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

In the Matter of the Accusation Against: Thuc Ba Tu, M.D. Physician's and Surgeon's Certificate No. A 84863 Respondent.	Case No. 800-2017-037456

DECISION

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

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

IT IS SO ORDERED: February 4, 2021.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: **THUC BA TU, M.D.** **6552 Bolsa Avenue, Suite N** **Huntington Beach, CA 92647** **Physician's and Surgeon's Certificate No. A 84863** Respondent.	Case No. 800-2017-037456 OAH No. 2020070354 **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.

2. Respondent Thuc Ba Tu, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about October 3, 2003, the Board issued Physician's and Surgeon's Certificate No. A 84863 to Thuc Ba Tu, M.D. (Respondent). The Physician's and Surgeon's Certificate will expire on July 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-037456 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 May 1, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2017-037456 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2017-037456. Respondent has also carefully read, 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 be represented by counsel at his own expense; 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. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2017-037456. Respondent further 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.

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CONTINGENCY

9. 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. 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.

10. 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. 800-2017-037456 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.

11. 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.

12. 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:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 84863 issued to Respondent Thuc Ba Tu, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. **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.

2. **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.

3. **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 practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (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 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.

4. **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.

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

6. **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.

7. **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.

8. **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.

9. **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.

10. **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's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model

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

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

11. **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.

12. **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.

13. **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.

14. **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.

15. **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. 800-2017-037456 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 Stipulated Settlement and Disciplinary Order. 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: 1/4/2021

THUC BA TU, M.D.
Respondent

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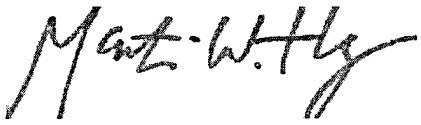
ENDORSEMENT

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

DATED: January 6, 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. 800-2017-037456

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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: **THUC BA TU, M.D.** **6552 Bolsa Avenue, Suite N** **Huntington Beach, CA 92647** **Physician's and Surgeon's Certificate No. A 84863,** Respondent.	Case No. 800-2017-037456 **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 October 3, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number A 84863 to Thuc Ba Tu, 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 July 31, 2021, unless renewed.

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JURISDICTION

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

STATUTORY PROVISIONS

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 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 725 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, and D, as more particularly alleged hereinafter:

PATIENT A[1]

9. On or about June 6, 2016, Respondent had his first visit with Patient A, a then-25-year-old female, who reported her main presenting problem as anxiety, insomnia and poor appetite. There was no detailed functional assessment or psychological questionnaire done regarding Patient A's anxiety. Respondent obtained vital signs and performed a cursory physical examination. Respondent prescribed Trazadone for insomnia and Xanax (alprazolam)[2] 0.5 mg (#45) (twice a day as needed) for anxiety. Respondent failed to consider any safer non-benzodiazepine alternatives.

10. During the remainder of 2016, Respondent had five more visits with Patient A which took place on July 12, August 16, September 15, November 10, and December 20, 2016. During this time, Patient A's problems were generally documented as including, but not limited to, anxiety and insomnia. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including

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

[2] 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.)

but not limited to, a review of California's Controlled Substance Utilization Review and Evaluation System (CURES)[3] and/or any urine drug screens. Respondent intermittently recommended Patient A to see a psychiatrist but there was no documentation or confirmation as to whether she did, in fact, follow up with any psychiatrist.[4] Respondent also failed to document and/or consider any safer non-benzodiazepine alternatives. According to the CURES report for Patient A, the following prescriptions for controlled substances were filled for Patient A for the remainder of 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
07-13-2016	Zolpidem Tartrate[5]	5 mg	30	30	Respondent
07-13-2016	Alprazolam	0.5 mg	45	23	Respondent
08-17-2016	Alprazolam	0.5 mg	35	17	Respondent
09-16-2016	Alprazolam	2 mg	55	27	Respondent
11-11-2016	Alprazolam	2 mg	50	24	Respondent
12-21-2016	Alprazolam	2 mg	50	24	Respondent
12-21-2016	Zolpidem Tartrate	5 mg	30	30	Respondent

11. 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 27, March 30, April 25, May 26, June 30, July 25, August 22, September 21, October 20, November 20, and December 19, 2017. During this time, Patient A's problems were generally documented as

[3] CURES is California's prescription drug monitoring program which tracks Schedule II, III and IV controlled substance prescriptions that are dispensed in California. One of the explicit purposes of the CURES database is to assist "law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances." (Health & Saf.Code, § 11165 (a).)

[4] During his interview before a Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (hereinafter "HQIU") investigator, Respondent was asked whether he ever attempted to consult with any psychiatrist that might have been seeing Patient A, if any, and Respondent admitted that he did not.

[5] 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.

including, but not limited to, anxiety, insomnia, and a concern about weight loss that was raised on June 30, 2017. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems including her concern of weight loss raised on June 30, 2017. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. Respondent intermittently recommended that Patient A see a psychiatrist but there was no documentation or confirmation as to whether she did, in fact, follow up with a psychiatrist. 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	Alprazolam	2 mg	50	25	Respondent
01-25-2017	Zolpidem Tartrate	5 mg	30	30	Respondent
02-28-2017	Alprazolam	2 mg	50	25	Respondent
02-28-2017	Zolpidem Tartrate	5 mg	30	30	Respondent
03-31-2017	Alprazolam	2 mg	50	25	Respondent
04-28-2017	Alprazolam	2 mg	50	25	Respondent
04-28-2017	Zolpidem Tartrate	5 mg	30	30	Respondent
05-30-2017	Alprazolam	2 mg	50	25	Respondent
05-30-2017	Zolpidem Tartrate	5 mg	30	30	Respondent
06-29-2017	Clonazepam	1 mg	45	15	Dr. A.W.
07-01-2017	Alprazolam	2 mg	50	25	Respondent
07-27-2017	Alprazolam	2 mg	55	28	Respondent
08-24-2017	Alprazolam	2 mg	55	27	Respondent
09-21-2017	Alprazolam	2 mg	55	27	Respondent
09-21-2017	Zolpidem Tartrate	5 mg	30	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-20-2017	Alprazolam	2 mg	60	30	Respondent
10-20-2017	Zolpidem Tartrate	5 mg	30	30	Respondent
11-20-2017	Alprazolam	2 mg	60	30	Respondent
12-19-2017	Alprazolam	2 mg	55	27	Respondent

12. During the period of on or about January 1, 2018, through July 12, 2018, Patient A had seven visits with Respondent which took place on January 19, February 15, March 15, April 16, May 15, June 15, and July 12, 2018. During this time, Patient A's problems were generally documented as including, but not limited to anxiety and periodic insomnia. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including, but not limited to, a review of CURES and/or any urine drug screens. Respondent intermittently recommended that Patient A see a psychiatrist but there was no documentation or confirmation as to whether she did, in fact, follow up with a psychiatrist. According to Respondent's medical records, during the period of January 1, 2018, through July 12, 2018, Respondent continued to prescribe Patient A Xanax (alprazolam) on a near monthly basis (one prescription for #60 and other prescriptions for # 55).

13. 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 records were cursory and consistently failed to adequately document, among other things, vital signs, physical examinations, informed consent for the controlled substances being prescribed, detailed assessments for the patient's presenting problems, the benefits, if any, of the controlled substances being prescribed and any risk

screening measures including but not limited to, a review of CURES and/or any urine drug screens; and

(b) Respondent failed to perform a proper evaluation of Patient's A weight loss to exclude any serious and potentially terminal diagnoses.

PATIENT B

14. On or about August 3, 2015, Respondent had his first visit with Patient B, a then-61-year-old female, whose past history was documented as including, among other things, migraines, osteoarthritis, pedal edema, a fall eight years prior with serious injury to her right ankle, three vertebrates rebuilt in 2014, diabetes mellitus, and heartburn. Patient B's medications were reported as Prilosec (for heartburn) and Victoza (for glycemic control). As part of her initial visit, vital signs were recorded and Respondent documented a review of symptoms and a basic physical examination. Respondent's assessment was Type 2 diabetes mellitus, history of migraines, osteoarthritis generalized and heartburn. The treatment plan was to refill the same medications, Prilosec and Victoza, and add ranitidine hydrochloride (Zantac) typically used for acid reduction. The note for this visit indicates "request records from old PCP" with some records in the file which pre-date the initial visit with Respondent.

15. On or about June 30, 2016, after an approximate eleven-month absence, Respondent had his second visit with Patient B. The purpose of the visit was to "refill medicine" and for evaluation of a persistent cough. Patient B's medications from her previous primary care physician, Dr. M.E., and/or her pain management physician, Dr. P.C., were now documented as including, but not limited to, Soma (carisoprodol)[6] 350 mg b.i.d. (two a day); Norco

[6] Soma® (carisoprodol) 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. Soma® 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."

(hydrocodone/acetaminophen [APAP])[7] 10/325 mg (#120) 1-2 tabs as needed; and Neurontin 300 mg for cervical pain with a note to follow up with pain management. Respondent ran a CURES report on Patient B, which was included as part of his medical records for Patient B.[8] Respondent's assessment was Type 2 diabetes mellitus, cervical spine pain, URI (upper respiratory infection), HTN (hypertension), migraines, anxiety and cough. Respondent's plan included prescribing hydrocodone/APAP (Norco) 10/325 mg (#90) (three tabs a day as needed), carisoprodol (Soma) 350 mg (#60) (two tabs a day as needed), alprazolam (Xanax) 1 mg (#30) (one a day), and other medications; and sending an authorization letter to obtain medical records from Dr. M.E., Patient B's previous primary care physician.

16. During the remainder of 2016, Respondent had four more visits with Patient B which took place on September 12, October 13, November 8, and December 20, 2016. During this time, Patient B's problems were generally documented as including, but not limited to, insomnia, anxiety, pain, bronchitis, neck spasm, asthma, sore throat, fatigue and daily wheezing. During this time, Respondent consistently failed to obtain and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed (including the dangers associated with the concurrent use of opiates and benzodiazepines), and consistently

[7] Hydrocodone APAP (Vicodin®, Lortab® and 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."

[8] The CURES report indicates that from January 8, 2016, to June 16, 2016, patient B was prescribed controlled substances from other prescribers, which included, among others, Dr. P.C. (pain management), Dr. M.E. (primary care) and listed seven prescriptions for hydrocodone/APAP (Norco) in various quantities and strengths; five prescriptions for carisoprodol (Soma) 350 mg (#90); three prescriptions for alprazolam (Xanax) 0.5-1.0 mg (#80-90); and one prescription of Nucynta ER 100 mg (#60).

failed to document any detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. There was documentation of referrals to pain management and orthopedics. According to the CURES report for Patient B, the following prescriptions for controlled substances were filled for Patient B for the remainder of 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
09-13-2016	Hydrocodone/APAP	10/325 mg	90	30	Respondent
09-13-2016	Alprazolam	1 mg	80	27	Respondent
09-13-2016	Carisoprodol	350 mg	60	30	Respondent
10-13-2016	Alprazolam	1 mg	40	12	Respondent
10-13-2016	Carisoprodol	350 mg	45	15	Respondent
10-14-2016	Hydrocodone/APAP	10/325 mg	45	15	Respondent
11-08-2016	Hydrocodone/APAP	10/325 mg	90	30	Respondent
11-08-2016	Alprazolam	1 mg	80	27	Respondent
11-08-2016	Carisoprodol	350 mg	60	30	Respondent
12-20-2016	Hydrocodone/APAP	10/325 mg	90	30	Respondent
12-20-2016	Alprazolam	1 mg	80	27	Respondent
12-20-2016	Carisoprodol	350 mg	60	30	Respondent

17. During the period of on or about January 1, 2017, through December 31, 2017, Patient B had eight visits with Respondent which took place on January 10, February 23, April 20, May 26, July 10, August 25, September 22, and November 17, 2017. During this time, Patient B's problems list was generally documented as including, but not limited to, Type II diabetes mellitus, generalized anxiety disorder, other chronic pain, gastro-esophageal reflux disease (GERD) and asthma. On February 23, the patient requested a "new referral to pain

management" because she believed her prior pain management physician "hurt her neck during examination." Respondent failed to obtain and/or document vital signs for two visits (January 10 and August 25) and consistently failed to conduct and/or document physical examinations,[9] informed consent for the controlled substances being prescribed, and consistently failed to document any detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. 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
01-27-2017	Alprazolam	1 mg	80	26	Respondent
01-27-2017	Carisoprodol	350 mg	60	30	Respondent
01-30-2017	Hydrocodone/APAP	10/325 mg	90	30	Dr. P.T.
02-23-2017	Carisoprodol	350 mg	60	20	Respondent
02-23-2017	Alprazolam	1 mg	80	26	Respondent
02-23-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
04-20-2017	Hydrocodone/APAP	10/325 mg	45	15	Respondent
04-20-2017	Carisoprodol	350 mg	60	30	Respondent
04-21-2017	Alprazolam	1 mg	90	30	Respondent
05-05-2017	Hydrocodone/APAP	10/325 mg	45	15	Dr. H.N.
05-26-2017	Alprazolam	1 mg	90	30	Respondent
05-26-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
05-26-2017	Carisoprodol	350 mg	60	30	Respondent
07-10-2017	Carisoprodol	350 mg	70	23	Respondent
07-10-2017	Alprazolam	1 mg	90	30	Respondent

[9] Respondent documented a physical examination conducted on February 23, 2017.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
07-11-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
08-25-2017	Carisoprodol	350 mg	70	23	Respondent
08-25-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
08-25-2017	Alprazolam	1 mg	90	30	Respondent
09-22-2017	Carisoprodol	350 mg	70	23	Respondent
09-22-2017	Alprazolam	1 mg	90	30	Respondent
09-23-2017	Hydrocodone/APAP	10/325 mg	90	30	Respondent
10-26-2017	Carisoprodol	350 mg	90	30	A.E.
10-26-2017	Hydrocodone/APAP	10/325 mg	90	30	A.E.
11-17-2017	Alprazolam	1 mg	90	30	Respondent
11-23-2017	Hydrocodone/APAP	10/325 mg	90	30	A.E.
11-23-2017	Carisoprodol	350 mg	90	30	A.E.
12-19-2017	Suboxone[10]	2.5-0.5 mg	5	5	A.E.
12-30-2017	Carisoprodol	350 mg	90	30	A.E.

18. During the period of on or about January 1, 2018, through June 4, 2018, Patient B had five visits with Respondent which took place on January 12, January 26, March 9, April 20, and June 4, 2018. During this time, Patient B's problems were generally documented as including, but not limited to, chronic pain syndrome, muscle spasms, Type II diabetes mellitus, generalized anxiety disorder, hypertension and history of asthma. On January 12, Respondent, through his assistant, documented the pain management specialist wanted to discontinue Norco and start on Suboxone (buprenorphine), the patient had weaned off of Xanax (alprazolam), the patient did not

[10] Suboxone® (buprenorphine and naloxone) is a Schedule III 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 is used for the treatment of opioid dependence and should be used as part of a complete treatment program to include counseling and psychosocial support.

want to take Suboxone, that a tapering plan[11] would be instituted, and "will refer Pt [patient] to pain management if [patient] wants to [increase] Norco." Respondent occasionally failed to conduct and/or document physical examinations and there was no documented informed consent for the controlled substances being prescribed. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no urine drug screens conducted. According to the CURES report for Patient B, the following prescriptions for controlled substances were filled for Patient B up until through April 20, 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-12-2018	Hydrocodone/APAP	10/325 mg	60	30	Respondent
02-03-2018	Carisoprodol	350 mg	90	30	Respondent
02-11-2018	Hydrocodone/APAP	10/325 mg	45	23	Respondent
03-09-2018	Hydrocodone/APAP	10/325 mg	45	22	Respondent
03-09-2018	Carisoprodol	350 mg	90	30	Respondent
04-20-2018	Hydrocodone/APAP	10/325 mg	45	22	Respondent
04-20-2018	Carisoprodol	350 mg	90	30	Respondent

19. 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 records were cursory and consistently failed to adequately document, among other things, vital signs, physical examinations, informed consent for the controlled substances being prescribed, detailed assessments for the patient's presenting problems, the benefits, if any, of the controlled substances being prescribed and any risk screening measures including but not limited to, a review of CURES and/or any urine drug screens.

[11] Specifically, the plan, as documented in the chart note, was that "Pt [patient] will stop Suboxone. Will go down on Norco 10/325 mg by 10 pills monthly & to stop completely, pt agreed. Will refer to pain management if pt wants to [increase] Norco..."

PATIENT C

20. On or about November 3, 2014, Respondent had his first visit with Patient C, a then-50-year-old male, who reported he had attention deficit disorder (ADD) and wanted medication refills for his Adderall.[12] Respondent documented a surgical history of a right leg screw and rod when the patient was eighteen years old and his current medications as including Adderall 10 mg b.i.d (twice a day). Respondent did not perform any screening in regard to the self-reported diagnosis of ADD, he did not document any symptoms suggestive of ADD, and he did not take other measures to confirm the self-reported diagnosis of ADD, such as speaking with Patient C's prior physician. Respondent's treatment plan consisted of providing Patient C with a prescription of Adderall 10 mg (twice a day).

21. During the remainder of 2014, Respondent had four more visits with Patient C which took place on November 10, December 1, December 8, and December 29, 2014 (increase of Adderall to 40 mg daily without any documented justification). During this time, Patient C's problems were generally documented as including, but not limited to, right ankle pain due to osteoarthritis and ADD. Respondent did not perform and/or document any physical exams or any x-rays for the ankle pain. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. Respondent's treatment plan included providing an orthopedic referral, prescribing hydrocodone/APAP (Norco) 10/325 mg (#120) q.i.d. (four a day) as needed for pain, and refilling the prescription for Adderall 10 mg

[12] Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

(two a day).

22. During the period of on or about January 1, 2015, through December 31, 2015, Patient C had eighteen visits with Respondent which took place on January 8, January 26, February 6, February 24, March 5, March 24, April 2, April 20, April 24, May 15, May 22, June 16, June 30, August 18, September 18, October 16, November 12, and December 11, 2015. During this time, Patient C's problems were generally documented as including, but not limited to, right ankle pain due to osteoarthritis and ADD. Patient C had ankle surgery in approximately July 2015. Respondent documented continued right ankle pain and past or present physical therapy. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. 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
06-16-2015	Adderall	20 mg	60	30	Respondent
06-20-2015	Tramadol HCL[13]	50 mg	60	30	Respondent
06-20-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
07-13-2015	Hydrocodone/APAP	10/325 mg	60	5	J.K.
07-16-2015	Adderall	20 mg	60	30	Respondent

[13] 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 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."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
07-19-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
07-25-2015	Hydrocodone/APAP	10/325 mg	60	8	S.R. (PA-C)
08-16-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
08-18-2015	Adderall	20 mg	60	30	Respondent
08-31-2015	Hydrocodone/APAP	10/325 mg	60	5	S.R. (PA-C)
09-12-2015	Hydrocodone/APAP	10/325 mg	60	5	S.R. (PA-C)
09-18-2015	Adderall	20 mg	60	30	Respondent
09-21-2015	Hydrocodone/APAP	10/325 mg	90	30	Respondent
10-07-2015	Hydrocodone/APAP	10/325 mg	60	5	S.R. (PA-C)
10-19-2015	Adderall	20 mg	60	30	Respondent
10-19-2015	Hydrocodone/APAP	10/325 mg	80	26	Respondent
11-12-2015	Tramadol HCL	50 mg	75	25	Respondent
11-16-2015	Adderall	20 mg	60	30	Respondent
11-20-2015	Hydrocodone/APAP	10/325 mg	60	10	S.R. (PA-C)
12-12-2015	Tramadol HCL	50 mg	90	22	Respondent
12-15-2015	Adderall	20 mg	60	30	Respondent
12-15-2015	Hydrocodone/APAP	10/325 mg	60	10	S.R. (PA-C)
12-27-2015	Hydrocodone/APAP	10/325 mg	60	8	S.R. (PA-C)

23. During the period of on or about January 1, 2016, through December 31, 2016, Patient C had thirteen visits with Respondent which took place on January 15, January 28, February 15, March 3, March 17, April 15, May 16, June 14, August 12, September 13, October 11, November 11, and December 12, 2016. During this time, Patient C's problems were generally documented as including, but not limited to, right ankle pain due to osteoarthritis and ADD. On January 21, Patient C was seen at an orthopedic institute with the recommendation that he be seen by "a foot/ankle specialist." On February 15, Respondent documented that the "[patient] is seeing a podiatrist for his chronic right ankle pain [due] to severe OA

[osteoarthritis]." During this time, Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. 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
01-08-2016	Hydrocodone/APAP	10/325 mg	60	7	S.R. (PA-C)
01-15-2016	Adderall	20 mg	60	30	Respondent
01-18-2016	Hydrocodone/APAP	10/325 mg	60	15	Respondent
01-28-2016	Hydrocodone/APAP	10/325 mg	60	15	Respondent
02-07-2016	Hydrocodone/APAP	7.5/325 mg	60	15	C.D. (M.D.)
02-15-2016	Adderall	20 mg	60	30	Respondent
02-21-2016	Hydrocodone/APAP	10/325 mg	60	15	Respondent
03-06-2016	Hydrocodone/APAP	10/325 mg	60	15	Respondent
03-18-2016	Adderall	20 mg	60	30	Respondent
03-20-2016	Hydrocodone/APAP	10/325 mg	60	15	Respondent
04-08-2016	Hydrocodone/APAP	10/325 mg	60	5	S.R. (PA-C)
04-19-2016	Adderall	20 mg	60	30	Respondent
04-24-2016	Hydrocodone/APAP	10/325 mg	90	30	Respondent
05-18-2016	Hydrocodone/APAP	10/325 mg	90	30	Respondent
05-18-2016	Adderall	20 mg	60	30	Respondent
06-15-2016	Adderall	20 mg	60	30	Respondent
06-17-2016	Hydrocodone/APAP	10/325 mg	85	28	Respondent
07-15-2016	Hydrocodone/APAP	10/325 mg	80	26	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
07-15-2016	Adderall	20 mg	60	30	Respondent
08-13-2016	Hydrocodone/APAP	10/325 mg	75	25	Respondent
08-13-2016	Adderall	20 mg	60	30	Respondent
09-13-2016	Hydrocodone/APAP	10/325 mg	70	23	Respondent
09-14-2016	Adderall	20 mg	60	30	Respondent
10-12-2016	Hydrocodone/APAP	10/325 mg	70	23	Respondent
10-13-2016	Adderall	20 mg	60	30	Respondent
11-11-2016	Hydrocodone/APAP	10/325 mg	70	23	Respondent
11-14-2016	Adderall	20 mg	60	30	Respondent
12-12-2016	Hydrocodone/APAP	10/325 mg	65	22	Respondent
12-12-2016	Adderall	20 mg	60	30	Respondent

24. 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 12, February 10, March 10, April 10, May 11, June 10, July 10, August 10, September 8, October 7, November 4, and December 4, 2017. During this time, Patient C's problems were generally documented as including, but not limited to, right ankle pain due to osteoarthritis and ADD. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during 2017:

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Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-12-2017	Hydrocodone/APAP	10/325 mg	65	21	Respondent
01-12-2017	Adderall	20 mg	60	30	Respondent
02-10-2017	Hydrocodone/APAP	10/325 mg	60	30	Respondent
02-13-2017	Adderall	20 mg	60	30	Respondent
03-10-2017	Hydrocodone/APAP	10/325 mg	57	28	Respondent
03-13-2017	Adderall	20 mg	60	30	Respondent
04-10-2017	Hydrocodone/APAP	10/325 mg	55	27	Respondent
05-11-2017	Adderall	20 mg	60	30	Respondent
05-11-2017	Hydrocodone/APAP	10/325 mg	50	25	Respondent
06-12-2017	Adderall	20 mg	60	30	Respondent
06-12-2017	Hydrocodone/APAP	10/325 mg	50	25	Respondent
07-10-2017	Adderall	20 mg	60	30	Respondent
07-10-2017	Hydrocodone/APAP	10/325 mg	45	23	Respondent
08-10-2017	Adderall	20 mg	60	30	Respondent
08-10-2017	Hydrocodone/APAP	10/325 mg	40	20	Respondent
09-08-2017	Adderall	20 mg	60	30	Respondent
09-08-2017	Hydrocodone/APAP	10/325 mg	40	20	Respondent
10-07-2017	Adderall	20 mg	60	30	Respondent
10-07-2017	Hydrocodone/APAP	10/325 mg	38	19	Respondent
11-04-2017	Adderall	20 mg	60	30	Respondent
11-04-2017	Hydrocodone/APAP	10/325 mg	33	16	Respondent
12-04-2017	Adderall	20 mg	60	30	Respondent
12-04-2017	Hydrocodone/APAP	10/325 mg	31	15	Respondent
12-13-2017	Hydrocodone/APAP	10/325 mg	20	5	Respondent

25. During the period of on or about January 1, 2018, through June 4, 2018, Patient C had six visits with Respondent which took place on January 2, February 1, March 1, April 2, May 1,

and June 7, 2018. During this time, Patient C's problems were generally documented as including, but not limited to, right ankle pain due to osteoarthritis and ADD. Respondent consistently failed to obtain, perform, provide and/or document vital signs, physical examinations, informed consent for the controlled substances being prescribed or detailed assessments for the patient's presenting problems. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and there were no risk screening measures documented and/or utilized, including but not limited to, a review of CURES and/or any urine drug screens. According to the CURES report for Patient C, the following prescriptions for controlled substances were filled for Patient C during May 1, 2018:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2018	Adderall	20 mg	60	30	Respondent
01-02-2018	Hydrocodone/APAP	10/325 mg	31	16	Respondent
02-01-2018	Adderall	20 mg	60	30	Respondent
02-01-2018	Hydrocodone/APAP	10/325 mg	25	25	Respondent
03-01-2018	Adderall	20 mg	60	30	Respondent
03-01-2018	Hydrocodone/APAP	10/325 mg	25	25	Respondent
04-02-2018	Adderall	20 mg	60	30	Respondent
04-02-2018	Hydrocodone/APAP	10/325 mg	22	22	Respondent
05-01-2018	Adderall	30 mg	60	30	Respondent
05-01-2018	Hydrocodone/APAP	10/325 mg	15	30	Respondent

26. 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 records were cursory and consistently failed to adequately document, among other things, vital signs, physical

examinations, informed consent for the controlled substances being prescribed, detailed assessments for the patient's presenting problems, the benefits, if any, of the controlled substances being prescribed and any risk screening measures including but not limited to, a review of CURES and/or any urine drug screens; and

(b) Respondent failed to conduct a detailed assessment and seek confirmation of Patient C's alleged need for Adderall prior to routinely and repeatedly prescribing Adderall.

PATIENT D

27. On or about July 3, 2013, Respondent had his first visit with Patient D, a then-70-year-old female with mild dementia, prior CVA (stroke) with hemiparesis, chronic obstructive pulmonary disease (COPD), hypertension, hypothyroidism, and neuropathy. Patient D was living in a long-term nursing home facility and Respondent followed her on a near monthly basis as required by federal regulations. In general, Respondent provided treatment which included, but was not limited to, Neurontin for peripheral neuropathy, thyroid supplementation for hypothyroidism, blood pressure and blood thinning medications for stroke, inhalers for the patient's COPD, and intermittent Trazadone for insomnia.

28. During the period of on or about January 1, 2015, through December 31, 2015, Patient D had seventeen visits with Respondent which took place on January 9, January 21, February 22, March 10, March 23, March 31, April 12, May 24, June 11, June 30, July 19, August 20, September 21, October 20, November 30, December 7, and December 20, 2015. During this time, Patient D's problems were generally documented as including, but not limited to, mild dementia, prior CVA (stroke) with hemiparesis, COPD, hypertension, hypothyroidism, and neuropathy. Respondent consistently failed to obtain perform, provide, and/or document vital signs, informed consent for the controlled substances being prescribed and consistently failed to document any detailed neuromuscular examinations as is often needed in any detailed pain management assessment. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and the actual controlled substances

being prescribed, including the drug name, strength and quantity. There was also no risk assessment performed and/or documented for the controlled substances being prescribed and no indication that safer non-opiate options were considered for pain reduction. 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
06-08-2015	Hydrocodone/APAP	5/325 mg	30	3	Respondent
07-22-2015	Hydrocodone/APAP	5/325 mg	60	15	Respondent
08-16-2015	Hydrocodone/APAP	5/325 mg	60	5	Respondent
09-01-2015	Hydrocodone/APAP	5/325 mg	60	5	Respondent
10-18-2015	Hydrocodone/APAP	5/325 mg	60	5	Respondent
10-21-2015	Hydrocodone/APAP	5/325 mg	60	5	Respondent
11-12-2015	Hydrocodone/APAP	5/325 mg	30	5	Respondent
11-20-2015	Hydrocodone/APAP	5/325 mg	75	9	Respondent
12-24-2015	Hydrocodone/APAP	5/325 mg	60	5	Respondent

29. During the period of on or about January 1, 2016, through December 31, 2016, Patient D had 16 visits with Respondent which took place on January 30, February 18, February 25, March 27, April 29, May 30, June 10, June 29, July 31, August 29, September 5, September 30, October 30, November 13, November 30, and December 18, 2016. Respondent consistently failed to obtain perform, provide, and/or document vital signs, informed consent for the controlled substances being prescribed and consistently failed to document any detailed neuromuscular examinations as is often needed in any detailed pain management assessment. Respondent also failed to consistently document and/or assess the benefits, if any, of the controlled substances being prescribed and the actual controlled substances being prescribed, including the drug name, strength and quantity. There was also no risk assessment performed and/or documented for the controlled substances being prescribed and no indication that safer

non-opiate options were considered for pain reduction. During this time, Patient D's problems were generally documented as including, but not limited to, mild dementia, prior CVA (stroke) with hemiparesis, COPD, hypertension, hypothyroidism, and neuropathy. 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
01-21-2016	Hydrocodone/APAP	5/325 mg	60	5	Respondent
02-15-2016	Hydrocodone/APAP	5/325 mg	60	5	Respondent
03-20-2016	Hydrocodone/APAP	5/325 mg	30	5	Respondent
04-07-2016	Hydrocodone/APAP	5/325 mg	60	5	Respondent
05-03-2016	Hydrocodone/APAP	5/325 mg	60	10	Respondent
06-03-2016	Hydrocodone/APAP	5/325 mg	60	7	Respondent
06-27-2016	Hydrocodone/APAP	5/325 mg	30	10	Respondent
07-05-2016	Hydrocodone/APAP	5/325 mg	30	5	Respondent
07-08-2016	Hydrocodone/APAP	5/325 mg	75	15	Respondent
09-08-2016	Hydrocodone/APAP	5/325 mg	90	10	Respondent
10-20-2016	Hydrocodone/APAP	5/325 mg	60	5	Respondent
11-21-2016	Hydrocodone/APAP	5/325 mg	60	5	Respondent
12-15-2016	Hydrocodone/APAP	5/325 mg	56	5	Respondent

30. During the period of on or about January 1, 2017, through April 23, 2017, Patient D had three visits with Respondent which took place on January 8, March 2, and April 23, 2017. During this time, Patient D's problems were generally documented as including, but not limited to, mild dementia, prior CVA (stroke) with hemiparesis, COPD, hypertension, hypothyroidism, and neuropathy. Respondent consistently failed to obtain perform, provide, and/or document informed consent for the controlled substances being prescribed and consistently failed to document any detailed neuromuscular examinations as is often needed in any detailed pain management assessment. Respondent also failed to consistently document and/or assess the

benefits, if any, of the controlled substances being prescribed and the actual controlled substances being prescribed, including the drug name, strength and quantity. There was also no risk assessment performed and/or documented for the controlled substances being prescribed and no indication that safer non-opiate options were considered for pain reduction. According to the CURES report for Patient D, the following prescriptions for controlled substances were filled for Patient D through April 23, 2017:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-09-2017	Hydrocodone/APAP	5/325 mg	60	5	Respondent
02-09-2017	Hydrocodone/APAP	5/325 mg	60	10	Respondent
02-20-2017	Hydrocodone/APAP	5/325 mg	30	5	Respondent
03-22-2017	Hydrocodone/APAP	5/325 mg	30	10	Respondent
04-06-2017	Hydrocodone/APAP	5/325 mg	60	5	Respondent
05-10-2017	Hydrocodone/APAP	5/325 mg	60	15	Respondent

31. 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 records were cursory and consistently failed to adequately document, among other things, vital signs, any detailed neuromuscular examinations as is often needed in any detailed pain management assessment, informed consent for the controlled substances being prescribed, including the drug name, strength and quantity, benefits, if any, of the controlled substances being prescribed, any risk assessments for the controlled substances being prescribed, and no indication that safer non-opiate options were considered for pain reduction.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

32. 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, and D, as more particularly alleged herein.

PATIENT A

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

(a) Paragraphs 9 through 13, 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 records were cursory and consistently failed to adequately document, among other things, vital signs, physical examinations, informed consent for the controlled substances being prescribed, detailed assessments for the patient's presenting problems, the benefits, if any, of the controlled substances being prescribed and any risk screening measures including but not limited to, a review of CURES and/or any urine drug screens;

(c) Respondent failed to perform a proper evaluation of Patient's A weight loss to exclude any serious and potentially terminal diagnoses;

(d) Respondent repeatedly failed to properly manage Patient A's generalized anxiety disorder by, among other things, failing to perform and/or document a thorough assessment of the patient's anxiety disorder; failing to use safer, non-benzodiazepine, options to address the anxiety disorder; and failing to address the patient's failure to follow up with a mental health care provider; and

(e) Respondent repeatedly failed to properly manage and monitor the controlled substances being prescribed by, among other things, failing to

conduct and/or document proper assessments of the risks and benefits of the controlled substances being prescribed; failing to perform periodic urine drug screens; and failing to periodically check CURES.

PATIENT B

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

(a) Paragraphs 14 through 19, 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 records were cursory and consistently failed to adequately document, among other things, vital signs, physical examinations, informed consent for the controlled substances being prescribed, detailed assessments for the patient's presenting problems, the benefits, if any, of the controlled substances being prescribed and any risk screening measures including but not limited to, a review of CURES and/or any urine drug screens;

(c) Respondent repeatedly failed to properly manage Patient B's generalized anxiety disorder by, among other things, failing to perform and/or document a thorough assessment of the patient's anxiety disorder; and failing to use safer, non-benzodiazepine, options to address the anxiety disorder;

(d) Respondent repeatedly failed to properly manage and monitor the opiates being prescribed by, among other things, failing to conduct and/or document proper assessments of the risks and benefits of the controlled substances being prescribed, failing to obtain and/or document information concerning pain intensity, adverse side effects, functional improvement, and overall affect, if any, on the patient, failing to perform periodic urine drug screens, and failing to periodically check CURES; and

(e) Respondent repeatedly failed to manage the care of Patient B in regard to his concurrent prescribing of opiates, benzodiazepines, and Soma considering, among other things, Patient B's chronic asthmatic condition.

PATIENT C

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

(a) Paragraphs 20 through 26, 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 records were cursory and consistently failed to adequately document, among other things, vital signs, physical examinations, informed consent for the controlled substances being prescribed, detailed assessments for the patient's presenting problems, the benefits, if any, of the controlled substances being prescribed and any risk screening measures including but not limited to, a review of CURES and/or any urine drug screens;

(c) Respondent failed to conduct a detailed assessment and seek confirmation of Patient C's alleged need for Adderall prior to him routinely and repeatedly prescribing Adderall;

(d) Respondent repeatedly failed to consider other possible non-opiate-based medication regimen for the control of Patient C's pain; and

(e) Respondent repeatedly failed to properly manage and monitor the opiates, he prescribed by, among other things, failing to conduct and/or document proper assessments of the risks and benefits of the controlled substances being prescribed, failing to obtain and/or document information concerning pain intensity, adverse side effects, functional improvement, and overall affect, if any, on the patient, failing to perform periodic urine drug screens, and failing to periodically check CURES.

PATIENT D

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

(a) Paragraphs 27 through 31, 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 records were cursory and consistently failed to adequately document, among other things, vital signs, any detailed neuromuscular examinations as is often needed in any detailed pain management assessment, informed consent for the controlled substances being prescribed, including the drug name, strength and quantity, benefits, if any, of the controlled substances being prescribed, any risk assessments for the controlled substances being prescribed, and no indication that safer non-opiate options were considered for pain reduction;

(c) Respondent repeatedly failed to consider other possible non-opiate-based medication regimen for the control of Patient D's pain;

(d) Respondent repeatedly failed to properly manage and monitor the opiates, he prescribed by, among other things, failing to conduct and/or document proper assessments of the risks and benefits of the controlled substances being prescribed, failing to obtain and/or document information concerning pain intensity, adverse side effects, functional improvement, and overall affect, if any, on the patient, failing to perform periodic urine drug screens, and failing to periodically check CURES.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

37. 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, and D, as more particularly

alleged in paragraphs 8 through 36, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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 84863, issued to Respondent Thuc Ba Tu, M.D.;

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

3. Ordering Respondent Thuc Ba Tu, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: May 1, 2020

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

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