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

In the Matter of the Accusation Against: John Geoffrey Lockie, M.D. Physician's and Surgeon's Certificate No. A 39051 Respondent.	Case No. 800-2017-036090

DECISION

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

This Decision shall become effective at 5:00 p.m. on April 9, 2021.

IT IS SO ORDERED April 2, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
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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: **JOHN GEOFFREY LOCKIE, M.D.** **7051 Alvarado Road** **La Mesa, CA 91942** **Physician's and Surgeon's Certificate No. A 39051,** Respondent.	Case No. 800-2017-036090 OAH No. 2020100401 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). 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 Christine A. Rhee, Deputy Attorney General.

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2. John Geoffrey Lockie, M.D. (Respondent) is represented in this proceeding by Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about August 30, 1982, the Board issued Physician's and Surgeon's Certificate No. A 39051 to John Geoffrey Lockie, M.D. (Respondent). Physician's and Surgeon's Certificate No. A 39051 was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-036090 and will expire on October 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-036090 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 July 30, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2017-036090 is attached as Exhibit A and incorporated by reference herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-036090. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2017-036090, agrees that he has thereby subjected his license to disciplinary action, and hereby surrenders his Physician's and Surgeon's Certificate No. A 39051 for the Board's formal acceptance.

9. Respondent agrees that if he ever petitions for reinstatement of his license, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations in Accusation No. 800-2017-036090 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

10. Respondent understands that by signing this stipulation, he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Pursuant to Business and Professions Code section 2224, subdivision (b), the Executive Director of the Board has been delegated the authority to adopt or reject a stipulation for surrender of a Physician's and Surgeon's Certificate.

12. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved by the Executive Director on behalf of the Board. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it

shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion, and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

13. The Executive Director shall have a reasonable period of time in which to consider and act upon this stipulation after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director considers and acts upon it.

ADDITIONAL PROVISIONS

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

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

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 39051, issued to Respondent John Geoffrey Lockie, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

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2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations, and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-036090 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-036090 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: March 19th, 2021

John Geoffrey Lockie
JOHN GEOFFREY LOCKIE, M.D.
Respondent

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

DATED: March 22, 2021

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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

DATED: _____

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: March 23, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-036090

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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: **JOHN GEOFFREY LOCKIE, M.D.** **7051 Alvarado Road** **La Mesa, CA 91942-8901** **Physician's and Surgeon's Certificate No. A39051,** Respondent.	Case No. 800-2017-036090 **ACCUSATION**

PARTIES

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

2. On or about August 30, 1982, the Medical Board issued Physician's and Surgeon's Certificate No. A39051 to John Geoffrey Lockie, M.D. (Respondent). Physician's and Surgeon's Certificate No. A39051 was in full force and effect at all times relevant to the charges brought herein and will expire on October 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.

4. Section 2227 of the Code states, in pertinent part:

> (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.
>
> ...

5. Section 2234 of the Code, states, in pertinent part:

> 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:
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> ...
>
> (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.

...

6. 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."

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. A39051 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in the care and treatment of Patients A, B, C, D, and E,[1] as more particularly alleged hereafter:

Patient A

8. During the time period referenced in this pleading, Respondent was a family physician working within a medical group in San Diego. Respondent treated Patient A, a male born in 1943, for approximately 35 years.

9. On or about December 11, 2013, Patient A, then 70 years old, saw Respondent for medication refills. At the time, Respondent had Patient A on a medication regimen of 640 mg of OxyContin[2] and 10 mg of zolpidem[3] per day. Respondent told Board investigators that Patient A had chronic pain in his hips, with a history of hip replacement surgeries, degenerative disc disease with compression fractures, osteoporosis, morbid obesity, chronic idiopathic peripheral neuropathy, recurrent congestive heart failure, lymphoma, and chronic obstructive pulmonary disease (COPD). To treat his pain, Patient A tried previous trials of amitriptyline, gabapentin, pregabalin, and Cymbalta.

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[1] Patients' names have been omitted to protect their privacy. Respondent is aware of the patients' identities.

[2] OxyContin, brand name for oxycodone, is an opioid analgesic and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

[3] Zolpidem is a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

10. From on or about January 8, 2014 through December 14, 2014, Respondent maintained Patient A's medication regimen of 640 mg of OxyContin per day. On or about June 20, 2014, Respondent changed Patient A's daily zolpidem dose from 10 to 12.5 mg.

11. On or about March 26, 2014, Patient A submitted to a urine drug screen which was consistent with the medications he was being prescribed.

12. On or about June 24, 2014, Patient A submitted to another urine drug screen which showed positive results for amphetamine, opiates, and oxycodone. Respondent signed off on the lab report showing the aberrant results, but failed to either address or document that he addressed the inconsistent results with Patient A.

13. On or about June 26, 2014, Patient A submitted to another urine drug screen which was positive for oxycodone.

14. On or about August 19, 2014, Patient A requested a referral to a spine specialist or an orthopedist.

15. On or about August 21, 2014, studies were done of Patient A's cervical and thoracic spine. The studies showed mild degenerative changes and bone demineralization. Respondent documented that Patient A was notified of the results and was told to return to the office to discuss his osteoporosis.

16. On or about September 16, 2014, Patient A returned to the office and saw Respondent. Respondent wrote that they had a "discussion of Rx options," but no medications or treatment were documented.

17. On or about September 18, 2014, Respondent administered facet joint injections in Patient A's low back.

18. From on or about January 4, 2015 through December 11, 2015, Respondent maintained Patient A's medication regimen of 640 mg of OxyContin and 12.5 mg of zolpidem per day.

19. On or about May 5, 2015, Patient A complained of an exacerbation of his lower back pain and requested facet injections. The injections were planned for June 16, 2015, but were canceled when Patient A developed nausea and frequent voiding.

20. On or about July 27, 2015, Patient A's CURES[4] report was printed and placed in Respondent's medical records.

21. From on or about August 14, 2015 through August 19, 2015, Patient A was in the hospital for edema, a urinary tract infection, and anemia.

22. On or about November 12, 2015, Respondent noted that Patient A's pain management was not well controlled, as Patient A complained of chronic breakthrough pain in his feet, legs, and lower back. At this visit, Respondent documented that Patient A appeared to be drowsy which might have been a possible side effect from his pain medication. Respondent's plan was to obtain a pain management consultation.

23. On or about December 9, 2015, Patient A returned to the office and saw Respondent. He complained of fatigue and a lack of energy. Respondent noted that Patient A was taking a high dose of OxyContin and zolpidem for sleep. Patient A and his wife agreed to a consultation with a pain management specialist to consider a spinal cord stimulator or other options to get Patient A off of his pain medications.

24. On or about December 10, 2015, Patient A submitted to an MRI of the lumbar spine which showed lumbar spondylosis and indeterminable intramedullary lesions.

25. From on or about January 7, 2016 through March 6, 2016, Respondent continued to maintain Patient A's medication regimen of 640 mg of OxyContin and 12.5 mg of zolpidem per day.

26. On or about March 29, 2016, Patient A returned to the office and saw Respondent. Respondent noted that Patient A had been treated recently at the hospital for sudden onset of confusion. While at the hospital, Patient A underwent an extensive work up for a possible stroke. The treating physician at the hospital discontinued Patient A's zolpidem and decreased his OxyContin dose. Respondent gave Patient A a 30-day refill for 180 tablets of 80 mg OxyContin, enough for 480 mg per day. Respondent also ordered a referral for a pain management consultant for a spinal cord stimulator.

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[4] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies, and law enforcement.

27. On or about April 1, 2016, Patient A filled a prescription written by Respondent for 180 tablets of 80 mg OxyContin. On or about April 20, 2016, Patient A filled another prescription written by Respondent for 60 tablets of 80 mg OxyContin.

28. On or about April 28, 2016, Patient A returned to the office and saw Respondent. Respondent gave Patient A a prescription that put him back on 640 mg of OxyContin per day, in addition to 12.5 mg of zolpidem.

29. From on or about April 29, 2016 through December 27, 2016, Respondent maintained Patient A's medication regimen of 640 mg of OxyContin and 12.5 mg of zolpidem per day.

30. On or about September 13, 2016, Patient A complained of an exacerbation of arthritis symptoms causing discomfort, aching, and soreness in his joints. Respondent ordered labs to rule out polymyalgia rheumatica.

31. On or about September 22, 2016, Respondent prescribed prednisone for possible polymyalgia rheumatism.

32. From on or about January 13, 2017 through May 20, 2017, Respondent continued to maintain Patient A's medication regimen of 640 mg of OxyContin and 12.5 mg of zolpidem per day.

33. On or about April 5, 2017, Respondent noted that Patient A recently had his right great toe amputated for neuropathy with an injury that failed to heal.

34. On or about June 2, 2017, Patient A returned to the office and saw Respondent. Respondent noted that Patient A had two surgeries for his leg and toe and was taking a "huge dose" of OxyContin. Respondent also noted that Patient A ran out of his medications one week prior. Patient A had last received a refill for 240 tablets of 80 mg OxyContin on or about May 20, 2017. Respondent gave Patient A a new prescription for 5-325 mg oxycodone APAP[5] to be taken every 6 hours as needed. Respondent noted Patient A's high opiate tolerance and lack of aberrant behavior. He also documented that this new prescription was only for a short period of time.

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[5] APAP is acetaminophen. Percocet is one of the brand names for oxycodone APAP.

35. From on or about June 2, 2017 through December 31, 2017, Respondent maintained Patient A's medication regimen of 640 mg of OxyContin, 10 mg of oxycodone, and 12.5 mg of zolpidem per day.

36. On or about June 28, 2017, Patient A signed an office policy for controlled substance prescriptions. In it, Patient A agreed to take his controlled substance medications as prescribed, submit to drug tests, and not share his medications with others.

37. On or about July 28, 2017, Respondent gave Patient A a referral for an orthopedist for bilateral hip pain.

38. On or about September 19, 2017, Patient A returned to the office and saw Respondent. Respondent documented that he had a long discussion with Patient A and his wife. Respondent gave Patient A a referral to a pain management physician, M.M., M.D. He also ordered CT scans of Patient A's spine.

39. On or about September 25, 2017, Patient A's CT scan of his lumbar spine showed compression fractures, abnormal bone marrow, and mild disc disease.

40. On or about October 11, 2017, Patient A returned to the office and saw Respondent. Patient A reported that he had started seeing M.M., M.D., for pain management. Respondent learned through Patient A that M.M., M.D., had recommended that Patient A's OxyContin be gradually reduced to a minimal dose.

41. On or about November 6, 2017, Patient A returned to the office and saw Respondent. Respondent documented that Patient A remained on the same medications which "ha[d] been 100% approved by [M.M.]."

42. From on or about January 24, 2018 through June 4, 2018, Respondent maintained Patient A's medication regimen of 640 mg of OxyContin, 10 mg of oxycodone, and 12.5 mg of zolpidem per day.

43. On or about May 17, 2018, Patient A returned to the office and saw Respondent. Respondent documented that he had a long discussion with Patient A about his pain management and prior visit with M.M., M.D. Respondent noted that he repeatedly tried contacting M.M., M.D., to discuss Patient A's treatment but never got a consultant report. He wrote that M.M.,

M.D., had said he would take over prescribing OxyContin for Patient A. Ultimately, Respondent concluded that he would write M.M., M.D., another letter to request that M.M., M.D., take over Patient A's pain management.

44. From on or about June 18, 2018 through July 31, 2018, Respondent started reducing Patient A's OxyContin and oxycodone doses. On or about June 18, 2018, Patient A filled a prescription for 210 tablets of 80 mg OxyContin, or 540 mg per day. On or about July 12, 2018, Patient A filled a prescription for 30 tablets of 5-325 mg oxycodone APAP, or 5 mg per day. On or about July 16, 2018, Patient A filled a prescription for 90 tablets of 80 mg OxyContin, or 240 mg per day. Respondent failed to document these prescriptions with lowering doses in his medical records for Patient A.

45. On or about July 31, 2018, Patient A returned to the office and saw Respondent. Respondent documented that Patient A was still being treated by M.M., M.D. Patient A reported that he was experiencing withdrawal symptoms and wanted to switch pain management consultants.

46. Respondent committed gross negligence in the care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent prescribed Patient A high dose opiates for approximately five years without properly documenting the nature of Patient A's pain and the justification for such doses, consider the use of drug rotation, buprenorphine, or other long lasting agents, refer Patient A to a mental health provider, or prescribe naloxone in case of overdose even after Patient A presented twice with somnolence;

b. Respondent failed to appropriately monitor Patient A's controlled substance use through the periodic review of a prescription drug monitoring program, periodic drug testing, or screening for and arranging for treatment for opioid use disorder;

c. Respondent failed to perform periodic physical examinations on Patient A by continually re-examining the areas in which Patient A continued to report pain; and

d. Respondent failed to properly diagnose and treat Patient A's osteoporosis.

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Patient B

47. Respondent started treating Patient B, a female born in 1953, in approximately 2003 or 2004. On or about December 11, 2013 and December 13, 2013, Patient B, then 60 years old, saw Respondent in his office for leg ulcers. Respondent documented that Patient B had a history of four spinal surgeries and cubital tunnel syndrome in her right arm with weakness and deformity. Patient B last worked in February 2001.

48. From on or about January 15, 2014 through February 13, 2014, Respondent prescribed Patient B 240 mg of OxyContin and 40 mg of oxycodone (via oxycodone acetaminophen prescriptions) per day. Respondent was also prescribing Patient B 20 mg of Valium per day, although Patient B admitted on or about January 15, 2014 that she took up to 30 mg of Valium a day.

49. On or about February 13, 2014, Patient B returned to the office and saw Respondent. Patient B reported that she had discontinued Valium approximately three to four weeks prior and had not felt well since. Respondent re-started Patient B on Valium for 5 mg twice per day and refilled her OxyContin and oxycodone acetaminophen prescriptions.

50. Despite the lowered prescribed dose, Patient B filled a prescription for 180 tablets of 10 mg diazepam on or about March 8, 2014. On or about March 17, 2014, Patient B filled another prescription written by Respondent for 60 tablets of 5 mg diazepam.

51. According to Patient B's CURES report, Patient B filled a prescription written by another treatment provider, R.R., for 60 tablets of Norco[6] on or about April 14, 2014.

52. On or about April 17, 2014, Patient B returned to the office and saw Respondent. He noted that Patient B went to a spine specialist and was planning to undergo another back surgery. Respondent did not document whether Patient B was receiving any other pain medications from any other treatment providers. Respondent refilled Patient B's OxyContin prescription and increased Patient B's 325-10 mg oxycodone acetaminophen prescription to 9 tablets per day. Respondent failed to document this increased dose.

[6] Norco is the brand name for hydrocodone acetaminophen. Hydrocodone is an opioid analgesic and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

53. On or about May 12, 2014, Patient B filled a prescription written by R.R. for 60 tablets of 325-10 mg Norco.

54. On or about May 15, 2014, Patient B returned to the office and saw Respondent. Patient B reported that she was going to undergo lower back surgery soon. Respondent's documented assessment of Patient B at this visit was chronic discogenic degenerative low back pain.

55. According to Patient B's CURES report, on or about May 19, 2014, Patient B filled a prescription written by Respondent for 270 tablets of 350 mg carisoprodol.[7] Respondent failed to document this prescription in his records.

56. From on or about May 16, 2014 through December 12, 2014, Respondent gave Patient B monthly prescriptions of 90 tablets of 80 mg OxyContin, or 240 mg per day.

57. On or about June 19, 2014, Patient B returned to the office and saw Respondent. Patient B reported that she saw doctors for her workers compensation case and they recommended spine surgery. Patient B complained of severe pain in her shoulders and shoulder joints. Respondent gave Patient B injections of Kenalog[8] and Marcaine[9] in her left shoulder.

58. On or about July 5, 2014, Patient B filled a prescription written by R.R. for 90 tablets of 325-10 mg Norco.

59. On or about July 15, 2014, Patient B returned to the office and saw Respondent. She reported that with physical therapy (PT), she had improved and her surgery was postponed. Patient B complained of painful spasms in her hands. Respondent refilled her medications.

60. On or about July 16, 2014, Patient B filled a prescription written by Respondent for 270 tablets of 10-325 mg oxycodone acetaminophen. On or about August 8, 2014, Patient B filled a prescription written by Respondent for 270 tablets of 350 mg carisoprodol. On or about August 21, 2014, Patient B filled a prescription written by Respondent for 180 tablets of 5 mg diazepam.

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[7] Carisoprodol, brand name Soma, is a muscle relaxant. Potential adverse effects of Soma include sedation, confusion, weakness and dizziness. These side effects are exacerbated with the concomitant use of alcohol, benzodiazepines and opiates.

[8] Kenalog is a corticosteroid.

[9] Marcaine is a local anesthetic.

61. On or about September 15, 2014, Patient B returned to the office and saw Respondent. Patient B wanted to change her medications because OxyContin made her nauseous and Percocet was ineffective. Patient B complained of malaise, anorexia, depression, suicidal thoughts, episodes of anger, anxiety, and nausea. Respondent considered a psych follow up. He documented that he would talk to a colleague about switching Patient B's pain medications.

62. On or about a date that appears to be September 16, 2014, Respondent wrote a note documenting that Patient B had run out of her medications. Patient B had elected to stay on OxyContin and to start taking Zofran to treat her nausea. Respondent discontinued Patient B's Percocet and switched her to morphine sulfate[10] for rescue pain. He also noted that Patient B should see a therapist or psychiatrist.

63. From on or about September 17, 2014 through December 12, 2014, Respondent gave Patient B prescriptions for 15 mg of morphine sulfate per day.

64. On or about September 26, 2014, Patient B returned to the office and saw Respondent. Patient B reported that she tolerated morphine sulfate, but went back to taking Percocet. Respondent noted that Patient B did not want to change her pain medications for the time being.

65. On or about October 13, 2014, Patient B returned to the office and saw Respondent. Respondent noted that Patient B was taking OxyContin, morphine sulfate, Percocet, and diazepam.

66. On or about October 14, 2014, Patient B filled a prescription written by Respondent for 180 tablets of 5 mg diazepam. On or about October 28, 2014, Patient B filled a prescription written by Respondent for 270 tablets of 10-325 mg oxycodone acetaminophen.

67. On or about October 31, 2014, Respondent filled out DMV forms for Patient B regarding her health status. On the forms, Respondent had to list Patient B's medications. He did not document that Patient B was taking Percocet, morphine sulfate, or diazepam.

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[10] Morphine Sulfate, brand name MS Contin, is an opioid analgesic and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

68. On or about December 12, 2014, Patient B returned to the office and saw Respondent for refills. Patient B submitted to a urine drug screen, which was positive for Valium, OxyContin, and morphine sulfate. The drug screen was also positive for meprobamate,[11] which was documented as an inconsistent result. No further follow up for this inconsistent result was documented in Respondent's records.

69. On or about December 18, 2014, Patient B filled a prescription written by Respondent for 60 tablets of 5 mg diazepam.

70. On or about December 30, 2014, Patient B returned to the office and saw Respondent for refills. Patient B also complained of pain in the right side of her back. Respondent's assessment was cervical and lumbar spinal stenosis, degenerative disc disease with chronic pain, and right flank pain. He ordered labs.

71. On or about January 2, 2015, Patient B filled a prescription written by Respondent for 180 tablets of 5 mg diazepam.

72. From on or about January 12, 2015 through March 10, 2015, Respondent continued prescribe Patient B 240 mg of OxyContin per day.

73. On or about January 26, 2015, Patient B filled a prescription written by Respondent for 89 tablets of 10-325 mg oxycodone acetaminophen.

74. On or about February 9, 2015, Patient B returned to the office and saw Respondent. Respondent put Patient B on a trial of Subsys[12] to replace oxycodone. Respondent documented that Patient B's other pain medications would stay as is.

75. On or about February 23, 2015, despite the plan to replace Percocet with Subsys, Patient B filled a prescription written by Respondent for 40 tablets of 10-325 mg oxycodone acetaminophen. On or about February 25, 2015, Patient B filled a prescription written by Respondent for 180 tablets of 5 mg diazepam.

76. On or about March 1, 2015, Patient B returned to the office and saw Respondent. Patient B reported that she had a severe reaction to Subsys and she did not want to keep taking it.

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[11] Meprobamate is a metabolite of Soma.

[12] Subsys, brand name for fentanyl, is an opioid analgesic and a Schedule II controlled substance pursuant to Health and Safety Code section 11055. It is a sublingual spray.

Respondent documented that his plan was to give Patient B prescription refills in three-month increments if the drug store would permit it.

77. On or about April 8, 2015, Patient B returned to the office and saw Respondent. Patient B had discontinued Subsys and morphine sulfate. She complained of a lot of pain which woke her up at night. She also said that she was taking extra Percocet, up to four tablets per day. Patient B was given a Toradol[13] injection.

78. On or about April 19, 2015, Patient B returned to the office and saw Respondent. Respondent noted that Patient B had gotten one epidural steroid injection (ESI) in the past with some benefit, but that it had not been repeated. He also documented that Patient B's insurance no longer covered her Soma prescriptions.

79. On or about May 4, 2015, Patient B filled a prescription written by Respondent for 180 tablets of 5 mg diazepam.

80. On or about May 27, 2015, Patient B returned to the office and saw Respondent. Patient B requested stronger pain medication for acute exacerbations of her low back pain. Respondent noted that Patient B had tried Dilaudid[14] in the past with no adverse effects and that Ambien[15] was helpful for sleep. Respondent gave Patient B prescriptions for 24 tablets of 4 mg Dilaudid, 30 tablets of 5 mg Ambien, and a refill for OxyContin. He also gave Patient B a referral to a sports medicine clinic for PT.

81. From on or about May 27, 2015 through August 28, 2015, Respondent gave Patient B prescriptions for an average of 4 mg of Dilaudid per day.

82. On or about June 6, 2015, August 1, 2015, August 31, 2015, and September 29, 2015, Patient B filled prescriptions written by Respondent for 90 tablets of 80 mg OxyContin.

83. On or about July 30, 2015, Patient B returned to the office and saw Respondent. Respondent documented that Patient B was taking 1,050 mg of Soma per day, and that she was taking Percocet or Dilaudid, and that the Dilaudid was only to be used when the pain was

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[13] Toradol is a nonsteroidal anti-inflammatory drug (NSAID).

[14] Dilaudid, brand name for hydromorphone, is a narcotic and a Schedule II controlled substance pursuant to Health and Safety Code section 11055.

[15] Ambien, brand name for zolpidem tartrate, is a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

extreme. Respondent's records include a CURES report for Patient B showing her controlled substance medication history from July 30, 2014 through July 30, 2015.

84. On or about August 28, 2015, Patient B returned to the office and saw Respondent for an extended visit. Patient B was seeing another specialist for her trigger finger. She needed refills for Soma, OxyContin, and Dilaudid. Patient B requested to increase her Ambien dose from five to 10 mg.

85. On or about September 25, 2015, Patient B returned to the office and saw Respondent. Respondent documented that Patient B's pain management was stable on her current medication regimen, and that the Soma and Valium prescriptions were for muscle spasms. He also noted that, at times, Patient B increased her medications when her low back pain was exacerbated.

86. On or about September 29, 2015, Patient B filled a prescription written by Respondent for 60 tablets of 5 mg diazepam. On or about October 1, 2015, Patient B filled prescriptions written by Respondent for 120 tablets of 350 mg carisoprodol and 30 tablets of 5 mg zolpidem tartrate.

87. On or about October 28, 2015, Patient B returned to the office and saw Respondent. Patient B reported that she was experiencing profound weakness in her left thumb and grip. Respondent considered regional pain syndrome. He noted that Patient B had severe pain in her hips and pelvis and that she was significantly disabled. He documented that he gave Patient B refills for OxyContin, Percocet, and Dilaudid. Imaging taken that day of Patient B's back and left hand showed degenerative disc disease and mild osteoporosis, respectively.

88. On or about October 31, 2015, Patient B filled prescriptions written by Respondent for 90 tablets of 80 mg OxyContin and 30 tablets of 4 mg Dilaudid.

89. On or about November 23, 2015 and December 21, 2015, Patient B returned to the office and saw Respondent. At both visits, Patient B received Kenalog injections and refills for her medications.

90. On or about January 19, 2016, Patient B returned to the office and saw Respondent. Patient B had been "experimenting" with her medications. She wanted to discontinue Dilaudid

and Ambien and increase OxyContin from 240 to 320 mg per day. She also wanted back injections. Respondent noted that she wanted to continue receiving her prescription for 360 tablets of Percocet. He noted that Patient B was reluctant to see a pain management specialist.

91. On or about February 13, 2016, Patient B filled a prescription written by Respondent for 120 tablets of 350 mg carisoprodol.

92. On or about March 31, 2016, Patient B filled a prescription written by Respondent for 60 tablets of 1 mg clonazepam.[16] Respondent's records do not reflect this new prescription.

93. On or about May 17, 2016, Patient B returned to the office and saw Respondent. Patient B was given a Toradol injection.

94. On or about May 17, 2016, Patient B filled a prescription written by another treatment provider, D.K., for 60 tablets of 1 mg clonazepam.

95. In an undated note, Respondent documented that Patient B had returned to the office. Patient B reported that her house had burned down 10 days prior. Patient B was overwhelmed and needed refills for all of her medications. She told Respondent that she was taking more of her pain medications because of her increased activity due to the fire.

96. On or about August 10, 2016, Patient B returned to the office and saw Respondent. She requested prescriptions for Dilaudid, MS Contin, and Soma.

97. On or about August 22, 2016, Patient B returned to the office and saw Respondent. She was confused about her medications and what refills she needed. Respondent documented that Patient B was temporarily given Dilaudid when her house burned down and she did not have access to her normal medications. Respondent's plan was to get Patient B off of her pain medications and to refer her to a pain management specialist. Respondent's records include a printout of Patient B's CURES on or about the same date.

98. On or about September 8, 2016, Patient B returned to the office and saw Respondent. Once again, Patient B was confused and thought she needed refills. Respondent noted that the refills were already ready at the pharmacy.

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[16] Clonazepam is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057.

99. On or about October 5, 2016, Patient B returned to the office and saw Respondent. Respondent documented that they discussed Patient B's pain and anti-anxiety medications and the possibility of an accidental overdose. Respondent noted that Patient B had no support systems and her house had burned down. Patient B reported that she occasionally had suicidal thoughts, but declined therapy or a psychiatrist.

100. On or about January 3, 2017, Patient B returned to the office and saw Respondent for refills. Respondent noted that Patient B was depressed and that she ran out of oxycodone. She received a Toradol injection. Respondent wrote that Patient B would be referred to a pain management specialist for better pain management "as she takes a large amount of current meds including Soma as well."

101. On or about January 5, 2017, a CT of Patient B's lumbar spine showed a disc bulge with spurring and moderate to severe bilateral foraminal stenosis.

102. On or about January 18, 2017, Patient B returned to the office and saw Respondent. Respondent noted Patient B's high doses of medications and wrote that she was to see the pain management specialist. Respondent's plan was to discontinue Patient B's pain medications.

103. On or about January 18, 2017, Patient B filled prescriptions written by Respondent for 120 tablets of 10-325 mg oxycodone acetaminophen and 120 tablets of 350 mg carisoprodol.

104. On or about January 31, 2017, Patient B filled a prescription written by Respondent for 60 tablets of 1 mg clonazepam. On or about February 3, 2017, Patient B filled a prescription written by Respondent for 120 tablets of 80 mg OxyContin. On or about February 16, 2017, Patient B filled a prescription written by Respondent for 120 tablets of 350 mg Soma. On or about February 17, 2017, Patient B filled a prescription written by Respondent for 90 tablets of 10-325 mg oxycodone acetaminophen.

105. On or about March 9, 2017, Patient B returned to the office and saw Respondent for refills. Respondent noted that Patient B was on long- and short-acting narcotics for pain control, and that she could not change her current regimen. He documented that he counseled Patient B about decreasing her medications.

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106. From on or about March 9, 2017 through May 13, 2017, Respondent maintained Patient B's medication regimen of an average of 320 mg of OxyContin, 2 mg of clonazepam, 30 mg of oxycodone, and 1,400 mg of Soma per day.

107. On or about April 6, 2017 and May 4, 2017, Patient B returned to the office and saw Respondent. She reported that she had been using cannabidiol for pain management which was helpful, but that she still needed her other medications.

108. On or about June 1, 2017, Patient B asked for additional oxycodone to take while she was moving into her newly rebuilt house. On or about the same day, Respondent documented that he had a discussion about the amount of medication that Patient B was taking.

109. On or about June 1, 2017, Patient B filled prescriptions written by Respondent for 120 tablets of 80 mg OxyContin and 60 tablets of 1 mg clonazepam. On or about June 19, 2017, Patient B filled a prescription written by Respondent for 120 tablets of 10-325 mg oxycodone acetaminophen.

110. On or about August 1, 2017, Respondent wrote a letter to Patient B dismissing her from his practice. According to Respondent, Patient B sent a neighbor to the office who caused a scene in the waiting room. The neighbor claimed that Respondent was not providing Patient B with enough medication.

111. Respondent committed gross negligence in the care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent prescribed Patient B high doses of opiates from 2013 to 2017 with minimal medical justification, little to no consideration of alternative therapies, and little to no follow up after issuing referrals to pain management specialists or PT. Respondent failed to screen Patient B for opioid use disorder or give her a prescription for naloxone;

b. Respondent prescribed Patient B a combination of benzodiazepines and opiates with little to no documentation justifying the long-term use of benzodiazepines or documentation of any discussion of the risks of side effects, sedation, addiction, or accidental overdose; and

c. Respondent failed to perform periodic physical examinations on Patient B by continually re-examining the areas in which Patient B continued to report pain.

Patient C

112. As of October 2019, Respondent had been treating Patient C for approximately 20 years. On or about December 16, 2013, Respondent was prescribing Patient C, then a 53 year-old male, 180 mg of OxyContin, 60 mg of oxycodone, and 700 mg of Soma per day. Respondent documented that Patient C had chronic back pain, hypertension, and hyperlipidemia.

113. From on or about January 13, 2014 to June 24, 2014, Respondent maintained Patient C's medication regimen of 180 mg of OxyContin, 60 mg of oxycodone, and 700 mg of Soma per day.

114. On or about April 7, 2014, Respondent spoke to Patient C about his chronic low back pain. Patient C did not want to explore surgical options to treat his low back pain. Respondent noted that Patient C had tried ESIs and PT in the past with brief benefits.

115. On or about June 24, 2014, Patient C told Respondent that his pain medications were helping, but were less effective than they used to be. Patient C wanted to reduce his medications. Respondent's plan was to discuss alternative treatments when Patient C returned from a trip.

116. On or about July 29, 2014, Patient C and his wife returned to the office and saw Respondent. Patient C's wife reported that Patient C's breakthrough pain was worse and more frequent. She also told Respondent that her husband had finished his monthly Soma medication 10 days early, and that she wanted him to stop taking Soma and take an increased amount of oxycodone. In his medical records, Respondent wrote, "[l]ogically, one should [increase] OxyContin dose if his breakthru [sic] is so frequent but p[atien]t used to take 80 mg dose + does not wish to resume it. Instead [discontinue] Soma and [increase] oxycodone 15 [mg] to 1 q4h prn 180 [and] oxycontin 60 ... tid."

117. On or about August 26, 2014, Patient C returned to the office and saw Respondent. Patient C reported that he was taking between 60 to 90 mg of oxycodone per day. Respondent changed Patient C's monthly oxycodone prescription to 120 20 mg tablets, or 80 mg per day.

118. From on or about August 26, 2014 through June 2, 2015, Respondent maintained Patient C's medication regimen of 180 mg of OxyContin, 80 mg of oxycodone, and 700 mg of Soma per day.

119. On or about September 23, 2014, Patient C returned to the office and saw Respondent. Respondent documented that Patient C had sciatic nerve pain and symptoms of degenerative disc disease (DDD).

120. On or about February 10, 2015, Patient C submitted to a urine drug screen which was consistent with his medications.

121. On or about June 2, 2015, Patient C returned to the office and saw Respondent. Patient C reported an acute exacerbation of his low back pain with no specific cause. Respondent's treatment plan included a trial of Medrol[17] and an MRI.

122. On or about June 3, 2015, Patient C's MRI showed disc bulges.

123. On or about June 12, 2015, Patient C returned to the office and saw Respondent. Patient C had continued severe lower back pain. Respondent noted that the MRI showed DDD and nerve root impingement. His plan was to consult an outside physician.

124. From on or about June 17, 2015 through July 28, 2015, Patient C filled prescriptions written by Respondent averaging 180 mg of OxyContin, 120 mg of oxycodone, and 700 mg of Soma per day.

125. From on or about August 25, 2015 through July 26, 2016, Respondent maintained Patient C's medication regimen of 180 mg of OxyContin, 80 mg of oxycodone, and 700 mg of Soma per day.

126. On or about January 12, 2016, Patient C submitted to a urine drug screen which was consistent with his prescribed medications.

127. On or about May 31, 2016, Patient C returned to the office and saw Respondent. Respondent documented that Patient C had symptoms of degenerative joint disease (DJD) at the base of his thumbs.

128. On or about August 23, 2016, Patient C returned to the office and saw Respondent. Respondent put Patient C on a trial of Celebrex[18] to treat the DJD in his finger joints.

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[17] Medrol, brand name for methylprednisolone, is a steroid that treats inflammation.
[18] Celebrex is a NSAID.

129. From on or about August 23, 2016 through January 9, 2017, Respondent maintained Patient C on a medication regimen of an average of 180 mg of OxyContin, 93 mg of oxycodone, and 700 mg of Soma per day.

130. On or about January 9, 2017, Patient C returned to the office and saw Respondent. Respondent noted that Patient C had several consultations with specialists for his low back pain in the past and that no further surgery was recommended or desired. He also noted that he would discuss the "MS equivalents required by DEA now" with a colleague.

131. On or about the same date, Patient C submitted to a urine drug screen. The results were inconsistent in that there was a negative result for Soma. Respondent failed to address or document this inconsistent drug screen with Patient C.

132. On or about February 6, 2017, Patient C returned to the office and saw Respondent. Respondent noted that "[Patient C] is on higher MS equivalents than is recommended." Respondent's plan was for Patient C to decrease his OxyContin to 120 mg per day, and to start decreasing his oxycodone as well. Respondent still gave Patient C prescriptions for 180 mg of OxyContin, 80 mg of oxycodone, and 700 mg of Soma per day.

133. On or about March 6, 2017, Patient C returned to the office and saw Respondent. The plan was for Patient C to reduce his OxyContin dose to 80 mg per day and to continue to decrease his oxycodone use.

134. Despite Respondent's directions to reduce Patient C's medication use, from on or about March 6, 2017 through July 24, 2017, Respondent continued to prescribe Patient C enough pain medications to take approximately 180 mg of OxyContin and 93 mg of oxycodone per day. From on or about March 6, 2017, Respondent also maintained Patient C on 700 mg of Soma per day until approximately May 1, 2017, when he increased Patient C's dose to 1,050 mg per day.

135. On or about August 18, 2017, Patient C returned to the office and saw Respondent. Respondent documented that he had a "discussion at length" with Patient C about his pain medications. He recommended that Patient C discontinue his long-acting opiate. Respondent's plan was for Patient C to reduce his OxyContin dose from 180 to 120 mg. His plan also allowed Patient C to increase his oxycodone dose up to 90 mg per day.

136. On or about September 14, 2017, Patient C returned to the office and saw Respondent. Patient C asked to change his OxyContin from 60 to 40 mg tablets. Respondent agreed to this request, and Patient C continued to take 120 mg of OxyContin per day.

137. From or about September 14, 2017 through April 17, 2018, Respondent maintained Patient C's medications of 120 mg of OxyContin, 120 mg of oxycodone, and 1,050 mg of Soma per day.

138. On or about December 6, 2017, Patient C returned to the office and saw Respondent. Respondent noted that his plan was to refer Patient C to M.M., M.D., a pain management specialist.

139. On or about January 30, 2018, Patient C returned to the office and saw Respondent. Respondent documented that M.M., M.D., did not take Patient C's insurance.

140. On or about February 27, 2018, Patient C submitted to a urine drug screen. The results were inconsistent with Patient C's prescribed medications, showing that the sample was negative for Soma or its metabolite. Respondent failed to either address or document that he addressed this discrepancy with Patient C.

141. On or about May 15, 2018, Patient C returned to the office and saw Respondent. Respondent documented that he spoke to Patient C at length about his medication use. Respondent gave Patient C a referral for another pain management specialist, Dr. S., and decreased his oxycodone to a maximum of 80 mg per day.

142. From on or about May 18, 2018 through October 1, 2018, Respondent maintained Patient C's medication regimen of 120 mg of OxyContin, 80 mg of oxycodone, and 1,050 mg of Soma.

143. On or about July 10, 2018, Patient C returned to the office and saw Respondent. Respondent documented that he had another long discussion with Patient C about his pain medications. Respondent noted that Patient C was agitated and probably experiencing some withdrawal symptoms and low back pain. Respondent's plan was to write to another pain management specialist, Dr. W., to see if he would take over Patient C's pain management care.

144. On or about August 7, 2018, Patient C returned to the office and saw Respondent. Respondent noted that Patient C had run out of his pain medications early.

145. On or about September 4, 2018, Patient C told Respondent that he had scheduled an appointment with Dr. W.

146. On or about October 1, 2018, Patient C signed a form detailing Respondent's office's policy for controlled substance prescriptions.

147. On or about October 5, 2018, Patient C submitted to a urine drug screen which was inconsistent in that no Soma or its metabolites were detected.

148. Respondent committed gross negligence in the care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent failed to appropriately monitor Patient C's controlled substance use through the periodic review of a prescription drug monitoring program, periodic drug testing, or screening and arranging for treatment for opioid use disorder;

b. Respondent failed to correctly interpret Patient C's urine drug test results and failed to address the inconsistent results with Patient C in the records; and

c. Respondent documented minimal physical examinations in Patient C's medical records.

Patient D

149. As of October 2019, Respondent had been treating Patient D for approximately 30 years. On or about November 1, 2013, Respondent was prescribing Patient D, then a 54 year-old female, an average of 120 mg of methadone[19] and 2.33 mg of alprazolam[20] per day. Respondent diagnosed Patient D with chronic degenerative arthritis, disc disease, and anxiety disorder.

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[19] Methadone is an opioid agonist and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c).

[20] Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

150. From on or about December 27, 2013 through January 24, 2014, Respondent maintained Patient D's medication regimen of 120 mg of methadone and 2.33 mg of alprazolam per day.

151. On or about March 21, 2014, Patient D returned to the office and saw Respondent. Respondent noted that Patient D was trying to reduce her methadone intake.

152. On or about April 7, 2014, Patient D returned to the office and saw Respondent. Respondent noted that Patient D was "very disabled with chronic pain," even with her current medications.

153. On or about April 17, 2014, Patient D filled prescriptions written by Respondent for 340 tablets of 10 mg methadone and 140 tablets of 0.5 mg alprazolam.

154. On or about May 15, 2014, Patient D returned to the office and saw Respondent. Respondent noted that Patient D had tried epidural steroids, PT, and other treatments before resorting to pain medications. He also documented that in the past, Patient D was supposed to have disc replacement surgery, but never followed through.

155. On or about May 20, 2014, an MRI of Patient D's lumbar spine showed that she had mild degenerative disc disease and mild facet arthropathy.

156. On or about May 27, 2014, Patient D returned to the office and saw Respondent. Respondent noted the "unremarkable" MRI, and wrote that it was "difficult to see where all [Patient D's] pain was from and [the] need for these very high methadone doses." His plan was to review and compare the newest MRI with prior studies and get a re-evaluation from a neurosurgeon.

157. From on or about June 9, 2014 through October 28, 2015, Respondent increased Patient D's methadone dose. During this time, Patient D's medication regimen went back to 120 mg of methadone and 2.33 mg of alprazolam per day.

158. On or about January 12, 2015, Patient D returned to the office and saw Respondent. Respondent's plan was to conduct an EKG to monitor for adverse affects from long-term methadone use and to do a urine drug screen at the next visit. Respondent eventually ordered the

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EKG which took place on or about October 28, 2015. Patient D finally submitted to a urine drug screen on or about December 19, 2016.

159. On or about November 9, 2015, Patient D returned to the office and saw Respondent. Respondent documented that Patient D's pain management was discussed and her medications were refilled.

160. From on or about November 11, 2015 through November 9, 2016, Respondent maintained Patient D's medication regimen of 120 mg of methadone and 2.5 mg of alprazolam per day. Respondent failed to document the reasons for increasing Patient D's alprazolam dose.

161. On or about January 4, 2016, Patient D returned to the clinic and saw Respondent. Respondent wrote that he counseled Patient D on reducing her pain medications. He continued prescribing enough medications so that Patient D could continue taking 120 mg of methadone and 2.5 mg of alprazolam daily.

162. On or about February 29, 2016, Patient D returned to the clinic and saw Respondent. Respondent wrote that he discussed alternatives to pain medications with Patient D, including a spinal cord stimulator.

163. On or about March 28, 2016, Patient D returned to the office and saw Respondent. Respondent documented that he spoke to Patient D about her medications. He noted that Patient D used alprazolam to prevent panic attacks. He also documented that PT was not helpful to Patient D in the past.

164. On or about August 19, 2016, a CURES report for Patient D was printed and placed in Respondent's medical records.

165. On or about October 17, 2016, Patient D returned to the office and saw Respondent. Respondent documented another discussion with Patient D about her medications. He wrote that he spoke to Dr. L., a colleague, about the new guidelines from the Drug Enforcement Administration (DEA) and the Medical Board about morphine equivalents. Despite all of this, Respondent gave Patient D refills of her pain medications, maintaining the same doses.

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166. On or about November 21, 2016 and December 2, 2016, Patient D filled prescriptions for 150 tablets of 0.5 mg alprazolam and 360 tablets of 10 mg methadone from another treatment provider.

167. On or about December 5, 2016, an updated CURES report for Patient D was printed and placed in Respondent's medical records. This CURES report showed the prescriptions from another treatment provider referenced in paragraph 164, above. A note saying, "red flag" was written on the CURES report.

168. On or about December 19, 2016, Patient D returned to the office and saw Respondent's colleague, R.L, M.D. R.L., M.D., wrote that he did not feel comfortable providing Patient D with such a high dose of methadone, and that Patient D needed to be worked up by a pain management specialist. He gave her a referral to Dr. V., a pain management specialist, and a prescription for 30 tablets of 0.5 mg alprazolam. R.L., M.D., also noted that he spoke to Patient D about early refills and pain management guidelines.

169. On or about December 19, 2016, Patient D submitted to a urine drug screen which was consistent with the medications she was prescribed.

170. On or about January 5, 2017, Patient D returned to the office and saw Respondent. He noted that R.L., M.D., had reduced Patient D's medications. Patient D complained of increased anxiety and low back pain. Respondent's plan was to continue the decreased doses of the medications, prescribing 40 mg of methadone and 1 mg of alprazolam per day. He also gave Patient D a prescription for sertraline[21] to treat Patient D's anxiety.

171. On or about January 6, 2017, consistent with Respondent's plan, Patient D filled prescriptions for 120 tablets of 10 mg methadone and 60 tablets of 0.5 mg alprazolam.

172. On or about January 15, 2017, Respondent administered a peripheral nerve block on Patient D.

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[21] Sertraline, brand name Zoloft, is a selective serotonin reuptake inhibitor (SSRI) and an anti-depressant.

173. On or about January 25, 2017, Patient D returned to the office and saw Respondent. Patient D complained of right shoulder pain. Respondent increased her medications to 60 mg of methadone and 1.5 mg of alprazolam per day.

174. On or about February 22, 2017, Patient D returned to the office and saw Respondent. Respondent documented that Patient D had stopped taking escitalopram[22] because she had read that it was not be taken with methadone.

175. From on or about February 24, 2017 through April 21, 2017, Respondent continued Patient D's medication regimen of 60 mg of methadone and 1.5 mg of alprazolam per day.

176. On or about April 20, 2017, Patient D returned to the office and saw Respondent. Respondent documented that Patient D had tried SSRIs and other medications for anxiety in the past, but that none have worked.

177. On or about May 8, 2017, Patient D signed a controlled substances agreement.

178. On or about May 18, 2017, Patient D signed a copy of Respondent's office's policies on controlled substance prescriptions.

179. On or about June 15, 2017, Patient D returned to the office and saw Respondent. Respondent documented that he talked to Patient D about her pain medications. His plan was to refer Patient D to a pain management specialist.

180. On or about July 13, 2017, Patient D returned to the office and saw Respondent. Patient D requested and Respondent agreed to increase her methadone dose.

181. From on or about July 14, 2017 through May 16, 2018, Respondent maintained Patient D's medication regimen of 70 mg of methadone and 1.5 mg of alprazolam per day.

182. On or about September 8, 2017, Patient D returned to the office and saw Respondent. Respondent documented that he had a "long discussion" with Patient D about her medications, specifically about taking methadone and alprazolam at the same time. Patient D referred to new DEA regulations about opiate dosing.

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[22] Escitalopram, brand name Lexapro, is an SSRI and an anti-depressant. It appears that Respondent was referring to the sertraline prescription he previously gave Patient D.

183. On or about October 6, 2017, Patient D returned to the office and saw Respondent. Respondent noted that "[Patient D] remains aware of her higher needs for pain meds than is accepted and that benzodiazepines [and opiates] are a high risk combination…."

184. On or about December 1, 2017, Patient D returned to the office and saw Respondent. Respondent documented that Patient D was trying to decrease her medication use.

185. On or about December 29, 2017, Patient D returned to the office and saw Respondent. Patient D reported that she was taking approximately 50 to 70 mg of methadone per day. Respondent gave her a referral for M.M., M.D., a pain management specialist.

186. On or about February 23, 2018, Patient D returned to the office and saw Respondent. Patient D said that she could not see M.M., M.D., because it was too expensive. Respondent gave Patient D a referral to another pain management specialist, Dr. A.

187. On or about March 22, 2018, Patient D returned to the office and saw Respondent. Patient D reported that she scheduled an appointment with Dr. A. for the following week. Respondent ordered a lumbar spine MRI in preparation for that appointment.

188. On or about April 19, 2018, Patient D returned to the office and saw Respondent. Respondent noted that Patient D's "morphine equivalents are way higher than is acceptable." Patient D said she was having issues scheduling an appointment with Dr. A. Respondent also noted that it was a bad time to change Patient D's medication regimen because her father had just died.

189. On or about May 2, 2018, Patient D returned to the office and saw Respondent. Respondent gave Patient D facet injections.

190. On or about June 7, 2018, Patient D returned to the office and saw Respondent. Patient D did not get any pain relief from the previous facet injections, and she was unable to see M.M., M.D., for pain management because she was traveling. Respondent's plan was to try other anti-depressants to manage Patient D's anxiety.

191. From on or about June 11, 2018 through July 13, 2018, Patient D continued to take an average of 70 mg of methadone per day. There were no new prescriptions for alprazolam after May 16, 2018.

192. On or about July 13, 2018, Respondent noted that he would write a letter to Dr. W. to request that he take over Patient D's pain management.

193. On or about August 10, 2018, Patient D returned to the office and saw Respondent. Patient D complained of aggravated back pain. Respondent told her that he could not keep prescribing her methadone at the current dose. He gave her a 30-day supply to take 50 mg of methadone per day.

194. On or about September 6, 2018, Patient D returned to the office and saw Respondent. Patient D reported that she was having a difficult time since she reduced her methadone dose by two tablets. Respondent noted that he had written a letter to Dr. W. asking that he take over Patient D's care and that Dr. W. had asked for additional medical records from Respondent.

195. On or about September 7, 2018, Patient D's insurance authorized an appointment with Dr. W.

196. On or about October 5, 2018, Patient D returned to the office and saw Respondent. Patient D reported that she was unable to make an appointment with Dr. W. Patient D had also changed insurance plans and her new insurance did not cover Dr. W. Respondent would have to find a new pain management specialist.

197. From on or about November 2, 2018 through January 17, 2019, Respondent maintained Patient D's medication regimen of 50 mg of methadone per day.

198. On or about November 2, 2018, Patient D returned to the office and saw Respondent. Respondent gave Patient D a referral for S.T., M.D., who took Patient D's insurance. Respondent noted that Patient D had been weaned off alprazolam, but that she was still experiencing anxiety. Respondent's plan was for another trial of sertraline.

199. On or about November 29, 2018, Patient D returned to the office and saw Respondent. Patient D reported that she had not seen S.T., M.D., yet. Respondent documented that he spoke to Patient D about "how inappropriate the federal and state authorities have issued a blanket policy on pain management when every day pain is an individual case."

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200. On or about February 22, 2019, Patient D returned to the office and saw Respondent. Patient D told Respondent she was not happy with the treatment she was receiving from S.T., M.D.

201. Respondent committed gross negligence in the care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent prescribed between 50 to 120 mg of methadone to Patient D from 2012 to 2019 without any clear indication justifying opiate therapy. Respondent failed to screen Patient D for opioid use disorder or consider alternative drug therapies; and

b. Respondent documented little to no evidence of physical examinations performed in Patient D's medical records.

Patient E

202. Respondent began treating Patient E when he was approximately 18 years old. Patient E was the son of Respondent's long-time receptionist. On or about January 20, 2014, when Patient E was 38 years-old, Respondent was treating Patient E for nodules in his lower back. Respondent's records include a note from December 2011 from B.L., M.D., an orthopedist, who performed a right shoulder arthroscopy, debridement, biceps tenotomy, and subacromial bursectomy.

203. From on or about March 6, 2014 through September 23, 2014, Respondent was treating Patient E for right shoulder pain and left shoulder tendinitis. Respondent prescribed Percocet for the pain, and Respondent tried injecting Patient E's left shoulder with Kenalog to treat tendinitis. On or about September 23, 2014, Respondent documented that Patient E was supposed to have shoulder surgery but it was delayed because of his employment.

204. On or about October 22, 2014 and December 5, 2014, Patient E filled prescriptions written by Respondent for 60 tablets of 325-5 mg oxycodone acetaminophen.

205. Patient E's CURES report shows that on or about January 13, 2015, Patient E filled a prescription for 65 tablets of oxycodone acetaminophen, which was written by B.L., M.D. On or about January 23, 2015, Patient E filled another prescription written by B.L., M.D., for 50 tablets of 10-325 mg oxycodone acetaminophen.

206. From on or about January 28, 2015 through November 25, 2015, Patient E filled controlled substance prescriptions from both Respondent and B.L., M.D., for oxycodone acetaminophen, Ambien, and acetaminophen/codeine.[23] Respondent's records do not reference any of the prescriptions written by B.L., M.D.

207. On or about May 26, 2015, Patient E told Respondent that he was taking between two to three Percocet per day.

208. On or about July 28, 2015, Respondent noted that Patient E was "using very few pain meds now."

209. On or about January 29, 2016, Patient E told Respondent that he was seeing Dr. V., a pain management specialist, for his chronic shoulder pain. Respondent documented that Patient E wanted to stop taking his chronic pain medications. On or about the same day, Patient E filled a prescription written by Respondent for 120 tablets of oxycodone acetaminophen.

210. From on or about April 1, 2016 through July 22, 2016, Respondent continued Patient E's medication regimen, providing prescriptions for Patient E to take an average of four tablets of 10-325 mg oxycodone acetaminophen per day.

211. On or about August 11, 2016, Respondent received a letter from Patient E's insurance inquiring about Patient E's continued use of Percocet.

212. On or about August 24, 2016, Patient E told Respondent that he did not want to continue taking Percocet in the long-term, but that he did not want to submit to a spinal cord procedure suggested by Dr. V. Respondent increased Patient E's prescription to 180 tablets of oxycodone acetaminophen, for an average of six tablets per day. Respondent also documented that this increased prescription was only going to be given once.

213. On or about August 24, 2016, October 23, 2016, November 30, 2016, December 30, 2016, January 26, 2017, February 28, 2017, March 2, 2017, April 6, 2017, May 1, 2017, May 23, 2017, and June 22, 2017, Patient E filled prescriptions written by Respondent for 180 tablets of oxycodone acetaminophen.

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[23] Codeine is a opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

214. From on or about April 20, 2017 through May 16, 2017, Respondent was treating Patient E for leg pain, weakness, and numbness.

215. On or about July 14, 2017, Patient E submitted to a urine drug screen which was positive for Percocet. On or about the same day, Patient E filled a prescription for 120 tablets of oxycodone acetaminophen which was written by R.L., M.D.

216. On or about July 20, 2017, a neurologist examined Patient E and recommended further studies.

217. On or about July 28, 2017, Patient E saw Respondent in the office. Respondent noted that Patient E was going to find a new primary care provider based on an existing conflict of interest.

218. Respondent committed gross negligence in the care and treatment of Patient E which includes, but is not limited to, the following:

a. Over approximately three years, Respondent prescribed escalating doses of oxycodone to Patient E for shoulder pain without considering or trying alternative therapies including anti-inflammatories, PT, topical agents, or lower potency opiates;

b. Respondent failed to appropriately monitor Patient E's controlled substance use through a written pain agreement, repeated and periodic review of CURES, or urine drug screens; and

c. Respondent failed to perform periodic physical examinations or adequately document specific findings from the physical examinations that were done.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

219. Respondent has further subjected his Physician's and Surgeon's Certificate No. A39051 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 hereafter:

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Patient A

220. Respondent committed repeated negligent acts in the care and treatment of Patient A which includes, but is not limited to, the following:

a. Paragraphs 8 through 46, above, are hereby incorporated by reference and re-alleged as if fully set forth herein; and

b. Respondent failed to maintain adequate and accurate documentation.

Patient B

221. Respondent committed repeated negligent acts in the care and treatment of Patient B which includes, but is not limited to, the following:

a. Paragraphs 47 through 111, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent failed to appropriately monitor Patient B's controlled substance use. Respondent ordered only one urine drug screen in a four-year period, failed to address the inconsistent results from this test with Patient B, and failed to screen Patient B for opioid use disorder despite exhibiting warning signs;

c. Respondent treated Patient B with Subsys based, in part, of a recommendation from a non-clinician drug representative, and allowed this drug representative to supervise this treatment;

d. For over four years, Respondent prescribed Soma to Patient B for spasm although no spasm was ever documented on examination. Respondent also prescribed Soma in combination with high doses of opiates and failed to document any discussion with Patient B regarding the risks of taking the medication; and

e. Respondent failed to maintain adequate and accurate documentation.

Patient C

222. Respondent committed repeated negligent acts in the care and treatment of Patient C which includes, but is not limited to, the following:

a. Paragraphs 112 through 148, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent prescribed high doses of opiates to Patient C for approximately four years for chronic back pain, mild disc disease, and degenerative changes of the spine. Respondent failed to document any consideration of alternative treatment modalities including PT, a surgical consultation, lower potency opiates, gabapentin, topical NSAIDs, or more aggressive weight loss efforts;

c. Respondent prescribed Soma to Patient C for approximately four years without any documented consideration of alternative treatment (including cyclobenzaprine) or counseling regarding the risks and side effects; and

d. Respondent failed to maintain adequate and accurate documentation.

Patient D

223. Respondent committed repeated negligent acts in the care and treatment of Patient D which includes, but is not limited to, the following:

a. Paragraphs 149 through 201, above, are hereby incorporated by reference and re-alleged as if fully set forth herein;

b. Respondent failed to appropriately monitor Patient D's controlled substance use through urine drug screens, screen for opioid use disorder, or address methadone and alprazolam prescriptions from another treatment provider;

c. Respondent continued to prescribe a combination of opiate and benzodiazepines to Patient D for seven years without insisting that Patient D see a psychiatrist; and

d. Respondent failed to maintain adequate and accurate documentation.

Patient E

224. Respondent committed repeated negligent acts in the care and treatment of Patient E which includes, but is not limited to, the following:

a. Paragraphs 202 through 218, above, are hereby incorporated by reference and re-alleged as if fully set forth herein; and

b. Respondent failed to maintain adequate and accurate documentation.

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THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

225. Respondent has further subjected his Physician's and Surgeon's Certificate No. A39051 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records for Patients A, B, C, D, and E, as more particularly alleged in paragraphs 8 to 224, above, which are hereby incorporated by reference and re-alleged 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 No. A39051, issued to Respondent John Geoffrey Lockie, M.D.;

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

3. Ordering Respondent John Geoffrey Lockie, 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: JUL 30 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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