Oxycodone HCL	10/325 mg	90	22	N.P.
11-18-2016	Alprazolam	2 mg	60	30	N.P.
11-18-2016	Oxycodone HCL	10/325 mg	90	15	N.P.
12-15-2016	Alprazolam	2 mg	60	30	Respondent
12-15-2016	Oxycodone HCL	10/325 mg	90	22	Respondent

34. During the period of on or about January 1, 2017, through December 31, 2017, Patient D had three visits with Respondent which took place on January 16, February 16, and March 16, 2017. During this time, Patient D's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), and "hypnotic or anxiolytic dependence, continuous." On March 16, Respondent sought authorization for a referral to pain management (which was authorized on March 23). Respondent claimed that he also discussed weaning Patient D down or off of his narcotics but

admitted that his conversation was not documented in his medical records. During this period of time, Patient D was receiving an opiate (Oxycodone) at a MED as high as 90 milligrams per day concurrently with a benzodiazepine. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-16-2017	Alprazolam	2 mg	60	30	Respondent
01-16-2017	Oxycodone HCL	10/325 mg	90	15	Respondent
02-16-2017	Alprazolam	2 mg	60	30	Respondent
02-16-2017	Oxycodone HCL	10/325 mg	90	15	Respondent
03-16-2017	Alprazolam	0.5 mg	60	30	Respondent
03-16-2017	Oxycodone HCL	10/325 mg	90	18	Respondent

35. During the period of on or about January 1, 2018, through December 31, 2018, Patient D had nine visits with Respondent which took place on February 14, March 14, April 16, May 17, June 15, July 18, August 28, September 28, and November 12, 2018. During this time, Patient D's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, hip pain, osteoarthritis of hip, anxiety (with a notation that if increase in Xanax needed [patient] will be sent to mental health for evaluation), and "hypnotic or anxiolytic dependence, continuous." Respondent acknowledged that he did not check CURES upon Patient D's return from an approximate eleven month gap in treatment even though he was "suspicious at that time that he [Patient D] [was] probably abusing his medication" and may have been "a drug seeker." On February 14, the assessment documented continuation of treatment plan, however, Percocet was discontinued. On May 17, Ibuprofen was prescribed while Patient D was already on Naproxen.[25] On June 15, Patient D complained of a toothache for three days and patient was diagnosed with gingival abscesses and prescribed Clindamycin (used to treat bacterial infections), however, no abnormal oral exam was documented. According to the CURES report

[25] Ibuprofen and Naproxen are both non-steroidal anti-inflammatory drugs which are used to treat, among other things, pain and inflammation.

for Patient D, the following prescriptions for controlled substances were filled for Patient D during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-14-2018	Alprazolam	0.5 mg	60	30	Respondent
03-14-2018	Alprazolam	0.5 mg	60	30	Respondent
04-16-2018	Alprazolam	0.5 mg	60	30	Respondent
05-17-2018	Alprazolam	0.5 mg	60	30	Respondent
06-15-2018	Alprazolam	0.5 mg	60	30	Respondent
08-28-018	Alprazolam	0.5 mg	60	30	Respondent
09-28-2018	Alprazolam	0.5 mg	60	30	Respondent
11-12-2018	Alprazolam	0.5 mg	60	30	Respondent

36. In general, during the course of treatment for Patient D during 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.[26]

37. Respondent committed gross negligence in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

[26] Respondent acknowledged during his subject interview that there were issues with his medical records not matching what was actually being prescribed to Patient D. (Transcript, at pp. 155-156.)

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing timely tapering or antidote therapy which increased the risk of harm to the patient including, but not limited to, the risk of respiratory depression.

PATIENT E

38. During the period of on or about January 1, 2015, through December 31, 2015, Patient E, a then-63-year-old male, had twelve visits with Respondent which took place on January 28, March 2, April 2, April 30, May 28, June 25, July 23, August 21, September 18, October 16, November 16, and December 16, 2015. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, opioid dependence, backache, and lumbar spondylosis. There was no documentation, or other indication, of Respondent checking CURES at any time during his care and treatment of Patient E. On December 16, Patient E requested medications due to an upcoming vacation. During this period of time, Patient E was receiving overlapping prescriptions of an opiate (hydrocodone/APAP), a benzodiazepine (Lorazepam), a sleep aid (zolpidem tartrate), and codeine cough syrup. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-05-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
01-28-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
02-12-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
03-02-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
03-23-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
04-02-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-02-2015	Hydrocodone/APAP	10/325 mg	150	30	Respondent
04-20-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
04-30-2015	Hydrocodone/APAP	10/325 mg	150	28	Respondent
05-15-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
05-28-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
06-10-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
06-25-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
07-08-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
07-23-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
07-23-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
08-12-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
08-21-2015	Lorazepam	0.5 mg	30	30	Respondent
08-24-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-18-2015	Hydrocodone/APAP	10/325 mg	150	15	Respondent
09-18-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-21-2015	Lorazepam	0.5 mg	30	30	Respondent
10-16-2015	Hydrocodone/APAP	10/325 mg	150	15	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-19-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
10-29-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
10-29-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
11-04-2015	Lorazepam	0.5	30	30	Respondent
11-16-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	6	Respondent
11-16-2015	Hydrocodone/APAP	10/325 mg	150	15	Respondent
11-30-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	6	Respondent
12-16-2015	Zolpidem Tartrate	5 mg	30	30	Respondent
12-16-2015	Hydrocodone/APAP	10/325 mg	150	25	Respondent
12-16-2015	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent

39. During the period of on or about January 1, 2016, through December 31, 2016, Patient E had fifteen visits with Respondent which took place on January 18, February 18, March 17, April 15, May 13, June 13, July 11, July 26, August 11, September 12, September 26, October 10, November 10, December 13, and December 16, 2016. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, opioid dependence (removed after January 18), chronic cough, lumbar spondylosis, chronic back pain, chronic obstructive pulmonary disease (COPD) (added April 15), and being overweight. During this period of time, Patient E was receiving prescriptions for an opiate (hydrocodone/APAP), a benzodiazepine (Lorazepam), a sleep aid (zolpidem tartrate), and codeine cough syrup. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2016:

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Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
01-13-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
01-18-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
01-25-2016	Lorazepam	0.5	30	30	Respondent
01-25-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
02-18-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
02-18-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
03-04-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
03-17-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
03-17-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
03-29-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-05-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-15-2016	Hydrocodone/APAP	10/325 mg	150	20	Respondent
04-15-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-28-2016	Zolpidem Tartrate	5 mg	30	30	Respondent
04-28-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-13-2016	Hydrocodone/APAP	10/325 mg	150	20	Respondent
05-13-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-27-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
06-13-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-13-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
07-11-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
07-11-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
07-26-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
08-11-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
08-11-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
09-07-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-12-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
09-26-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
10-10-2016	Hydrocodone/APAP	10/325 mg	150	25	Respondent
11-10-2016	Hydrocodone/APAP	10/325 mg	150	15	Respondent
11-10-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
12-13-2016	Hydrocodone/APAP	10/325 mg	150	37	Respondent
12-16-2016	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent

40. During the period of on or about January 1, 2017, through December 31, 2017, Patient E had twelve visits with Respondent which took place on January 12, February 16, March 16, April 18, May 18, June 19, July 19, August 18, September 18, October 19, November 20, and December 19, 2017. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, chronic cough, lumbar spondylosis, chronic back pain, COPD, and being overweight. On January 12, a change of "current meds" was documented for Norco (hydrocodone/APAP) but the prescription essentially remained the same. On February 21, a change of "current meds" was documented again for Norco (hydrocodone/APAP) but the

prescription essentially remained the same. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-12-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
01-12-2017	Hydrocodone/APAP	10/325 mg	150	37	Respondent
02-16-2017	Carisoprodol[27]	350 mg	90	30	Respondent
02-16-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
03-16-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
03-16-2017	Carisoprodol	350 mg	90	30	Respondent
03-21-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
04-18-2017	Hydrocodone/APAP	10/325 mg	150	38	Respondent
04-18-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	16	Respondent
04-18-2017	Carisoprodol	350 mg	90	30	Respondent
05-18-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
05-18-2017	Carisoprodol	350 mg	90	30	Respondent
05-18-2017	Hydrocodone/APAP	10/325 mg	150	38	Respondent
06-19-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
06-19-2017	Carisoprodol	350 mg	90	30	Respondent

[27] Carisoprodol (Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of acute and painful musculoskeletal conditions. Carisoprodol is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high." According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States. According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-19-2017	Hydrocodone/APAP	10/325 mg	150	38	Respondent
07-24-2017	Hydrocodone/APAP	10/325 mg	150	37	Respondent
08-25-2017	Hydrocodone/APAP	10/325 mg	150	20	Respondent
09-18-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
09-21-2017	Hydrocodone/APAP	10/325 mg	150	20	Respondent
10-19-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
10-19-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
11-20-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
11-20-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
12-19-2017	Hydrocodone/APAP	10/325 mg	150	25	Respondent
12-19-2017	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	06	Respondent

41. During the period of on or about January 1, 2018, through December 31, 2018, Patient E had thirteen visits with Respondent which took place on January 24, February 19, March 19, April 19, May 18, June 18, July 9, July 18, August 17, September 18, October 18, November 19, and December 13, 2018. During this time, Patient E's problems were generally documented in the EMR's assessment/plan section as including, but not limited to, peripheral vascular disease, hypertension, diabetes, chronic cough, lumbar spondylosis, chronic back pain, COPD, and being overweight. On January 18, the EMR documented "[Left] ear itchy" and prescribed Cortisporin-TC (used to treat outer ear infections caused by bacteria) one drop in each ear twice a day, however, the ear examination was documented as normal. According to the CURES report for Patient E, the following prescriptions for controlled substances were filled for Patient E during 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-18-2018	Hydrocodone/APAP	10/325 mg	150	20	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-24-2018	Carisoprodol	350 mg	90	30	Respondent
02-19-2018	Hydrocodone/APAP	10/325 mg	150	20	Respondent
02-19-2018	Carisoprodol	350 mg	90	30	Respondent
03-19-2018	Hydrocodone/APAP	10/325 mg	150	20	Respondent
04-04-2018	Carisoprodol	350 mg	90	30	Respondent
04-19-2018	Hydrocodone/APAP	10/325 mg	150	25	Respondent
05-04-2018	Carisoprodol	350 mg	90	30	Respondent
05-18-2018	Zolpidem Tartrate	5 mg	30	30	Respondent
05-18-2018	Hydrocodone/APAP	10/325 mg	150	25	Respondent
06-04-2018	Carisoprodol	350 mg	90	30	Respondent
06-16-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.[28]
06-18-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
06-27-2018	Zolpidem Tartrate	5 mg	30	30	Respondent
07-09-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
07-10-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
08-21-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
09-17-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
09-18-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
10-15-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.
10-18-2018	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	240	12	Respondent
11-12-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.

[28] Dr. A.L., board certified in Physical Medication and Rehabilitation, was associated with a pain management practice. Respondent's medical records for Patient E contain copies of Dr. A.L.'s medical records for his visits with Patient E of November 12, 2018, November 14, 2018, December 10, 2018, and February 5, 2019. According to Dr. A.L.'s medical records, his diagnoses were radiculopathy, lumbar region; other spondylosis, lumbar region; cervicalgia and chronic instability of right knee.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
12-10-2018	Hydrocodone/APAP	10/325 mg	150	30	Dr. A.L.

42. In general, during the course of treatment for Patient E during 2015 through 2018, alleged herein, Respondent's handwritten notes were often cursory and largely illegible while Respondent's EMR's often appeared to have been copied and pasted and, at times, did not reflect the actual condition of the patient, contained conflicting information and/or inadequately or inaccurately listed the medications that were being prescribed.[29]

43. Respondent committed gross negligence in his care and treatment of Patient E which included, but was not limited to, the following:

(a) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to be copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(b) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant

[29] In discussing the problem with failing to reconcile the medication list and the medication list in the EMR's being inaccurate, at times, Respondent acknowledged "it did happen" and noted that "sometimes" there was a problem in failing to update the medication list when a medication or medications was discontinued." In his subject interview, Respondent, through his counsel, expressed his intent to take a medical record keeping course and agreed that such a course would be helpful in improving his practice. (Transcript, at pp. 165-166, 179.)

behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior; and

(c) Respondent failed to perform a proper diagnostic workup and failed to properly treat the patient's chronic cough.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

44. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged herein.

PATIENT A

45. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Paragraphs 8 through 15, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the

patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent and failed to utilize or document the use of a pain management agreement; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

PATIENT B

46. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Paragraphs 16 through 22, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

PATIENT C

47. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Paragraphs 23 through 30, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent and failed to utilize or document the use of a pain management agreement; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

PATIENT D

48. Respondent committed repeated negligent acts in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Paragraphs 31 through 37, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions

and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without utilizing or documenting the use of a pain management agreement; and

(f) Respondent repeatedly prescribed opiates and benzodiazepines concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression.

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PATIENT E

49. Respondent committed repeated negligent acts in his care and treatment of Patient E which included, but was not limited to, the following:

(a) Paragraphs 38 through 43, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent repeatedly failed to maintain adequate and accurate medical records in that his handwritten notes were often cursory and illegible; and his EMR's appeared to have been copied and pasted on several occasions and, at times, contained conflicting information, did not address chief complaints in the assessment and plan, did not document the mechanism for medication reconciliation and/or incorrectly listed the medications that were being prescribed;

(c) Respondent repeatedly prescribed opiates for the treatment of pain without adequately evaluating or documenting non-pharmacological or non-opiate options;

(d) Respondent repeatedly prescribed opiates without proper management of the patient in regard to the initiation and continuation of opioid therapy, titration and monitoring of chronic opioid pain therapy which included, but was not limited to, Respondent's failure to adequately verify the patient's previous treatment modality; failing to risk stratify or document any risk stratification for opioid misuse; failing to consider or document functional goals; failing to adequately titrate doses or clearly document any titration of doses; and/or failing to monitor the risks of aberrant behavior by checking CURES, utilizing urine drug screens and/or other measures to guard against aberrant behavior;

(e) Respondent repeatedly prescribed opiates and other controlled substances without adequately providing or documenting informed consent and failed to utilize or document the use of a pain management agreement;

(f) Respondent repeatedly prescribed opiates and benzodiazepines; concurrently without utilizing tapering or antidote therapy in a timely manner which increased the risk of harm including, but not limited to, the risk of respiratory depression; and

(g) Respondent failed to perform a proper diagnostic workup and failed to properly treat the patient's chronic cough.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

50. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to Patient B, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 16 through 22, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

51. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 8 through 49, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 51602, issued to Respondent Assad Ullah Darawal, M.D.;

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

3. Ordering Respondent Assad Ullah Darawal, 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: JAN 13 2020

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

SD2019702500
Accusation (Word Clean Copy).docx