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

In the Matter of the First Amended Accusation Against: **Patricia Jeh-Yee Chang, M.D.** Physician's & Surgeon's Certificate No. G 76535 Petitioner.	Case No. 800-2016-023076

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Thomas F. McAndrews, Esq., attorney for Patricia Jeh-Yee Chang, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on April 26, 2021.

IT IS SO ORDERED: April 26, 2021.

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

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

In the Matter of the First Amended Accusation Against: **Patricia Jeh-Yee Chang, M.D.** Physician's & Surgeon's Certificate No. G 76535 Respondent.	Case No. 800-2016-023076 **ORDER GRANTING STAY** (Government Code Section 11521)

Thomas F. McAndrews, Esq., on behalf of respondent, Patricia Jeh-Yee Chang, has filed a Request for Stay of execution of the Decision in this matter with an effective date of April 16, 2021, at 5:00 p.m..

Execution is stayed until April 26, 2021, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: April 14, 2021

William Prasifka
Executive Director
Medical Board of California

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

In the Matter of the First Amended Accusation Against: **Patricia Jeh-Yee Chang, M.D.** **Physician's and Surgeon's Certificate No. G 76535** **Respondent.**	**Case No. 800-2016-023076**

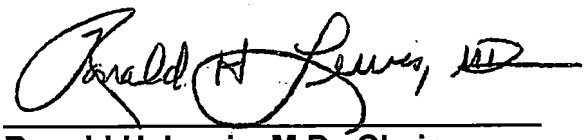
DECISION

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

This Decision shall become effective at 5:00 p.m. on April 16, 2021.

IT IS SO ORDERED: March 18, 2021.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the First Amended Accusation Against:

PATRICIA JEH-YEE CHANG, M.D., Respondent

Physician and Surgeon's License Number G-76535

MBOC Case No. 800-2016-023076

OAH No. 2019081071

PROPOSED DECISION

Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by telephone and video conference on July 13 through July 17, 2020.

Tan N. Tran, Deputy Attorney General, represented Complainant Christine J. Lalley, by telephone.

Respondent Patricia Jeh-Yee Chang, M.D., was represented by Thomas F. McAndrews, Reback, McAndrews and Kifir. Both were present and participated by video conference on all hearing days.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on July 17, 2020.

The parties each moved for a protective order, to seal the exhibits to protect the privacy of Respondent's patients and their families. There being no practical way to redact the exhibits, which were voluminous, all the exhibits will be sealed. A separate protective order will issue.

SUMMARY AND STATEMENT OF THE CASE

This matter pertains to Respondent's care and treatment of five patients, between 2013 and 2016, excepting Patient 3, who treated with Respondent until May 2017. Complainant alleges Respondent's record keeping was inadequate for each of the five patients, an allegation that Respondent did not dispute.

Complainant also alleges repeated negligent acts by Respondent, some being alleged as gross negligence. The bulk of those claims are focused on Respondent's prescribing of controlled substances, primarily pain medications, but other controlled substances as well. As to the prescription of controlled substances, Complainant alleges that as to three of the patients, Respondent is subject to discipline for excessive prescribing, and/or for prescribing to an addict.

Respondent adduced evidence her care and treatment was within the standard of care for the relevant time period. She also established she has taken and successfully completed the courses in Medical Record Keeping and Medical Prescribing Practices offered by the University of California, San Diego (UCSD), Medical School, through its PACE program.

Complainant has prevailed on some claims, such that an order placing Respondent's license on probation is appropriate for protection of the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. Complainant filed and maintained the First Amended Accusation (FAA) while acting in her official capacity as Interim Executive Officer of the Medical Board of California (Board).[1] Her predecessor and successor Executive Officers acted in their official capacity as well.

2. Respondent holds Physician's and Surgeon's certificate number G76535. It was first issued to her in May 1993 and is due to expire on February 28, 2021. Respondent's certificate was unencumbered during the time period relevant to this case.

3. The Accusation was filed in April 2019. After it was served on Respondent, she filed a Notice of Defense. This proceeding ensued, all jurisdictional requirements having been met. Pursuant to Government Code, section 11507, Respondent is deemed to deny the allegations of the FAA.

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[1] The original Accusation was filed by Kimberly Kirchmeyer, then the Executive Director of the Board. William Prasifka became the Executive Director after Ms. Lalley filed the FAA.

Respondent's Background, Experience, and Practice

4. Respondent practices internal medicine, and during the times relevant to this case was practicing on the west side of Los Angeles, in the area known as Century City. She is board certified in internal medicine.

5. Respondent attended UCLA as an undergraduate, and she received her medical degree from that university in 1991. She was an intern and resident at UCLA-affiliated St. Mary's Hospital in Long Beach. From 1994 to 1997 she practiced with Health Care Partners, working as a primary care physician, treating adolescents, seniors, and those in between. Thereafter, Respondent practiced primary care with two groups in Long Beach, and in 1999 opened a solo practice. In 2011, Respondent went to work with an oncology group which specialized in prostate cancer. Though not an oncologist, the group wanted her internal medical skills to augment and support their practice. About 20 percent of the patients had high narcotics use. After working with the oncology group for approximately two years, Respondent left that practice and began an association with Century City Primary Care, LLC. She worked for that group, labelled sometimes in the record as "the LLC," as an independent contractor, with an eye toward joining the practice. For about six months she covered patients of Dr. Jeremy Fine, who was transiting out of that practice to engage in a solo concierge practice.

6. Ultimately Respondent did not join the LLC, instead operating as a solo practitioner in Century City. A number of Dr. Fine's patients followed her; four of the five patients relevant to this case had been Dr. Fine's patients before they became Respondent's patients. The exception was Patient 2, who had not been Dr. Fine's patient. Respondent maintained her solo practice in Century City throughout the relevant time period, and through the hearing.

7. Respondent charged her patients for care and treatment, the patient's paying her directly. She had a practice of courtesy billing the patients' insurance carriers or Medi-Care.

The Expert Witnesses[2]

8. Each party presented expert testimony to support their case. Complainant's expert, Hyman J. Millstein, M.D., is an internist who worked with Kaiser from 1979 until his retirement in 2008. However, he still sees patients. He graduated Phi Betta Kappa from Columbia University, and he then attended the Yale School of Medicine, graduating from that institution in 1975. Following medical school, Dr. Millstein spent three years as an intern and resident at Emory University School of Medicine. Dr. Millstein was, at one point, certified by the American Academy of Addiction Medicine, but he declined to recertify in addiction medicine approximately 12 years ago. He is an Assistant Clinical Professor of Medicine at UCLA.

9. William G. Brose, M.D., testified on behalf of Respondent. Dr. Brose is board certified in Anesthesiology, with the added qualification of Pain Management, by the American Board of Anesthesiology. He has been so certified since 1993, recertifying in 2003 and 2013. He has been certified by the American Board of Pain Management since 1993.

10. Dr. Brose established the University Pain Service at Stanford University in 1989 and served as its director through 1997. At Stanford, he was promoted to Adjunct Professor of Anesthesia, Perioperative, and Pain Medicine, a post he still holds.

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[2] This section summarizes the experts' qualifications; their opinions are in the findings that follow.

Over the years he helped found Stanford University's Clinical Inpatient and Outpatient Services, Interdisciplinary Pain Treatment Program, and a fellowship training program. Dr. Brose estimates he has trained over 100 ACGME (Accreditation Council for Graduate Medical Education) certified Pain Fellows in pain management, all of whom have gone on to be American Board of Medical Specialties certified.

Respondent's Medical Records

11. Respondent acknowledges that her record keeping was substandard. Indeed, her expert agrees with Dr. Millstein that Respondent's record keeping was deficient for all five patients.

12. Respondent acknowledged the poor state of her charts when interviewed by the Board in 2018. For example, in colloquy with Dr. Klessig, the District Medical Consultant for the Board, Respondent recognized that while she is a solo practitioner, her charts must be sufficient for another physician to work with them if Respondent became unavailable for some reason. She acknowledged that there were confusing entries, such as entries for abdominal exams that did not take place. Where the patient complained of pain, a level of pain was not always set out in the chart. Numerous other problems are found in the charts.

13. There are some mitigating factors. Respondent had two different electronic record keeping software programs during the first year (approximately) of the relevant time period, and she was taking over a number of Dr. Fine's patients, whose charts had been handwritten.[3] For some patients, Respondent was working with

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[3] Dr. Fine's handwritten charts were not always a model of legibility; Dr. Brose described some of them as illegible.

the LLC's system. Respondent was then trying to learn her first electronic record-keeping system, Glowstream, while putting information from Dr. Fine's charts into the system. That process of putting Dr. Fine's charts into the Glowstream system did not always go smoothly. Further, the system had some quirks to be mastered. For example, a medication list that would appear on a computer screen would not print out; instead the entire medication history would print out. The system "prepopulated" certain steps or procedures, and Respondent often failed to go through the chart and delete the prepopulated notes.

14. (A) After approximately one year of working with Glowstream, Respondent had a dispute with the proprietor of the software and could not access her records. The dispute arose because Glowstream made reports to Medi-Care that caused Medi-Care to send Respondent money to which she did not believe she was entitled to. (She sent the money back.) When Respondent brought this matter to the attention of Glowstream, the dispute began, and she could no longer access the program.

(B) Respondent found a former employee of Glowstream who helped her get the records onto a laptop but not all of her problems with the records were solved. After her dispute with Glowstream, Respondent started using the Elation program for her charts. She attempted to move her records from the laptop with the Glowstream records into the Elation platform. During the hearing, she described that latter system as more user friendly, but still not without issues. She further testified that it became apparent, after the Board's initial inquiries, that some of Dr. Fine's records did not get into Glowstream, and some of the records from Glowstream did not get into the new system. Respondent and her staff were forced to try to move all of her records to one platform.

15. Both experts testified that the transition within the medical profession as a whole from traditional paper records to electronic records was difficult and time-consuming. Dr. Brose noted that at Stanford, where scores of medical practices had been brought under their one umbrella, it took a period of years to make the transition. If Stanford, with its resources, and the medical groups with their resources found the transition problematic, it can be fairly inferred that a sole practitioner would have a difficult time moving from paper charts to electronic ones, and from one electronic system to another.

16. During her interviews with Board staff, Respondent recalled substantial detail about the treatment of the five patients. She did that as well during her testimony. It appears that Respondent was carrying much information in her head, that was not always in the charts. This is not to say that there was no information in the charts, but plainly she did not satisfy record-keeping requirements.

17. During the hearing, Complainant's counsel noted (as he did in footnotes set out in the FAA) that Respondent had provided certified copies of the five charts before her first interview by the Board, in April 2018. During that interview, it became clear she had not produced all the records, in part because various billing records had not been included. It appears Respondent had had her staff copy the charts, and she believed them to be complete. It was agreed Respondent would provide further records at the next interview, scheduled for August 2018, which she did.

18. In January 2020, shortly before the original hearing date, Respondent produced further records for the patients. Although Complainant's counsel has questioned the fact that new records appeared so late in the process, the provenance of the late-submitted records has not been impeached. Because Dr. Millstein had not seen the last set of records before he wrote his report, some of his opinions were no

longer supported. However, that has not discredited him, as he can hardly be faulted for making opinions based on records that he did see. It must be clear, however, that the last iteration of the records did not cure the record-keeping deficiencies.

CURES

19. One of the criticism's levelled at Respondent was she was not using the Controlled Substance Utilization Review and Evaluation System, or CURES, to establish patient history or to monitor patient drug use during the period she was treating Patients 1 through 5. She acknowledges that she did not use CURES in that manner with the five patients.

20. However, it has not been established that using CURES reports in this manner was required by the standard of care during the generally relevant period, 2013 to 2016. Importantly, Complainant's expert, Dr. Millstein, stated in his report that "at the time of these cases, it [checking CURES] was recommended and encouraged but not specifically always required." (Ex. 27, p. 26; see also p. 31.)[4]

21. Dr. Brose pointed out that as of 2013, when Respondent began seeing some of the subject patients, the Department of Justice published information to the effect that only eight percent of California's physicians were registered with CURES. In the five patient cases, Dr. Brose is of the opinion the standard of care did not require

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[4] Page citations are to the page numbers stamped in the exhibits that have the legend "exh" or "ex" ahead of the page number, and not to internal original page numbers, or other "Bates stamp" numbers. If there are no stamped page numbers, the citation is to the original document page number.

Respondent to use CURES to check the patients' history or to monitor their drug usage.

22. Respondent testified that a pain management doctor she had consulted with regarding one of the patients, told her about the CURES system. Respondent attempted to register in the early part of 2016 and found it a difficult process. Her efforts to contact the Department of Justice for assistance were frustrated. Respondent did become registered, and she is now using the system, although she testified that she is not prescribing significant amounts of controlled substances at this time.

23. Both expert witnesses acknowledged that using CURES in the first few years of its existence was a cumbersome process. That testimony is credited, in part because it is consistent with testimony the ALJ has heard in other Board proceedings, and in hearings for the Pharmacy Board in its cases where over-prescribing was alleged.[5]

Treatment of Patient 1

24. Patient 1 was a 76-year-old man treated by Dr. Fine from at least early 2013. Respondent took over his care on July 8, 2013, but she first saw Patient 1 on May 21, 2013, while she was covering for Dr. Fine. She was unable to point to a chart entry in either Dr. Fine's charts or her own about the May 21 encounter, but a lab report indicates she saw him on May 21, 2013. Other lab reports indicate visits in June and July 2013. (See ex. D, pp. 261, 272.) At hearing, Respondent cited a note she wrote in Dr. Fine's chart on May 30, 2013, indicating she phoned the patient to discuss lab

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[5] An ALJ may use his or her experience, specialized knowledge, and technical competence to evaluate evidence. (Gov. Code, § 11425.50, subd. (c).)

results and she prescribed two medications, a thyroid supplement and Allopurinol. (*Id*, at p. 10.) Respondent prescribed Valium 10 mg. #60 on May 9, 2013, and Vicodin, 90, on June 27, 2013, though corresponding visits are not recorded either in her chart or what is available of Dr. Fine's chart. This is an example of the problems in her record keeping, although she was covering for Dr. Fine for part of that time. Dr. Fine's complete charts may not have been provided to Respondent when she took over care of the patient, or some may have become immured in the Glowstream system.

25. Patient 1 had chronic lower back pain and chronic shoulder pain, and when he saw Respondent on July 8, 2013, he had significant pain in his right thumb.[6] He had a laminectomy in 1997, and he had undergone another in January 2013, a few months before being seen by Respondent for the first time. During the time he was treating with Respondent, Patient 1 also underwent a shoulder replacement. According to Respondent's July 8, 2013 chart entry, Patient 1 had a history of lymphoma, non-Hodgkins; Waldenstrom Macroglobulinia; sleep apnea; Chronic Obstructive Pulmonary Disorder (COPD); hypothyroidism; and, spinal stenosis. He used a CPAP machine.

26. (A) A CURES report introduced by Complainant as exhibit 10 shows that in April 2013 Dr. Fine had prescribed Zolpidem (Ambien) 10 mg. and Diazepam (Valium), 10 mg. to Patient 1. Dr. Charles Gard had also prescribed the Zolpidem 10 mg. and Diazepam, 10 mg. to Patient 1 in March 2013.

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[6] Respondent's chart entry states "his right thumb is still giving him pain," implying she had previously seen him. (Ex. D-12.)

(B) Some of these prior prescriptions are found in Dr. Fine's records. His chart entry for March 13, 2013 shows him refilling Vicodin. He also notes on March 15, 2013 that Dr. Gard had prescribed Valium 10 mg., 120.

(C) Respondent prescribed those medications, in June and July 2013. She also prescribed Vicodin, 750 mg./7.5 mg., #90. It should be noted that in the first few months of 2013, Dr. Perri had prescribed that same drug, and Dr. Whelton had prescribed Vicodin before that. On March 25, 2013, Dr. Fine charted a refill of Vicodin. (Ex. D, p. 9.) The records indicate Respondent undertook a course of prescribing consistent with the prescribing by three other physicians who had treated Patient 1 before he became Respondent's patient. Dr. Brose noted in his testimony that Respondent had prescribed substantially less medication than had Dr. Gard. There is no evidence Patient 1 was obtaining such drugs from more than one physician at the same time.

27. When Patient 1 was seen by Respondent on January 30, 2014, complained of shoulder pain. She prescribed Celebrex, an anti-inflammatory medication, hoping to reduce discomfort and the need for stronger pain medications. Respondent's chart entry for March 7, 2014, made a few weeks before Patient 1's shoulder replacement, shows that Patient 1 presented that day with "severe" shoulder pain. The chart indicates that the patient had seen another physician, inferentially an orthopedic surgeon, who wanted to perform a complete shoulder repair. (Ex. D, p. 26.) The patient reported Norco was not covering the pain.

28. Patient 1's shoulder replacement took place on April 24, 2014. Approximately six months later he suffered further injury to his shoulder. Patient 1 was hospitalized in May 2015 for urosepsis. On June 9, 2015, the patient reported ear pain

to Respondent. Despite the surgery on his shoulder, it continued to be painful for the patient.

29. Respondent prescribed various medications including pain medications through September 10, 2015. The patient died by suicide on September 16, 2015. There is no apparent link between Respondent's care and treatment of Patient 1 and his suicide. At the time of his death, Respondent was prescribing Vicodin 10/300, and renewed the prescription on a monthly basis.

30. On September 10, 2015, a note in the chart states "last fill, need to follow up, unclear about shoulder, did he see second? Have not seen him, only comes to pick up pain med, did he get second or golden." (Ex. D, p. 63.) This is inferentially a reference to a second opinion about the recurring shoulder pain the patient was suffering. There is a prior chart reference to a Dr. Golden, who had treated the patient for his recurring shoulder problem, but another chart reference indicated the patient did not want to return to Dr. Golden. (Ex. D, p. 56.)

PATIENT 1'S ALCOHOL CONSUMPTION

31. Dr. Millstein, in his testimony and in his report, stated that his main concern regarding the care and treatment of Patient 1 was that Respondent was prescribing Ambien in significant amounts to an elderly patient, and when the patient consumed alcohol to a great extent. (He also opined Respondent should have done more to ascertain Patient 1's psychiatric condition.) As set forth in Factual Finding 26, Respondent's prescribing of Ambien was consistent with the prescribing by other physicians who treated Patient 1 before he became Respondent's patient. Dr. Millstein's criticism begs the question: what did Respondent know about Patient 1's alcohol consumption, because the thrust of the charges in the FAA are that

Respondent failed to adequately evaluate and monitor Patient 1's use of controlled substances in combination with Patient 1's use of alcohol, failing to adequately investigate Patient 1's alcohol history and psychiatric history.

32 Dr. Millstein pointed to a May 30, 2013 entry in Dr. Fine's records, to the effect that the patient was consuming two to four drinks of vodka per night. (Ex. 7, p. 233.) Dr. Millstein regarded that as a significant amount. Respondent in her charts indicated alcohol "3-4," testifying it meant three to four times per week, as it is her practice to measure alcohol intake by the week. Her chart entry from a visit by Patient 1 on November 11, 2014, states "etoh social." (*Id.*, at p. 21.)

33. In Dr. Fine's other records, Patient 1 reported social alcohol use, and even no alcohol use. On January 17, 2013, Dr. Fine made a chart entry "ETOH", accompanied by the null symbol. (Ex. D, p. 5.) Four days later, on January 21, 2013, Dr. Fine wrote a report just prior to back surgery that was to take place on January 24, 2013. That report it shows "ETOH: Social." (Ex. D, at p. 8.) At around that time, the patient told another physician, Brian Perri, O.D., that his drinking was "social." (*Id.*, at p. 69.) (The records indicate that Dr. Perri was the back surgeon.) (*Id.*, at p. 7.) Nearly two years later, in November 2014, the chart shows, in connection with a pre-operative report, "ETOH-social." (*Id.*, at p. 42.)

34. Patient 1's daughter-in-law testified that Patient 1 consumed large amounts of alcohol every day, basically all day. She testified that Patient 1 would start with beer in the morning, and then turn to vodka later in the day. She recalled that he would order a triple vodka at Dodger Stadium, toss out the ice, and consume the vodka. And, she testified that Patient 1 would do that more than once while at the Dodgers' games.

35. There was no evidence Patient 1 or anyone in his family ever reported such prodigious alcohol consumption to Respondent or to Dr. Fine. There is no evidence the standard of care, as it stood during the time that Respondent treated Patient 1, required Respondent to engage in what amounts to detective work. Dr. Brose testified that trusting in a patient's veracity was within the standard of care when Respondent was treating Patient 1.

36. Respondent, during her testimony, pointed to lab work that she contended was consistent with moderate alcohol intake. Lab results for SGOT/AST and Bilirubin levels were both in the normal range, over a period of months. (Ex. D, p. 205. See also pp. 236, 277.)[7] Respondent testified such lab results were consistent with someone who drank three or four drinks per week, and they were inconsistent with someone who drank as described by Patient' 1's daughter.

37. Also found in Patient 1's chart is a lab report, from April 11, 2014, (10 days before the patient's shoulder replacement) which states "no ethanol detected." (Ex. D, p. 260.) That report was generated when Patient 1 visited the Cedars-Sinai Hospital (Cedars-Sinai) emergency department for shoulder pain. Staff at Cedars-Sinai performed a "drug abuse 9 panel." (Ex. D, p. 255.) While the test was conducted mid-morning, it stands in contrast to the testimony Patient 1 started his day with beer, and basically drank hard liquor the rest of the day.

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[7] In August 2013, the SGOT (AST) level was 25, where the report shows the normal range to be 10 to 42; total Bilirubin was .5, with the report indicating a normal range of .5 to 1.3.

38. The Cedars-Sinai emergency department staff treated Patient 1 with morphine, 5 mg. subcutaneously, and 2 mg. by IV Push. Furthermore, Patient 1 was prescribed Norco 10-325 mg., #20 tablets, one to two tablets every six hours as needed for pain. (Ex. D, p. 255.) These medications were provided or prescribed by the hospital staff with their knowledge that Patient 1 was already taking Valium, Vicodin ES, Zoloft, Zocor, Ambien, and other medications. (*Id.*, at p. 258.)

39. Dr. Brose is of the opinion Respondent did not deviate from the standard of care in her treatment of Patient 1, aside from her record keeping.

40. It was not established by the requisite standard of proof that Respondent was grossly negligent in the care and treatment of Patient 1, either by a series of simple departures, by prescribing Ambien to Patient 1, or by failing to document a good faith encounter with the patient before prescribing controlled substances. As Complainant acknowledges in footnote 6 to the FAA, Respondent's additional records, submitted in January 2020, show that the patient had an encounter with another physician. And, Respondent testified that she inquired of Patient 1 about depression, and he denied being depressed.

Treatment of Patient 2

41. Patient 2 was a woman who first presented to Respondent on June 25, 2014, the patient then two months from her 52nd birthday. She was the one patient in this case who had not been treated by Dr. Fine. Respondent treated the patient until May 25, 2016, when Respondent refused to write anymore pain medication prescriptions for the patient. The June 25, 2014 visit is charted, but the copy of that part of the chart was not available to Dr. Millstein when he reviewed the records.

42. During that first examination, the patient indicated a history of Lupus, 4 years macular; Leukopenia; Lung Disease; pneumonia; Elevated LFTs; Sinusitis-recurrent; and, perforated septum. Patient 2 gave a history of fibromyalgia as well. Patient 2 also complained of pain and fatigue, sleep disorder and sleep walking, and pulmonary infection four times in a period of several months, for which she had been treated at UCLA. She had swelling over her left supraclavicular area, abdominal bleeding and weight gain. She gave a history of dry mouth and throat irritation, which had been treated by a Dr. Sugarman. She smoked every day.

43. Patient 2 reported she had been or was taking a substantial amount of medications. The list set forth in the June 25, 2014 chart entry included somewhat common medications, such as Amlodipine Besylate, Clotrimazole, and Doxycycline Hyclate. However, she had also been taking Abilify and Escitalopram, which are prescribed for mood disorders or depression.

44. (A) Patient 2 reported she had been taking various pain medications including Hydrocodone-Acetaminophin 10-325, Nycynta (Tapentadol) 200 mg., Oxycodone in various strengths including 10, 20, and 30 mg., as well as Vidodin Es. 7.5-300 mg. tablets. Further, she had a history of taking Dextroamphetamine 20 mg. tablets and Vyvanse, 30 mg. and 70 mg.

(B) Based on the foregoing, it was not established, as alleged in paragraph 17 of the Accusation, that there was no listing of the prior medications that Patient 2 had been taking.

45. Complainant introduced a CURES report for Patient 2. As previously found, Respondent had not obtained one during her treatment of Patient 2. According to the report, exhibit 15, in 2013 and 2014, before Patient 2 first treated with

Respondent, Patient 2 was seeing other physicians who were prescribing a number of drugs, including Oxycodone HCL, Vyvanse, Mixed Amphetamine Salts, Zolpidem Tartrate, Nucynta ER, and Hydrocodone Birtartrate-Acetaminophen. The CURES report indicates that Patient 2 gave a reasonably accurate history of her controlled substances prescriptions to Respondent.

46. In the initial appointment, the patient complained of significant pain, indicating a level of discomfort of 8 out of 10 at maximum. This appears to be the only completed pain scale in the chart, although the patient does report pain in other circumstances.

47. In the assessment portion of her notes for the June 25, 2014 visit, Respondent indicated "Lupus and or mctd, scleeraderma." (Ex. A, p. 8.) She noted "records ucla pulm and dr raskin," and "consider dr. grossman," who in her testimony was described as a rheumatologist at UCLA. (*Ibid.*) Respondent wanted to reduce or eliminate some of the pain medications Patient 2 had been taking, and therefor Respondent prescribed other drugs. Respondent indicated that she would add tudorza, simbicort 80, Mycelex, change to Duragesic 125, replaces oxycodone 240 daily, drop lyrica, and consider dropping Vyvance. Because Patient 2 was a smoker, Respondent also indicated she would prescribe a smoking patch.

48. On July 7, 2014, the patient reported the patch she was using was falling off and that she still needed medication for "breakthru-(hx of oxycodone 30-8 tabs daily)." (Ex. A, p. 8; spelling as in original.) Respondent told the patient not to use Tegaderm, which could presumably help to hold the fentanyl patch in place, and instead decided to make a trial of Butrans, another transdermal pain medication. In the July 7, 2014 handwritten chart note Respondent made a note to "review records/requested." (*Id.*)

49. (A) In the Accusation, Complainant alleges at paragraph 17 that there was no documentation of prior communications with previous doctors, no documentation that prior records had been reviewed, and no documentation that Respondent had adequately investigated Patient 2's history. In his report, Dr. Millstein pointed to notes of a July 22, 2014 visit, which stated that as part of the plan, Respondent would obtain old records. Dr. Millstein reported that that he could not find anything that showed that the records had been ordered or had arrived.

(B) There is an office message between Respondent and one of her assistants, dated August 28, 2014, to the effect that she needed records from Dr. Raskin, who had previously treated Patient 2. (Ex. 11, p. 107.) Dr. Raskin's records are found in exhibit A, but with one exception are not found in exhibit 11, the records that Dr. Millstein reviewed. (Exhibit 11 was provided to the Board during its investigation, and exhibit A was provided in January 2020, as noted previously.) The exception is an Advanced Health Care Directive (Directive) found in the records produced to the Board during its investigation, and also found in exhibit A. That Directive was executed in 2013 and refers to Dr. Raskin. (Ex. 11, pp. 26, 31, 34.)

(C) The Directive carries a fax banner on the top of each page with a date of "07/28/14," and on the last page the printed legend "electronically signed by Patricia Chang, M.D. on 08/03/2014 3:31 pm in ElationHealth." (Ex. 11, p. 34; ex. A, p. 165.)

50. (A) Dr. Raskin is board certified by the American Board of Internal Medicine.[8] The records found in exhibit A indicate he had treated Patient 2 for many

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8 See exhibit A, p. 415.

years, from August 6, 2007 to June 17, 2014. Along with his progress notes are found reports from other physicians as well as test reports and related documents. Thus, for example, there is a May 28, 2014 order for an MRI on Patient 2's lumbar spine and cervical spine, to be conducted by Landmark Imaging. (The report of that MRI was obtained and reviewed by Respondent. [Factual Finding 57 (A).].) The MRI order states "DX-chronic back pain, s/p fall 2009, failed NSAIDS & PT." (Ex. A, p. 415.) The diagnosis of chronic pain, sometimes stated as chronic neck pain or chronic backpain, is found many times in Dr. Raskin's progress notes, spanning several years. (E.g., ex. A, p. 340 [July 27, 2011]; p. 388 [September 25, 2013]; p. 398 [April 17, 2014].)

(B) Dr. Raskin's records contain numerous entries assessing Patient 2 with fibromyalgia. (E.g., Ex. A, pp. 341 [July 27, 2011]; p. 367 [August 7, 2012]; p. 388 [September 25, 2013].) Assessments of ADD—Attention Deficit Disorder—are replete in Dr. Raskin's records. (E.g., Ex. A, pp. 341 [July 27, 2011]; p. 367 [August 7, 2012]; p. 388 [September 25, 2013].) Dr. Raskin's charts indicate assessment of COPD. (Ex. A, pp. 367 [August 7, 2012]; p. 398 [April 17, 2014].) This is contrary to Dr. Millstein's opinion that Patient 2 did not have COPD.

(C) Dr. Raskin's records support the history provided by Patient 2 to Respondent, including Patient 2's history of chronic pain, fibromyalgia, and ADHD. They further indicate long-term prescription of pain medications of the type provided by Respondent during most of her treatment of Patient 2.

(D) Respondent testified she did not review a prior treating physician's records, excepting some from Dr. Belpario. It is true she did not document reviewing Raskin's records, excepting the Directive, and Dr. Raskin's MRI order. Just when she obtained Dr. Raskin's records is not disclosed by the record, and those records do not bear the statement that they were electronically signed by Respondent at some point

in time. However, they do tend to support the history provided by Patient 2, and they disclose a medication regimen similar to that used by Respondent. The MRI order reviewed by Respondent provided her the prior treating physician's diagnosis of one of Patient 2's complaints, chronic back pain from an injury in 2009.

51. (A) Respondent also obtained records generated for Dr. Wallace, who previously treated Patient 2, and had reportedly diagnosed her with Lupus. Those records constitute several pages of lab reports generated for Dr. Wallace in 2010 and 2011. (Ex. A, pp. 217, 220-222.) The records, on the letterhead of RDL Reference Laboratory, bear fax date stamps of July 21, 2014, although some also carry a fax date of July 28, 2014. Two pages state at the bottom thereof: "Electronically signed by Patricia Chang, M.D. on 08/03/2014 2:22 p.m." (*Id.*, pp. 221, 222.) The last page bears a similar statement, but with the date of July 21, 2014. (*Id.*, p. 226.)

(B) The chart note for a visit on July 22, 2014, under the heading "documents referenced," states "Labs 04/13/11." This is inferred to be a reference to some of the records identified in Finding 51 (A), above.

52. Whether Respondent was mistaken in her testimony about not reviewing prior treater's records, she had reviewed some such records of prior treatment, as early as July 2014, and thereafter.

53. From August 2014 until the doctor-patient relationship was terminated in May 2016, Respondent continued to prescribe pain medications and other controlled substances to Patient 2. She recognized Patient 2 was receiving substantial doses of medication, but she testified to being concerned about the problems that could arise if she abandoned the patient. Respondent attempted to transition Patient 2 to longer acting drugs, to substitute other drugs for those that Patient 2 had been taking, or she

was trying to reduce dosage. This occurred while Respondent attempted to obtain further information about the patient's ailments, through testing or consultation with specialists. Respondent often noted her goal of treating the underlying problems, and not just treating the patient's pain. For example, in a chart entry for April 2, 2015 Respondent wrote: "I want her to treat her problem and not mask the pain." (Ex. A, p. 78.) An earlier example of such treatment goals occurred on July 30, 2014, when Patient 2 saw Respondent for back pain. After finding objective signs of back pain, Respondent gave the patient an injection of Tordol, 30 mg., an anti-inflammatory medication, hoping to alleviate the underlying problem without prescribing further pain medication.

54. Another example of Respondent's efforts to treat underlying problems, and to thus prevent pain is shown by her efforts to have Patient 2 see a rheumatologist. Respondent counseled the patient that such a specialist could treat the cause of her pain directly. In September 2014 she counseled Patient 2 that treating with a rheumatologist could bring biologics into the picture and help wean the patient from pain medications. At that point the patient claimed to be amenable to such a course and said she would make an appointment. (Ex. A, p. 43.) It was some time, however, before Patient 2 saw a rheumatologist, in part because she claimed to have lost the referral phone number, or that there was an insurance issue. Eventually Patient 2 did consult with a rheumatologist, once seeing Sandra Ramer, M.D. in July 2015, and later consulting with Dr. Louie at UCL.A in December 2015.

55. From early in the relationship, Respondent counseled Patient 2 to consult with a pain specialist, and that discussion recurred until the doctor-patient relationship terminated. As with the other potential consultants, Patient 2 always said she would do so, but regarding pain specialists never did. Again, Patient 2 sometimes claimed she

lost the referral information or would state that the referrals didn't take her insurance. Respondent consulted with such specialists in an effort to smooth the process. Respondent even made appointments for some of the specialists, but Patient 2 would not appear. Again, this behavior was not limited to pain management specialists, but included pulmonologists, orthopedists, and later addiction specialists.

56. Dr. Millstein is critical of Respondent for prescribing three drugs in November 2014, in addition to the medications Patient 2 was already taking. The patient told Respondent she was travelling to New York and London, and she requested Xanax and soma for travel. Respondent prescribed Xanax, 2 mg., #90; fiorinal, #90; and Soma, #90. This was in addition to the patient's prescriptions for Vyvance and oxycodone. Dr. Millstein deemed this to be an extreme departure from the standard of care. Dr. Brose disagreed with Complainant's expert.

57. (A) In terms of testing, Respondent had several tests performed on Patient 2 during the period of their relationship, and Respondent reviewed reports generated by others. These included HDL labs in July 2014. Respondent reviewed reports of an MRI of the spine, conducted June 4, 2014 for Dr. Raskin at St. Johns Health Center. (Ex. A, pp. 249 to 252, signed by Respondent on August 3, 2014.)[9] Further blood tests were conducted in July and August 2015. An EKG test is found in

[9] Her electronic signature is found at page 252 of exhibit A.

the patient's records, from June 2015.[10] Respondent ordered a CT scan of Patient 2's brain in late July 2014 after the patient had fallen. *(Id.*, at p. 246.)

(B) A complete Venous Duplex Evaluation of Lower Extremity-Bilateral was performed on April 30, 2015. (*Id.*, at p. 234.) That test was preceded by CT Angiography of the abdomen, pelvis, and lower extremities, which revealed ulcerated plaque causing 35 per cent stenosis in the iliac artery. The radiology report notes that the presence of substantial aortoiliac atherosclerotic plaquing is unusual in a 52-year-old woman, and recommended that aside from typical etiologies, such as long-term smoking or diabetes, Respondent should consider auto-immune or infectious causes. (*Id.*, at p. 241.) Respondent ordered MRI's of the Lumbar Spine, Cervical Spine, and Sacrum Coccyx, which were conducted in July 2015. *(Id.*, at pp. 229-233.) A February 16, 2016 report of a CT Angiography (Chest) is found in the chart. (*Id.*, at p. 228.) Various blood tests were conducted during the patient-physician relationship.

(C) In September 2015, results of tests ordered by Respondent indicated that Patient 2 did not metabolize many of the drugs well, and Respondent sought alternatives. Thereafter, in October 2015 she reduced the Vyvance prescription, adding Nuvigel.

58. Respondent continued to prescribe pain medications and other controlled substances to Patient 2. There was charting of some 18 office visits by Patient 2 between June 2014 and May 2016, when the relationship terminated. The

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[10] The EKG report states: "borderline EKG" and notes possible left atrial enlargement and suggestion of right ventricular conduction delay. (Ex. A, p. 227.)

patient was receiving opioids, stimulants in the form of amphetamine-like drugs, sedatives and benzodiazepines. The doses were significant. Meanwhile, the chart entries indicate Respondent was becoming increasingly uneasy about the situation, in part because it appeared Patient 2 dragged her feet about consulting with other physicians, including pain management, and towards the end of the relationship, with addiction specialists.

59. (A) Patient 2 was examined by Dr. James S. Louie of UCLA Health on December 3, 2015; Respondent made the referral. Dr. Louie is a rheumatologist. He noted that four years prior to his exam, Dr. Wallace had diagnosed Patient 2 with systemic lupus erythmatosusu and fibromyalgia, and Dr. Louie noted three prior hospitalizations at UCLA for pneumonia. After conducting an examination and medical testing, in a note to Respondent, Dr. Louie stated that at that time Patient 2 did not show any clinical or serologic tests that supported a diagnosis of lupus, Sjogrens or a lupus-like syndrome. He further told Respondent that at the patient's request he would repeat the serologies for Lupus and Lupus-like syndromes. He suspected the patient suffered from osteoarthritis, degenerative disc disease with cervical hardware, and nodular infiltrates in her cervical glands. (Ex. A, p. 275.)

(B) Dr. Millstein indicated that Dr. Louie's assessment that Patient 2 did not have lupus shows Patient 2 was misleading Respondent. However, it appears Dr. Wallace had made that diagnosis previously, and the fact that two physicians disagreed does not establish that the patient was misleading Respondent.

60. By early in 2016, Respondent showed increasing concern about the situation with Patient 2. A chart entry for a January 20, 2016 visit includes: "long discussion regarding pain management and rheum follow up, she claims that some have not returned her call and some not covered by her insurance." (Ex. 11, p. 127.)

Respondent refilled "oxycodone 240, oxycontin 90, vyvanse 70/30 adderal 30 bid with understanding that she [Patient 2] will follow up with pain [management] and rheum[atology]." (*Id*, at p. 128.)

61. (A) The chart entries for the next several visits show Respondent was pressing Patient 2 to see specialists in pain management, and addiction, to little or no avail. Because Dr. Louie had disagreed with the prior diagnoses of lupus made by Dr. Wallace, Respondent was also counselling Patient 2 to follow up with other rheumatologists.

(B) For example, the chart entry for February 16, 2016 shows Respondent was trying to get the patient on board with treatment from others. Respondent had discussed Patient 2's case with Dr. Louie, and she discussed Dr. Louie's assessment that Patient 2 did not have lupus; and given the earlier diagnoses of lupus, the issue needed to be resolved. Respondent's wrote a chart entry that "the combination of all meds is very concerning. Pt has been tolerant of high doses but still in severe pain." (Ex. 11, p. 121.) Further, Respondent describes a discussion about pain management, rheumatology, alternative treatment, addiction, and withdrawal. Patient 2 asserted that the pain was so severe she could not function and "she adamtately [sic] denies having addictive issues." (*Ibid.*)

(C) During a visit in March 2016, Patient 2 again promised Respondent that she would see specialists. That had not occurred by the time of the next visit, April 25, 2016. The chart entry for that latter date shows Patient 2 reported anxiety daily and problems sleeping. Respondent discussed with Patient 2 the need to see pain management and an addiction specialist. Respondent emphasized that if the pain was from lupus, the patient would benefit from treating the problem directly. "Same discussion as always." (Ex. 11, p. 118.) On this occasion, Respondent in her discussion

with the patient "emphasized I cannot keep prescribing." (*Ibid.*) Patient 2 claimed she lost the phone numbers of the specialists, and Respondent stated that she had contacted the specialists, given them Patient 2's history, and the patient had not followed up. Respondent gave the patient a number of names of specialists that the patient should contact.

62. (A) During the February 16, 2016 office visit, Respondent prescribed Spironolactone, 100 mg. bid, citing concern about hypertension and fluid overload. Dr. Millstein was critical of this prescription, citing the chart entry showing blood pressure as 128/72. He asserted the patient also had a normal BNP (Brain Natriuretic Peptide) test. Dr. Millstein opines that the prescription was a simple departure from the standard of care.

(B) In her testimony, Respondent pointed to a lab test from January 2016, which showed the BNP as 295, the lab classifying the amount as "intermediate risk," and showing the optimal range to be less than 125. She further pointed out that the same test had been performed in July 2014, with the result then being 103, well within the optimal range. Thus, there had been a significant increase in BNP in an 18-month period, the reading almost tripling. (Ex. A, p. 176.)

(C) In her testimony Respondent disagreed with Dr. Millstein's opinion that Patient 2 did not have congestive heart failure. She said there was supporting evidence of, including the increased BNP. She pointed to records she obtained that showed that Patient 2 had her mitral and tricuspid heart valves replaced at Cedars-Sinai in October 2017, after the patient left her care. A report notes that there was rheumatic deformity, and evidence consistent with rheumatic heart disease. (Ex. A, pp. 166-168.)

63. On April 27, 2016, the patient wanted Respondent to write prescriptions for oxycontin, oxycodone and Adderall, but Respondent would not do so, noting she wanted to have Patient 2 see pain management physicians. Patient 2 said she had two appointments for late May, and Respondent wanted their identities. (Ex. 11, p. 118.) The record does not show that the doctors were identified for Respondent.

64. On May 19, 2016, Patient 2 contacted Respondent's office and asked for a pain management referral for UCLA, and Respondent provided such information to her. On May 24, 2016, Respondent confirmed Patient 2 had an appointment with Respondent, which occurred the next day. The May 25, 2016 appointment was Patient 2's last appointment with Respondent. On that day, Patient 2 came in to discuss pain medications, and Respondent again advised Patient 2 to see Dr. Keene, an addiction specialist. Respondent noted "I can no longer write the amount of meds which she needs or perceives to need." (Ex. A, p. 155.) Respondent further noted Patient 2 felt Respondent was being "accusatory." Patient 2 took down Dr. Keane's name, and told Respondent she would find another primary care physician.

65. During her interview with the Board in April 2018, Respondent stated she probably should have cut off Patient 2 sooner than she did, but she felt Patient 2 trusted her, and would follow up with the referrals to pain management and other specialists.

Treatment of Patient 3

PATIENT HISTORY AND INITIAL TREATMENT

66. Patient 3 was a 46-year-old man when Respondent first saw him in July 2013, and he remained her patient until May 2017.[11] He had been a patient of Dr. Fine since at least 2010. Patient 3 had a history of elbow and back pain. Dr. Fine had referred the patient to an orthopedic surgeon, Melvin H. Nutig, M.D. In October 2012, Dr. Nutig diagnosed epicondylitis medial elbow, bursitis hip, and pain lumbar spine. (Ex. 16, p. 300.) Patient 3 had complained of chronic abdominal pain to Dr. Fine as well. (*Id.*, at p. 246.) In January 2012, Dr. Fine referred the patient for tests, and an upper GI endoscopy was performed which disclosed duodenal erosion, and LA Grade B reflux esophagitis, and non-bleeding erosive gastropathy. Further history relevant to this matter is the fact that Patient 3 had been in a residential drug treatment program in late 2012, or a few months before he began treating with Respondent.

67. (A) When Patient 3 first presented to Respondent, he complained of pain in his right elbow, and of bilateral hip pain. He told Respondent he was unemployed and had a five-year-old child. They discussed Patient 3's anxiety. He reported occasionally taking Xanax. After an examination, Respondent assessed Olecranon bursitis-right, bilateral SI joint arthritis, and ADHD. Her plan was to have an MRI of the lumbar spine, hips, and elbow, as well as an X-ray of the elbow, to administer a vitamin

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[11] Complainant alleged Respondent last prescribed Valium to Patient 3 on May 3, 2016; this is based on exhibit 28, a CURES report for Respondent for the period June 1, 2013 to June 23, 2016. However, Respondent continued to treat Patient 3 until May 2017.

B12 shot, and to prescribe Celebrex and Vyvance, the latter 20 mg. (Ex. B, pp. 14. 19, 20.)

(B) The record of the initial examination does not indicate the basis for the ADHD diagnosis, and therefore the medical indication for the Vyvance prescription is not established by the first chart entry. Respondent testified the patient told her about his prior diagnosis of ADHD, but such is not shown in the notes of the initial visit. A later chart entry refers to Patient 3 telling Respondent about prior medication for ADHD.

68. Respondent referred Patient 3 to John T. Knight, M.D., an orthopedist. On November 11, 2013, Dr. Knight reported to Respondent his assessment that Patient 3 suffered from a lesion of the ulnar nerve, carpel tunnel syndrome, and medial epicondylitis of the elbow, these being problems in the right arm. (Ex. B, p. 420.)

69. As noted by Dr. Millstein, there is no record of any controlled substance refills to Patient 3 between the first visit in July 2013 and March 2014. In March and again in April 2014, Respondent prescribed Valium. The total prescriptions in this period were significant. Thus, on March 20, 2014, the patient filled a prescription by Respondent for Valium, 5 mg., #10. On April 1, 2014, he filled a prescription for 60 more tablets of Valium, 5 mg. Two weeks later, on April 15, 2014, Patient 3 filled a prescription for 30 more Valium, 5 mg. On April 22, 2014, Patient 3 obtained another 30 Valium tablets, 5 mg., and 30 tablets of Nuvigil, 250 mg. Thus, in April 2014, Respondent prescribed 130 tablets of Valium 5 mg. along with Nuvigil.

70. On June 4, 2014, Patient 3 presented for a physical exam, which followed an accident where his left ankle and knee were injured. He reported taking Ativan three or four times per day, Seroquel, ½ of 25, and Nuvigil during the day. He was

complaining of chronic pain that limited standing or sitting, or exercise. He also complained of lower quadrant abdominal pain. Celebrex and Neurontin did not bring improvement. On that date the patient obtained prescriptions for Nuvigil, 250 mg., #30, and Ativan, 2 mg., #30. The next day a prescription of Valium, 5 mg., #30 was filled. (Ex. 28, p. 23.)

71. Respondent's notes for a September 10, 2014 visit show Patient 3 was taking Ativan and Nuvigil, the Ativan being described subjectively as "excessive." (Ex. B, p. 52.) In her interview with the Board's medical consultant in August 2018, Respondent acknowledged that Patient 3 was overusing at this point. It is notable that on August 25, 2014, some two weeks before the September visit, Respondent told her assistant, Ms. Vollmer, that Patient 3 was receiving Ativan for anxiety disorder. (Ex. B, p. 51.) In any event, Patient 3 is described in the chart as having more anxiety and psychosocial issues due to unemployment, multiple musculoskeletal pain, and family dynamics. In her assessment/plan Respondent planned to consult with Dr. Vitti or another psychotherapist, to stop Nuvigil because the patient didn't like it, and to transition to topomax to wean off Ativan. She also wanted a psychiatric consultation; the patient wanted to see a therapist first. Respondent referred him to Dr. Vitti, a therapist who she described at the hearing as treating anxiety.

72. During the week after the September 10, 2014 visit described above, Respondent had a telephone exchange with Patient 3, who called her on September 15, 2014. She called him back on September 16, 2014, noting that they would try topomax instead of Ativan.

73. Notwithstanding Respondent's desire to wean Patient 3 off some drugs, she continued to prescribe benzodiazepines to Patient 3 after the September 10, 2014 visit. This does not mean she did not try other means of reducing his use of controlled

substances, and hopefully reduce his complaints of abdominal pain, which are documented in the chart during the life of the patient-physician relationship. She was ultimately unsuccessful, and she terminated the relationship in early May 2017.

74. The benzodiazepines prescribed for Patient 3 included Ativan, Valium, and Xanax. The prescriptions were often for significant amounts. For example, on October 6, 2014, Respondent prescribed 60 tablets of Valium, 5 mg. Eleven days later, on October 17, 2014, she prescribed 30 tablets of Ativan, 2 mg. She prescribed another 12 tablets of Ativan on October 30. On November 5, 2014, Respondent prescribed 90 more tablets of Ativan, 2mg., to Patient 3. (Ex. 28, p. 24.)

75. (A) The refill of Ativan on October 30, 2014 appears to be an early refill, although it was for a small amount. A chart entry indicates it may not have been the first early refill. The chart contains an Office Message dated October 16, 2014, documenting a communication to Respondent from her assistant, Vollmer. Vollmer asks, "CAN HE [Patient 3] HAVE A REFILL OF ATIVAN THE LAST TIME IT WAS FILLED WAS 9/29." (Ex. B., p. 60, capitalization in original.) Respondent's reply, some four hours later, was "30 only tabs but need to make a f/u appt." (*Id.*)

(B) On October 28, 2014, in another Office Message, Vollmer writes:

> He [Patient 3] wants another refill of Ativan, last pick up 10/17 . . He made f/u appt. The pharmacy wants to know whats going on. . If its approved, you have to call and approve. You might want to speak to him to see why he always needing refilling early.

(Ex. B, p. 61. Original in all caps; punctuation and spelling unchanged.)

(C) Respondent replied to Vollmer, "Can you have pharmacy send refill dated (sic) and amts." (*Ibid.*)

(D) On October 30, 2014, Vollmer sent a message to Respondent asking her to call Patient 3. Respondent replied: "needs to follow up." (Ex. B, p. 62.) However, the CURES report obtained by the Board does show that 12 Ativan tablets were prescribed for Patient 3 on October 30. Given that Vollmer told Respondent on October 28 that Patient 3 had an appointment, it is fairly inferred Respondent wrote a prescription for a small amount of Ativan, pending his follow-up visit. A subsequent November 5, 2014 prescription for 90 more Lorazepam, 2 mg. tablets was for a substantial amount. However, there is no record of a visit on that day (or on an earlier day) to be found in exhibit B, Respondent's last iteration of the chart for Patient 3. The next documented office visit was on November 13, 2014.

(E) These events should have been concerning to Respondent. First, it appears Patient 3 was asking for early refills, and that there had been a pattern of that behavior. Second, Vollmer communicated that the pharmacy was concerned with the situation; pharmacy staff may have communicated concerns about early refills to Vollmer, so she would relay them to Respondent. Third, Respondent was asking the pharmacy for information about the filling pattern. This indicates her own records were not clear on when and how much she had prescribed to Patient 3. There is no record of what information the pharmacy provided, assuming that Vollmer contacted it as Respondent requested.

76. Patient 3 complained of significant pain in his abdomen on November 13, 2014, and in the ensuing weeks. On November 13, 2014, Respondent prescribed Diphenoxylate HCO-Atropine Sulfate in response to his gastro-intestinal problems.

77. On November 25, 2014, or 20 days after Patient 3 obtained 90 Ativan tablets, 2 mg., he filled another prescription for Ativan, 2mg., in quantity 30. He obtained 30 more tablets on December 16, 2014, and 60 more tablets on December 30, 2014. The prescription of such significant drug quantities by Respondent continued for some months.

PATIENT 3'S PRIOR HOSPITALIZATION FOR DRUG AND ALCOHOL ABUSE

78. In a visit on February 3, 2015, Respondent again discussed reducing Patient 3's drug use; she had a plan to try to wean him away from Ativan with Neurontin. Her notes further provide an intent to use Seroquel 25 mg. "to start to help wean, had taken at hazelton (sic)." (Ex. B, p. 79.) "Hazelton" is a reference to Hazelden Springbrook (Hazelden), a drug and alcohol rehabilitation facility in Oregon, where Patient 3 had been an inpatient in late 2012.

79. However, the chart indicates Dr. Fine had become aware of Patient 3's treatment at Hazelden on February 1, 2013—before Respondent began treating the patient. Dr. Fine obtained records from Hazelden. It appears that the records generated at Hazelden were faxed to Dr. Fine on July 2, 2013, as they bear a fax banner with that date and page count totaling 22 pages. There is a fax cover sheet from Hazelden addressed to Vollmer on that same date, showing a total transmittal of 22 pages. (Ex. B, p. 428.)

80. (A) One of the records related to Patient 3's stay at Hazelden is a report by Gastroenterology Specialists of Oregon regarding an office visit on November 26, 2012 by Patient 3 for epigastric pain. It is accompanied by a report of an endoscopy performed on November 29, 2012. (Ex. B, pp. 292-296.) These records were faxed from Oregon on May 31, 2013, presumably to either the patient or Dr. Fine. The "history of

present illness" portion of the report describes Patient 3 as an inpatient at Hazelden, and further states "he has a significant addiction problem with EtOH [alcohol], cocaine, marijuana, and benzos. He is now off of all of those but has only been off of them for about 2 weeks." (*Id.*, at p. 292.) Respondent electronically signed this report on February 13, 2015. Further, during her interview with the Board in August 2018, she referred to the gastroenterology report.

(B) The endoscopy procedure did not reveal any physical ailments, leading the physician who performed it to report the impression that the patient's abdominal pain was "functional at this point." (Ex. B, p. 295.) The doctor recommended Patient 3 continue Protonix bid.

(C) Respondent's signature on the records from the gastroenterology consult establish she had written notice in mid-February 2015 of Patient 3's hospitalization at Hazelden in late 2012, and he was considered to have "significant addiction problem[s]."

81. (A) The Hazelden records sent to Dr. Fine (not those of the gastroenterology consultation) do not have Respondent's electronic signature, as did the gastroenterology report. In any event, the Hazelden records begin with an admission history and physical report. The admission records state the chief complaint is alcohol, benzodiazepine, cocaine, and marijuana abuse. Patient 3 related to Hazelden staff that he began drinking at age 12, and sometimes would have up to 10 drinks per day in the period before his admission to Hazelden. He started using Xanax in 2007, and before that Valium. A few days before his admission he was taking 15 mg. per day of Xanax. He would use Klonopin when he could not obtain Xanax and had started on Valium in 1983. He was then a daily marijuana user, and had first used cocaine in 1983, using it sporadically in the few months before his admission to

Hazelden. In 1989 he had spent 28 days at Hazelden Century City for cocaine, alcohol, and marijuana abuse. His sobriety lasted about one year. He went back to that facility in 1994 for another 28-day stay; his sobriety lasted six months. (Ex. B, pp. 423-424.)

(B) In terms of medical illnesses, Patient 3 reported irritable bowel syndrome, peptic ulcer disease and C. difficile, both reportedly diagnosed in December 2011. He reported chronic back pain, described as 2 of 10 daily, that he stated was only relieved by Xanax. (*Id.*, p. 424.)

(C) As to past psychiatric history, Patient3 reported anxiety, with symptoms throughout his life, diagnosed four years previously by an internist who "is prescribing Xanax." That internist would not have been Respondent, but could possibly have been Dr. Fine. Patient 3 also stated he was seeing a psycho-pharmacologist who was prescribing Klonopin. (*Id.*, at p. 424.)

(D) Hazelden's discharge diagnosis included alcohol, cannabis, Xanax, and cocaine dependence, all with physical dependence. *(Id.*, at p 431.)

(E) The records from Hazelden are contained in both iterations of the patient records, i.e., exhibits 16 and B. Aside from the February 3, 2015 chart entry with the passing reference to "hazelton" no other references to Hazelden or Patient 3's stay there were found in Respondent's chart entries.

FURTHER TREATMENT OF PATIENT 3

82. For the two years following the revelation that Patient 3 had been an inpatient at Hazelden, Respondent continued treating Patient 3. During that time, she either ordered tests, or sent him to specialists for consultation. She also advised him on a number of occasions to seek treatment with psychotherapists, pain specialists,

and specialists in addiction medicine. As noted above, she continued to prescribe benzodiazepines and other controlled substances until she severed the relationship in early May 2017.

83. As previously found, Respondent had referred Patient 3 to Dr. Knight, who confirmed problems with the patient's right arm. About one year later, in October 2014, Respondent ordered an MRI of the lumbar spine. In July 2015, she referred the patient to Leo Treyzon, M.D., who conducted a colonoscopy and an esophagogastroduodenoscopy. In December 2016 an MRI was conducted on Patient 3's right hip. The radiologist's report has a diagnosis of bursitis, but does not report any other significant problems, calling the findings minimal. (Ex. B, p. 269.)

84. (A) In October 2016, Respondent referred Patient 3 to Beny Charchian, M.D. regarding back pain. Dr. Charchian practices pain management and interventional spine medicine. In his report, Dr. Charchian states the patient had a flare up of pain which progressed to 10/10 in intensity. Charchian reported Medrol Dosepak and bilateral lumbar paraspinal trigger point injections, administered on September 21, 2016, had been ineffective, though Norco provided relief. Further, Patient 3 had undergone a bilateral L4-5 transforaminal epidural steroid injection on October 5, 2016, which had provided a 50 to 60 percent improvement for one week.

(B) Dr. Charchian reported that an MRI of the lumbar spine on September 23, 2016 revealed at L4-5 mild to moderate disc desiccation with a 3-4 mm posterior disc protrusion, mild central stenosis, along with other issues. Dr. Charchian assessed low back pain, myofascial pain, lumbar radiculopathy, prolapsed lumbar intervertebral disc, and spinal stenosis. He refilled a Norco prescription, and advised that if a conservative approach involving physical therapy and epidural injections failed, he

would consider platelet rich plasma therapy rather than a surgical referral. (Ex. B, p. 287.)

85. Respondent counseled Patient 3 to transition from benzodiazepines to other medications, and she advised him to consult with specialists such as pain specialists, those who treat addiction, or psychiatrists. These discussions occurred as an almost bi-monthly event in the latter part of 2015. During a June 2, 2015 office visit, Patient 3 told Respondent Ativan and Xanax were the only thing that helped his abdominal pain. Respondent was concerned about his drug intake and spoke to his therapist at around that time. According to Respondent's notes, the therapist advised Respondent to continue refilling the patient's benzodiazepine prescriptions, "as he will get elsewhere and need to work on weaning with me. Shared with her my concern of her [sic] overuse and discussed rehab option but he is very much against. (Ex. B, p. 90.)

86. The record for an office visit in August 2015 states a plan to wean the patient off Valium by adding Seroquel or Fetzima. Patient 3's valium use was discussed during a September 29, 2015 office visit, and Respondent prescribed Fetzima, an anti-depressant, in what apparently was an off-label use of that drug to manage the patient's anxiety. However, on October 19, 2015, the patient advised Respondent he had not been taking the Fetzima. On November 10, 2015, Respondent discussed with him he might start inpatient treatment, but he refused because of his family. Respondent discussed a psychiatrist, Dr. Keene, who treated addiction. She restated in her notes that she had spoken to his therapist, who was of the opinion that Respondent should continue to prescribe Valium because he would obtain it anyway, and Respondent might be able to control the amount. And, the notes for an office visit in December 2015 once again show a plan to wean from diazepam and Xanax. Respondent gave Patient 3 the name of an addiction specialist, Dr. Keene.

87. In the fall of 2015, and in the ensuing months, the chart indicates Respondent was less refill authorizations when the refills were requested by phone. She had the patient in for office visits, treating problems such as elevated Uric acid (ex. B, p. 138), and an outbreak of herpes in November 2016. (Id., at p. 146.) She referred the patient to Dr. Charchian, as noted above, who documented lumbar radiculopathy and other indications of back injury and back pain. In January 2017 Respondent again discussed finding substitutes for Valium, and in March 2017 she had a long discussion about Valium, from which the patient claimed he was weaning. At that time Respondent broached genetic testing that might help find alternative medications. The patient agreed to that testing if it could help find alternative medications. (Ex. B, p. 164.)

88. On August 29, 2016, Respondent saw the patient, who was complaining of foot pain. Under the "subjective" portion of the chart entry it states "valium off since 3wks." (Ex. B., p. 137.) This seemingly good news was overshadowed approximately six weeks later, during a visit on October 6, 2016. The notes for that visit, under "assessment/plan" state, as the number 1 entry: "ween off valium currently taking 10 mg. daily getting from dr li at urgent care." (*Id.*, at p. 143. Punctuation as in original.) On January 19, 2017, it appears that Respondent prescribed Valium 10 mg. daily. (Id., at p. 155.)

89. It appears from the chart that genetic testing was performed sometime prior to April 5, 2017, as Respondent wanted Patient 3 to come in to discuss the results. He resisted, pointing to the cost of an office visit, and asked Respondent to just send a detailed e-mail. (Ex, B., p. 172.) The record doesn't show what response, if any, was made by Respondent, but on April 10, 2017, Patient 3 left a message about a

bill he had received from Assurex Health, the company that was to perform the genetic testing.

90. On May 7, 2017, Respondent sent a short letter or note to Patient 3. She stated hesitancy to prescribe controlled substances to him in the past, and pointed out their multiple long and in-depth discussions about his use of controlled substances, and her efforts to have him see psychiatry, pain management, Dr. Charchian to help directly treat the source of his pain. She stated Dr. Vitti, his therapist, had suggested writing anxiety medications, but Respondent didn't feel comfortable. She reiterated her desire for Patient 3 to consult a pain doctor and a psychiatrist, and she provided the names of practitioners at Cedars-Sinai. (Ex. B, p. 174.)

91. By May 12, 2017, the doctor-patient relationship had ruptured, due to problems with the lab's bill for the genetic testing. On that day Respondent sent an e-mail to Patient 3, responding to his complaint that she had been having him undergo unnecessary tests, implying she was somehow profiting from that. She pointed out that she made nothing on the tests, and she stated she would continue to find out what the problem had been with the lab. However, she asked him to find another internist, gave him the name of a referral service, and said she would assist him with medical care through May 26, 2017.

92. During her interview with the Board, Respondent acknowledged that in retrospect, she had been dealing with an addict, and that she should not have followed the psychotherapist's advice to prescribe Valium so as to avoid the patient seeking the medications elsewhere. (Ex. 26, pp. 134, 136.) At hearing she testified to her concern about Patient 3 obtaining drugs on the street, because a patient's son had bought counterfeit drugs on the street, and was seriously harmed as a result.

Treatment of Patient 4

93. Patient 4 is a woman who was 70 years old when first seen by Respondent. Patient 4 had treated with Dr. Fine from at least January 2013.Her history included Hypothyroidism, Spinal Stenosis, Monoclonal Gammopathy, Raynaud's Phenomenon, Factor V Leiden, prothrombin gene mutation, ovarian cyst: rupture, and intestinal obstruction. (Ex. E, p. 21.) In April 2014 the patient complained of right knee pain. She was smoking cannabis two times per week.

94. The chart entry for April 3, 2014 contains a "new medication list" that includes Ambien 5 mg. tablet, Cymbalta 60 mg. capsule, Diazepam 2 mg. tablet oral as needed, and Diazepam 5 mg. tablet, 1 qhs. She was also prescribed Restoril (Temazepam). (Ex. E, p. 29.)

95. Dr. Millstein opined there were no problems with dosage of any of the medications prescribed to Patient 4; and thus there was no overprescribing claims. In his opinion Diazapam and Temazepam should not have been prescribed to the patient at the same time, but nonetheless he did not find a deviation from the standard of care. This was based on his perception of actual practice in the community, and his opinion that trying to take the patient off of the drugs could have deleterious consequences. In this regard, Dr. Millstein stated in his report:

> It is recognized that both of these drugs [temazepam and diazepam] are generally to be avoided in Seniors, as they may contribute to cognitive impairment, falls and other problems, however in the actual practice in the community, they are in fact prescribed to a considerable number of Seniors, especially those who have been on them for a long

> time in the past. . . . It is very difficult to get such a patient off these meds, as they often develop very uncomfortable insomnia and anxiety. The phenomenon is sometimes called "Low dose benzodiazepine dependence" and trying to stop these meds completely can cause more harm than good.

(Ex. 27, p. 7.)

96. Respondent changed her practice of prescribing both drugs in 2018. Patient 4 still treats with Respondent. Dr. Millstein is of the opinion Respondent did not adequately monitor the patient and she did not adequately discuss the two drugs with the patient, which he deems a simple departure from the standard of care. That opinion is based upon his review of the records. As in the cases of the other patients, Dr. Millstein is critical of Respondent's records, finding them overall to be inadequate, and the record keeping below the standard of care.

Treatment of Patient 5

97. Patient 5 was a man who was 68 years old when first seen by Respondent in November 2013. He had been Dr. Fine's patient and was suffering from bladder cancer which had become metastatic. He reported chronic lower abdominal pain and bloating. Respondent's notes are less than clear regarding her prescriptions to Patient 5, but a CURES report shows that he was receiving hydrocodone, initially 5mg. three times per day, increasing later to 10 mg. six times per day. The patient was also receiving lorazepam 1 mg. four times per day, and Ambien.

98. Respondent last saw the patient on June 25, 2014, but her prescriptions of opioids and sedatives continued to late December 2015.

99. Dr. Millstein did not find a departure from the standard of care in terms of the prescribing. He noted the patient was home-bound, in uncontrolled pain, and the patient refused hospice. Given the patient's condition, he did not find the prescriptions to be excessive, and he found that with the patient being home-bound, a lack of visits was not to be criticized.

100. Dr. Millstein found the records deficient because active medications were not clearly listed, and there was inadequate history in a pre-op visit. However, on cross-examination he acknowledged that the pre-op report contained information about the patient's prior coronary heart disease, including an MI and stent placement in 1995, and pulmonary disease. Dr. Millstein acknowledged he may not have seen the one page of that December 4, 2013 report, found at exhibit C, page 34, or exhibit 20, page 147. In Dr. Millstein's opinion the failure to list the active medications amounted to a simple departure from the standard of care.

Dr. Brose's Opinions

101. As noted above, Dr. Brose stated his opinion that Respondent's records were deficient. However, it was his opinion her prescribing was within the standard of care for the period in question, 2013-2016. Some other points he made, in his testimony or his report or both, should be elucidated.

102. Complainant pointed out that Dr. Millstein, like Respondent, is an internist, while Dr. Brose is a pain specialist. However, Dr. Brose has significant experience with the prescribing practices of primary care doctors. That experience has been garnered from his development and operation of a pain rehabilitation network, and in reviewing the care and treatment provided by more than 300 physicians who have referred patients to Dr. Brose's pain network. That experience was augmented by

his consulting to Multispecialty Group Practices, and his review of thousands of cases where patients have been prescribed pain medications by primary care providers.

103. In his testimony and his report, Dr. Brose gave a history of the evolution of prescribing practices, from 1986 when Portenoy and Foley published a report concluding that opioids could be a safe therapy for patients suffering from non-malignant, intractable pain, to the present. He discussed the sea change that occurred after 2001, when the Eden jury verdict against a physician for undertreatment of pain triggered a shift toward more liberal prescribing of opioids, and the passage of Health and Safety Code section 124691, establishing patient rights. Dr. Brose describes how prescribing of opioids was essentially liberalized during the first decade of this century. He noted that by 2009, there was no ceiling on dosing, which Dr. Brose contends is the case today, notwithstanding the efforts to publish guidelines that would seek to constrain prescription of opioids. (Ex. H, p. 4.)[12] After discussion of a number of issues, Dr. Brose states: "As described above even now, there is no published opioid analgesic ceiling and the patient demand for pain relief has continued to drive a wide range of dosing. It is not possible to establish a ceiling dose for safe prescribing nor is it possible to establish a ceiling dose for pain relief." (Ex. H, p. 10.) This should not be read to say that Dr. Brose is a proponent of unlimited pain medications.

104. Dr. Brose pointed out that the Board's 2007 Guidelines for Prescribing Controlled Substances for Pain (2007 Guidelines) very much liberalized prescribing of pain medication. They provided, at a Postscript, that while there were limitations on prescribing drugs for the treatment of chemical dependency, a physician could

[12] A color version of the report is found at exhibit I.

prescribe pain medications to a "'known addict'" as they would for any other patient. (Ex. 44, p. 5.)

105. Dr. Brose discussed the pendulum swing that occurred after November 2011, when the CDC published information pertaining to overdoses from opioids. New guidelines were published by the Board in late 2014, and the CURES system was established, though it was some time before it became a useful instrument. He noted, however, that guidelines, whenever published, take time to change the standard of care, relying on a study that indicated five years may pass.

106. Longer term use of opioids is associated with higher doses of opioids; such increases are clinically described as a result of drug tolerance and hyperalgesia. In Dr. Brose's opinion, such progressive dose escalation should be seen as the norm and "very much within the standard of care that has existed in the United States over the past 25 years." (Ex. H, p. 5.)

107. It became commonplace to prescribe benzodiazepines, or other medications, along with opioids. However, the combination of opioids and benzodiazepines could be dangerous to some patients, especially where higher opioid doses were provided. Dr. Brose cited a 2017 study showing increased risk of accidental death when both types of drugs were prescribed, especially where the opioid doses were 50 mg. or higher. (Ex. H, p. 15.)

108. Dr. Brose points out recent publications have made it clear that forced tapering of medications or even terminating the medications was not recommended, nor was patient abandonment recommended. Dr. Brose quoted extensively from a memorandum from the FDA Center for Drug Evaluation and Research Division of Anesthesia, Analgesia, and Addiction issued in May 2019, regarding unintended

consequences of incorrect interpretation of CDC guidelines. The gist of the memorandum was that inadequately treated chronic pain has consequences, as that pain is a risk factor for suicidality, and misinterpretation of the CDC 2016 guidelines contributed to substantial harm to some patients, through forced taper from medications, forced discontinuation of opioids, or patient abandonment. (Ex. H, p. 21-23.)

109. Dr. Brose cited a 2019 article where the authors concluded that discontinuation of chronic opioid therapy did not reduce risk of death and was associated with increased risk of overdose death. He noted the deaths might include a gateway from prescription drug refusal to illicit drug use, a matter requiring more study.

110. Dr. Brose found listening to the recording of Respondent's interviews with the Board revealed her to be a thoughtful, concerned, knowledgeable and penitent physician. (Ex. H, p. 37.) In his opinion, her main issue was record keeping, as he believes her prescribing was within the standard of care as it had evolved in the first eleven years of this century, and before the more restrictive practices became standard of care. He opined that to the extent that some of the patients appeared to have substance abuse disorders, such was a co-morbidity to be managed with their pain, not instead of their pain. (*Id.*, p. 38.) He noted Respondent's decisions to end the relationship with patients 2 and 3 were made after a long and protracted course of encounters where she attempted to have them consult with other physicians. Again, Dr. Brose pointed out there is ample authority for the proposition that patients should not be abandoned or cut off, certainly not at the first sign of trouble.

The 2014 Guidelines

111. In November 2014, the Board published its Guidelines for Prescribing Controlled Substances for Pain (2014 Guidelines). The 2014 Guidelines specifically state "these guidelines are not intended to mandate the standard of care. The Board recognizes that deviations from these guidelines will occur and may be appropriate depending on the unique needs of individual patients. Medicine is practiced one patient at a time and each patient has individual needs and vulnerabilities." (Ex 45, p. 4.)

112. The 2014 Guidelines state that experts are to review cases by defining the standard of care in terms of the level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question. (Ex 45, p. 5.)

113. The 2014 Guidelines note that while opioid withdrawal is generally not life threatening, that is not the case with benzodiazepine withdrawal, which can be life threatening. Thus, while opioids may be abruptly stopped, that is not the case with benzodiazepines. (Ex 45, p. 21)

114. The 2014 Guidelines provide: "That physicians who prescribe long-term opioid therapy should be knowledgeable in the diagnosis of substance use disorders and able to distinguish such disorders from physical dependence—which is to be expected in chronic therapy with opioids and many sedatives." (Ex. 45, p. 20.) The 2014 Guidelines in turn differentiate physical dependence from tolerance and from addiction. Physical dependence is manifested by drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reaction, decreasing blood level of the drug and/or administration of an antagonist. Addiction is

characterized by one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving. (*Id.*, at p. 7.)

115. The 2014 Guidelines speak to treating patients with a history of substance abuse disorder, describing use of opioids for such patients to be "challenging." (Ex. 45, p. 11.) Those 2014Guidelines go on to counsel that for patients using illicit drugs, the risks may outweigh the benefits. In other patients, the benefits may outweigh the risks. "Although evidence is lacking on the best methods for managing such patients [those with substance abuse disorder], potential risks may be minimized by more frequent and intense monitoring than for lower risk patients [and limiting quantities and working with an addiction specialist]." (*Ibid.*)

Respondent's Character Witnesses

116. Two witnesses testified on Respondent's behalf, one a physician and surgeon who is Respondent's patient, and one a lay person who is also a patient. Both portrayed Respondent in a very positive light.

117. (A) Kelley Baek, M.D., is a fertility specialist. She is Board certified in Obstetrics and Gynecology, and Reproductive Endocrinology and Fertility. She first met Respondent in 2011. In 2012 she began referring patients to Respondent. Dr. Baek noted her patients are challenging, and she testified her patients all "love" Respondent, informing Dr. Baek that they have never had such thorough care.

(B) Dr. Baek referred her husband to Respondent for treatment. He had been hospitalized eight times in a two-year period for pancreatitis, seeing many doctors who could not determine his problem. The hospitalizations were at Cedars-Sinai and UCLA, well-regarded institutions. Some of his physicians suspected that Dr. Baek's husband had an alcohol problem although he doesn't drink; this plainly

frustrated Dr. Baek. In any event, Respondent ran various tests on Dr. Baek's husband, and discovered a loop in a duct, finding the problem that eluded other physicians.

(C) Since that time, Dr. Baek, her family, and friends have treated with Respondent. A close friend from Dr. Baek's medical school days has treated with Respondent, travelling from out of state to do so.

(D) Dr. Baek summed up Respondent as the most conscientious data-driven physician that she has ever seen.

118. (A) Respondent's other character witness was long-term patient G. T. He has treated with Respondent for approximately 23 years. He has referred his wife and her parents to Respondent.

(B) G.T. described how Respondent promptly diagnosed his mother-in-law's cancer when other physicians dismissed her issues as a function of old age.

(C) G.T. described Respondent as a clear communicator, who explains the whys and wherefores of tests and treatments. He has referred others to Respondent and has not been disappointed.

Mitigation and Rehabilitation

119. In closing argument, Complainant painted Respondent as a physician who prescribed excessive controlled substances with an eye toward extra profit. The evidence does not support that claim. Respondent is guilty of rather poor record keeping, but she does not appear to be a drug peddler.

120. Respondent has no record of discipline prior to this matter, and she has never been sued in civil court for malpractice.

121. Respondent has taken remedial steps, as she has acknowledged her shortcomings during her interviews with the Board, and during the hearing. She acknowledged her failings with sincerity. After her Board interview in April 2018, her insurance carrier, CAP-MPT, as part of its risk management practice, provided in-service training to Respondent and her staff. She attended the PACE courses at the UCSD Medical School for record keeping and prescribing practices. She completed the three-day prescribing course on May 1, 2019, and she completed the two-day record keeping course on May 3, 2019. She testified that she has significantly cut back on prescribing controlled substances, and she is using CURES as it should be.

122. Throughout the hearing, Respondent was respectful of the process and the Board's role.

Credibility

123. Respondent was credible in her testimony, in terms of content, attitude, and demeanor, which was observable to the ALJ (but not to Complainant's counsel) by video. She acknowledged, as she had during her interviews with the Board, that her record keeping had been substandard. She also demonstrated a caring attitude toward her patients, not only those relevant to this case, but toward others.

124. Each expert was credible in their demeanor and the content of their testimony. It must be found that Dr. Brose, Respondent's expert, has superior qualifications to those possessed by Dr. Millstein, though Dr. Milstein is by all means qualified to provide opinions about Respondent's practice. Complainant's expert, who has been a pain management and addiction physician, has stopped practicing in that area. Dr. Brose has been on the cutting edge of both fields for many years, but also has extensive interaction with primary care providers, as found in Factual Finding 102.

Other Findings

125. While Dr. Brose pointed out that there is ample authority for the proposition that a physician should not abruptly terminate a patient, or cut them off from controlled substances, there was little or no evidence from either side as to how a physician should proceed when it becomes evident the patient has an actual or potential problem with controlled substances. It was implicit that at some point an internist should stop treating such a patient, and urge them to obtain treatment with others; but the clear import of the 2014 Guidelines, and from the expert opinions, is that cutting the patient off, especially from benzodiazepines, is contra-indicated. Dr. Millstein spoke to this in his analysis of Patient 4's medications, stating that trying to take the patient off of the two benzodiazepines might do more harm than good. (Factual Finding 95.) At bottom, especially with Patients 2 and 3, Respondent attempted to substitute medications, and to encourage the patients to see specialists to get to the root of the patient's problems, or to deal with the dependency that she perceived. Dr. Brose believed she acted within the standard of care by doing so, even if she continued to prescribe the patients' medications.

126. While Respondent was criticized for not obtaining an adequate history for some of the patients, and especially Patients 1, 2, and 3, it was not clear just what steps were required by the standard of care during the time in question. Dr. Brose opined in his report that during the relative time period, trusting to the veracity of one's patient was within the standard. As noted in Factual Finding 35, it appears Dr. Millstein would have the physician engage in detective work. For a physician to quiz a patient's family and friends about the patient's alcohol or drug use would be invasive of privacy and a potential HIPAA violation. To be sure, obtaining prior treater's records or consulting with them would not be such a violation, assuming consent from the

patient was forthcoming. There is no evidence the standard of care required Respondent to search court records for any patient, let alone Patient 2. Hence the fact that a family court proceeding in approximately 2007 required drug testing and rehabilitation for that patient was something that Respondent did not know about, and could not know about absent research into her patient's legal history.

LEGAL CONCLUSIONS

Jurisdiction

1. Jurisdiction to proceed in this matter pursuant to Business and Professions Code sections 2004 and 2227[13] was established, based on Factual Findings 1 through 3.

Statutes Allegedly Violated by Respondent

2. Complainant alleged violations of several statutes, claiming gross negligence as to Patients 1, 2, and 3 in violation of section 2234, subdivision (b); repeated negligent acts involving all the patients, in violation of section 2234, subdivision (c); excessive prescribing as to Patients 1, 2, and 3 in violation of section 725; inadequate records as to all five patients in violation of section 2266; and, prescribing to an addict, as to Patients 1, 2, and 3, in violation of section 2241.

3. Section 2234 states, in pertinent part:

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[13] Further statutory citations are to the Business and Professions Code unless otherwise noted.

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:

[¶] . . . [¶]

(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.

4. Section 725 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.

5. Section 2266 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."

6. Section 2241 states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her

treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

7. While not charged with violating section 2241.5, portions of that statute may be pertinent to this case. Section 2241.5, subdivisions (a) and (b) provide:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a

condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

Rules of General Applicability

8. The standard (as opposed to the burden) of proof in this proceeding is that of clear and convincing evidence, to a reasonable certainty. (*Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Complainant was therefore obligated to adduce evidence that was clear, explicit, and unequivocal—so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In Re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

9. (A) The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at p. 67–68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) The testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

(B) The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. Disbelief does not create affirmative evidence to the contrary of that which is discarded. "The fact that a jury may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative." (*Hutchinson v. Contractors' State License Bd. of Cal.* (1956) 143 Cal.App.2d 628, 632–633, quoting *Marovich v. Central Cal. Traction Co.* (1923) 191 Cal. 295, 304.)

(C) Discrepancies in a witness's testimony, or between that witness's testimony and that of others does not necessarily mean that the testimony should be discredited. (*Wilson v. State Personnel Bd.* (1976) 58 Cal.App.3d 865, 879.)

(D) "On the cold record a witness may be clear, concise, direct, unimpeached, uncontradicted—but on a face to face evaluation, so exude insincerity as to render his credibility factor nil. Another witness may fumble, bumble, be unsure, uncertain, contradict himself, and on the basis of a written transcript be hardly worthy of belief. But one who sees, hears and observes him may be convinced of his honesty, his integrity, his reliability." (*Wilson v. State Personnel Bd.* (1976) 58 Cal.App.3d 865, 877–878, quoting *Meiner v. Ford Motor Co.* (1971) 17 Cal.App.3d 127, 140.)

(E) An expert's credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co.* (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. Los Angeles County* (1968) 267 Cal.App.2d 837, 847.)

(F) The trier of fact may reject the testimony of a witness, including an expert witness even if it is uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3

Cal.3d 875, 890.) The expert's opinion is no better than the facts on which it is based and, "where the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923–924.)

(G) Even when the witness qualifies as an expert, he or she does not possess a carte blanche to express any opinion within the area of expertise. For example, an expert's opinion based on assumptions of fact without evidentiary support, or on speculative or conjectural factors, has no evidentiary value and may be excluded from evidence. Similarly, when an expert's opinion is purely conclusory because unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value because an expert opinion is worth no more than the reasons upon which it rests. (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116.) The bare conclusion of an expert without supporting facts is not entitled to evidentiary weight. (*Bushling v. Fremont Medical Center* (2004) 117 Cal.App.4th 493.)

(H) As noted previously, the presiding officer in an administrative proceeding may evaluate evidence based on his or her experience or training. (Gov. Code, § 11425.50, subd. (c).)

10. A professional is negligent if he or she fails to use that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. Just what that standard of care is for a given professional is a question of fact, and in most circumstances must be proven through expert witnesses. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v.*

Alta Bates Hospital (1992) 5 Cal.App.4th 208, 215; see 6 B. Witkin, *Summary of California Law* (9th. Ed.), Torts, sections 749, 750, and 774.)

11. The Code does not define just what "gross negligence" means in proceedings of this type. The Court of Appeal addressed this matter in *Kearl v. Board of Medical Quality Assurance,* (1986) 189 Cal.App.3d 1040. There the Second District Court of Appeal stated:

> Gross negligence is "'the want of even scant care or an extreme departure from the ordinary standard of conduct.'" (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.1053, 1063], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)[14]

(189 Cal.App.3d at 1052-1053.)

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[14] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App.3d 1040, 1058.

12. (A) "Mere error in judgment, in absence of a want of reasonable care and skill . . . , will not render a doctor responsible for unintentional consequences in treatment of his patient." (*Hufman v. Lindquist* (1951) 37 Cal.2d 465, 475.)

(B) In selecting a method of treatment, skillful members of the medical profession may differ; however, the practitioner must keep within the "recognized and approved methods." (*Callahan v. Hahnemann Hospital* (1934) 1 Cal.2d 447.) If so, negligence is not shown by evidence that other medicines or treatment might have been employed. (*Jensen v. Findlay* (1936) 17 Cal.App.2d 536.) The mere fact there is a difference of medical opinion concerning the desirability of one particular medical procedure over another does not establish the determination to use one of the procedures was negligent. (*Clemens v. Regents of Univ. of Cal.* (1970) 8 Cal.App.3d 1, 13.)

13. "Repeated negligent acts" is defined as two or more acts of negligence. (*Zabetian v. Medical Board* (2000) 80 Cal.App.4th 462, 468; see also Code § 2234, subd. (c)(1).)

14. (A) The purpose of proceedings of this type is to protect the public, and not to punish an errant licensee. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.)

(B) While public protection is the highest priority of the Board and the ALJ, the Board and the ALJ "shall, whenever possible take action that is calculated to aid in the rehabilitation of the licensee, ..." (§ 2229, subd. (b).) However, that rehabilitative effort must not endanger the public. (*Id.*, at subd. (c).)

Legal Conclusions Dispositive of the Case

FIRST CAUSE FOR DISCIPLINE—GROSS NEGLIGENCE

Patient 1

15. (A) It is alleged in the FAA that Respondent was grossly negligent by failing to monitor Patient 1's use of controlled substances in combination with his use of alcohol, by failing to investigate his alcohol use and psychiatric history, and by failing to document a good faith encounter before prescribing controlled substances to Patient 1.

(B) It was not proven by clear and convincing evidence that Respondent committed gross negligence in her care and treatment of Patient 1. The thrust of the charge as enunciated by Dr. Millstein during the hearing was Respondent should not have prescribed valium to an elderly patient who drank, heavily. Dr. Brose was of the opinion that the prescribing was within the standard of care. As found, the evidence indicates that Respondent had no knowledge that the patient was consuming great quantities of alcohol, and lab results did not indicate such. As to the allegation that Respondent prescribed controlled substances without a good faith encounter, the evidence indicates that when she first saw Patient 1, he was still Dr. Fine's patient, and as noted in footnote 6 to the FAA, the last iteration of the patient records include an encounter with another physician prior to being prescribed controlled substances. That Respondent did not perform an extensive investigation of the patient's psychiatric history is deemed at most a simple departure from the standard of care.

Patient 2

16. (A) It was alleged in the FAA that in the care and treatment of Patient 2 there were a series of recurring simple departures from the standard of care regarding controlled substances prescribing, and that the prescription of Fiorinal, Xanax, and Soma to Patient 2 on November 11, 2014, when she was receiving other habit forming medications was an extreme departure from the standard of care.

(B) It was not proven by clear and convincing evidence that Respondent committed gross negligence in prescribing Fiorinal, Xanax, and Soma to Patient 2 on November 11, 2014. In this matter, Dr. Brose's testimony was credited.

Patient 3

17. (A) As to Patient 3, it is alleged in the FAA that Respondent's prescribing as to Patient 3 represented recurring simple departures from the standard of care, which in the aggregate resulted in excessive prescribing, and prescribing to someone who Respondent should have known was an addict. It was further alleged that Respondent's care and treatment of Patient 3 represented a significant lack of knowledge of substance abuse and addiction.

(B) It was proven that Respondent was grossly negligent in her care and treatment of Patient 3, by continuing to prescribe controlled substances, primarily benzodiazepines, to him over a long course of treatment. The October 2014 communications (through her assistant) with his pharmacy, indicating early refills, and her lack of knowledge of just what had been prescribed to him indicates a substantial deviation from the standard of care. (Factual Finding 75.) The string of simple departures from the standard of care described by Dr. Millstein did aggregate into gross negligence sometime in 2015, after Respondent was on notice of Patient 3's

history of dependence on benzodiazepines, and after she had noted in September 2014 that his Ativan use was excessive.

Second Cause for Discipline—Repeated Negligent Acts

18. (A) The claim of repeated negligent acts repeats the factual allegations of the First Cause for Discipline, implicitly re-alleging the allegations of numerous acts of simple negligence over a period of time with Patients 1, 2, and 3, along with non-prescribing claims pertaining to Patients 4 and 5.

(B) It was proven that Respondent engaged in repeated acts of negligence, subjecting her to discipline pursuant to section 2234, subdivision (c). These acts pertain mainly to record keeping.

Third Cause for Discipline—Excessive Prescribing as to Patients 1, 2, and 3

19. (A) The FAA alleges that Respondent engaged in clearly excessive prescribing in violation of section 725 in her prescribing to Patients 1, 2, and 3.

(B) It was proven that Respondent engaged in clearly excessive prescribing to Patient 3. As set forth in Factual Finding 71, by September 2014 Respondent perceived Patient 3's Ativan use to be excessive, and she stated in her interview that at that point Patient 3 was overusing. The long course of prescribing (mainly) benzodiazepines for the patient's back pain and abdominal pain, and the amounts of the drugs, was excessive.

Fourth Cause for Discipline—Inadequate Records as to All Five Patients

20. It was proven Respondent failed to maintain adequate and accurate records as to her provision of services to five of her patients, subjecting her to discipline pursuant to section 2266.

Fifth Cause for Discipline—Prescribing to an Addict as to Patients 1, 2, and 3

21. The controlling statute—section 2241—makes clear a physician can prescribe controlled substances to a patient who is an addict, to treat conditions other than the addiction, which essentially must be treated in a specific manner, and in compliance with provisions of the Health and Safety Code.

22. (A) The first issue to be determined in this claim is whether these patients, or any one of them, was an addict. Section 2241, subdivision(d)(1), provides a definition of an addict as "a person whose actions are characterized by craving in combination with one or more of the following: "(A) Impaired control over drug use. (B) Compulsive use. (C) Continued use despite harm."

(B) Subdivision (d)(2) provides: "Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5." The statutory definition of an addict is mirrored in the 2014 Guidelines, which provide addiction is characterized by one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. (Factual Finding 114.)

(C) It was not proven that Patient 1 was an addict. He regularly used controlled substances, but it was not demonstrated he had impaired control over his drug use, that he was compulsive, or used the controlled substances despite harm.

(D)(i) Patient 2 showed signs she was compulsive in her prescription drug use, and had impaired control over it. This is inferred from her claimed loss of drugs, and other behaviors. Patient 2 therefor should be deemed to have been an addict, unless her drug-seeking behavior was "primarily due to the inadequate control of pain." (Code § 2241, subd. (d)(2).)

(D)(ii) There was evidence that Patient 2 was in pain; at her first visit she rated her pain at 8 of 10. Toward the end of the relationship Respondent noted that Patient 2 was tolerant of the dosages that were being administered, but was still in pain. At another point, again late in the relationship, Patient 2 claimed she couldn't function because of the pain.

(D)(iii) Patient 2 did have a history of conditions that would be the source of pain, such as back pain, fibromyalgia, and lupus, notwithstanding Dr. Louie's disagreement with Dr. Wallace's diagnosis. Dr. Raskin in his MRI order in June 2013 stated Patient 2 had chronic pain, and Dr. Louie believed Patient 2 had back issues that would be expected to be painful.

(D)(iv) On balance, there is sufficient evidence that Patient 2's drug seeking behavior was primarily due to the inadequate treatment of pain, removing her from the classification of addict by operation of section 2241, subdivision (d)(2).

(E) Patient 3 had been diagnosed as having substance abuse disorder (as to four substances) in 2012, and Respondent learned of his hospitalization for substance abuse disorder in February 2015, within a few months of the beginning of

the doctor-patient relationship. Prior to the revelation of the patient's prior hospitalization, Respondent had noted Patient 3's excessive Ativan use, and shortly thereafter had the communication from his pharmacy to the effect they would not fill his prescription without hearing directly from Respondent. (Factual Findings 71, 75, 78-81.) Although he complained of abdominal and back pain, and was treated for back pain by Dr. Charchian in October 2016, the evidence does not show his drug seeking behavior was "primarily" the result of pain. The evidence establishes that Patient 3 was an addict within the meaning of section 2241 and the 2014 Guidelines.

23. (A) Even though it is found Patient 3 was an addict, that does not end the inquiry, because a physician may prescribe controlled substances to an addict for a purpose other than to maintain the addict or to help the addict detoxify. (Code § 2241, subd. (a).) Further, even if the patient is an addict, a physician may prescribe controlled substances to that patient to treat pain or a condition causing pain, including, but not limited to, intractable pain. (Code § 2241.5, subd. (a).)

(B) Respondent was prescribing medications in response to back and abdominal pain, as well as anxiety. This was sufficient to bring her within the safe harbor provided by section 2241, subdivision (a).

The Board's Disciplinary Guidelines

24. Some grounds for discipline having been established, the issue becomes what should the disciplinary response be. The Board has developed disciplinary guidelines, entitled "Manual of Model Disciplinary Orders and Guidelines (2016)" (Disciplinary Guidelines) which are incorporated by reference into California Code of Regulations, title 16, section 1361, subdivision (a). The Disciplinary Guidelines provide guidance, at once general and specific, for what the disciplinary response should be

for violations of the Medical Practice Act. The Discipline Guidelines provide that where an ALJ would depart from those Guidelines, for reasons such as mitigating circumstances, the age of the case or evidentiary problems, such issues should be identified.

25. (A) In summary, the Disciplinary Guidelines usually recommend a maximum discipline, and a minimum, though revocation is the only remedy for some violations, such as registering as a sex offender.

(B) For gross negligence and repeated negligent acts under section 2234, or for failing to maintain adequate records in violation of section 2266, the maximum discipline is revocation of the physician's certificate, while the minimum may be summarized as revocation stayed, with five years of probation, with conditions to include various courses, such as the prescribing course, monitoring, solo practice prohibition, and prohibited practices.

(C) For excessive prescribing under section 725, the Disciplinary Guidelines provide for revocation of the certificate, while the minimum discipline is revocation stayed with five years' probation, a 60 day suspension, Drug Enforcement Administration (DEA) controlled substances restriction, controlled substances records, and various courses, including education course, prescribing and record keeping courses, clinical competence and professionalism courses, and monitoring.

Assessment

26. Respondent has practiced medicine for nearly 28 years without any prior discipline or civil claims. However, her conduct as established here was serious, and involved numerous failures to meet the standard of care related to three patients, and

her medical records did not provide accurate and complete information about her patient's care and treatment of five of her patients.

27. As set forth in the findings, there were some mitigating factors regarding the record keeping, in that Respondent was changing her practice, and had had to contend with two different electronic record keeping programs. Both experts agreed the process of adopting electronic record keeping was a challenge throughout the profession. It appeared that Respondent was keeping much information in her head, and not in the charts, but the Code doesn't call for cerebral record-keeping; it calls for records to be on paper or in electronic storage so that it can be printed out. A physician's records must be up to date and accurate to have any currency, and they must have currency to be of any use to other practitioner's and medical institutions, and thereby for the benefit of the patient.

28. As noted in Factual Finding 119, it was not proven that Respondent was some sort of for-profit pill pusher. She tried to transition Patients 1, 2, and 3 away from controlled substances virtually from the first encounter, and she tried to treat the malady, and not just the pain, which is commendable. By her demeanor during the hearing, and based on the comments of Dr. Brose and the two character witnesses, one a double-board certified physician who is Respondent's patient, Respondent is a caring practitioner who wants what is best for her patients. It appears she got in too deep with Patients 2 and 3, and she should have terminated the patient-physician relationship sooner than she did.[15] As set out in Factual Finding 125, there is no clear

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[15] In his report Dr. Millstein stated, regarding Patient 2, that he did credit Respondent for eventually catching her mistakes, and offering appropriate substance abuse counseling for the patient, which fell on deaf ears. He further acknowledged

cut guidance for an internist who is concerned with their patient's proclivities for controlled substances as to when to terminate the relationship, while the 2014 Guidelines make it clear abrupt termination of benzodiazepines is dangerous.

29. A mitigating factor is that these events occurred as the pendulum was swinging away from the liberal prescribing practices that began in the early part of this century. Respondent, who had practiced in the post-Eden era, may have been behind the curve. By early 2017, when she was still treating Patient 3, she should have been aware of the changing landscape.

30. Respondent has taken responsibility for her shortcomings from the first Board interview in April 2018. As found, she had her insurer come into her office and evaluate and train on record keeping. She took the prescribing practices and record keeping courses at UCSD, and her certificates of completion for those courses should have currency with the Board. She has reduced her prescribing of controlled substances, improved her record keeping, and is using CURES in the manner it is used by up-to-date practitioners. These are positive steps toward rehabilitation.

31. Respondent's counsel argued for a disciplinary response short of a probation order, but such a substantial departure from the Disciplinary Guidelines is not appropriate. That is not likely to be practicable for the Board to assure public protection outside the structure of license probation. Notably, Dr. Brose in his report, after discussing the changes that Respondent had made to her practice, believed some

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that "even the most conscientious physician may sometimes be duped by a substance abuser" but that Respondent's carelessness was far outside the norms for primary care practice. (Ex. 27, p. 16.)

monitoring of her practice was appropriate, although he did not believe that restrictions or further education was necessary. (Ex. H, p. 38.) While Respondent was credible in her testimony and appeared genuinely desirous of practicing better medicine, an appropriate response here is to "trust but verify."

31. (A) Some departures from the recommended length of probation and the probation are justified after some of the following are considered: the passage of nearly four years since the relationship with Patient 3 terminated, the other events being further in the past; the fact that Respondent has no prior discipline in over 27 years of practice; Respondent's recognition of her professional shortcomings; and, her efforts to change her practice, and to obtain further training and education. By her attitude about her mistakes, and her respectful attitude toward the Board and this process (unfortunately not seen in every Respondent's demeanor) it is reasonable to follow the legislative mandate of rehabilitating practitioners when it can be done with safety to the public. Therefore, the length of probation shall be set at three years, standard terms will be ordered, she will be allowed to conduct a solo practice, an actual suspension will not be ordered as it would be unduly punitive, and no restriction will be imposed upon her DEA registration or her practice.

ORDER

Certificate Number G76535. issued to Respondent Patricia Jeh-Yee Chang, M.D., is hereby revoked. However, the revocation is stayed, and Respondent is placed on probation for 36 months upon the following terms and conditions.

1. Controlled Substances—Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its

designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Prescribing Practices Course

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

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Medical Record Keeping Course

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

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and

successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. 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(s), 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(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating

whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. 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.

7. Notification

Within seven (7) days of the effective date of this Decision, 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.

8. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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 Board'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.

14. 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.

15. 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.

16. 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 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.

17. 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.

DATE: 02/18/2021

Joseph Montoya
Joseph Montoya (Feb 18, 2021 00:06 PST)
JOSEPH D. MONTOYA

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **Patricia Jeh-Yee Chang, M.D.** **2080 Century Park East, Suite 303** **Century City, CA 90067-2006** **Physician's and Surgeon's Certificate No. G76535,** Respondent.	Case No. 800-2016-023076 OAH No.: 2019081071 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Christine J. Lally (Complainant) brings this First Amended 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 May 17, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G76535 to Patricia Jeh-Yee Chang, 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 February 28, 2021, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

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

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

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

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

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the board deems proper.

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

"...."

7. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer

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dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

8. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of

the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

9. 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."

10. 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.

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"(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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – 3 Patients)

11. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of Patients 1, 2, and 3.[1] The circumstances are as follows:

Patient 1

12. Patient 1 (or "patient") was a 76-year-old male who treated with Respondent from approximately July 28, 2013 through June 9, 2015,[2] for various conditions including shoulder and thumb pain, ongoing bronchitis, and a lymph node in his neck.[3] Records indicate that Respondent prescribed to Patient 1 multiple medications including diazepam (Valium, which is also used to

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[1] The patients are identified by numbers to protect their privacy.

[2] These are approximate dates based on the medical records which were available to the Board. Patient 1 may have treated with Respondent before or after these dates, as the first set of records indicate that at least three prescriptions for controlled substances were written by Respondent to Patient 1 prior to the first documented visit on July 28, 2013. After the instant Accusation was filed, and more than a year after Respondent had produced records of Patient 1, and certifying that those records were "complete," on January 27, 2020, Respondent belatedly forwarded approximately 300 pages of additional discovery to Complainant's counsel, which necessitated the continuance of this case. Complainant has not been able to verify the authenticity of the additional discovery.

[3] Patient 1 may have been treated for other conditions/maladies besides pain, given the medications which were being prescribed, but the records were at times unclear as to those conditions/maladies.

treat anxiety and alcohol withdrawal syndrome), zolpidem (Ambien, which is used to treat insomnia), pain medications such as Vicodin (Norco), oxymorphone, Lyrica, Soma, and temazepam (a hypnotic/sedative).[4] Patient 1 died of an apparent suicide on September 16, 2015.[5]

13. Respondent's care and treatment of Patient 1 fell below the standard of care by failing to adequately evaluate and monitor Patient 1's use of controlled substances in combination with Patient 1's use of alcohol, failing to adequately investigate Patient 1's alcohol history (e.g. prior treatment for alcohol/drug use, etc.) and psychiatric history (e.g. to confirm whether Patient 1 was, in fact, seeing a psychiatrist, and what the psychiatrist or other treating physician was recommending or prescribing), and by failing to document a good faith encounter with Patient 1, prior to prescribing controlled substances to the patient.[6]

14. Overall, Respondent's care and treatment of Patient 1, as outlined above, represented recurring simple departures from the standard of care for not adequately evaluating and monitoring Patient 1's controlled substance use, particularly sedatives, and an extreme departure for prescribing controlled substances to Patient 1 prior to any documented good faith encounter.

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[4] These medications are also all controlled substances with serious side effects and risk for addiction.

[5] Additional discovery provided by Respondent documented, among other things, that Patient 1 likely abused alcohol. Patient 1 was an alcoholic for many years before his death in 2015, and would often drink vodka throughout the day.

[6] As stated in footnote 2 above, the additional discovery belatedly forwarded by Respondent appears to document that Patient 1 did have an encounter with another physician, prior to being prescribed controlled substances. However, no such encounter was documented in the previous "certified" records originally produced by Respondent.

Patient 2

15. Patient 2 (or "patient") was a 52-year-old female who treated with Respondent from approximately July 22, 2014 through May 25, 2016,[7] when Respondent realized that Patient 2 may have an addiction problem, and terminated the doctor-patient relationship. Patient 2 lists a number of medical problems including myopathy, arthropathy, side and back pain, and chronic pain associated with Lupus.[8] Patient 2 was on high doses of ADHD drugs, and other controlled medications such as Butrans, Morphine Sulfate, Vyvanse, oxycodone, lorazepam, and Dextroamphetamine.[9]

16. Throughout the time period from July 22, 2014 through May 25, 2016, records show that Patient 2 often claimed to have "lost" her medications and contact information of referrals to pain management specialists and other specialists. Patient 2 would request additional medications for "travel" (e.g. on November 11, 2014, three additional drugs (Fiorinal, Xanax, and Soma) were

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[7] Again, these are approximate dates based on the medical records which were available to the Board. Patient 2 may have treated with Respondent before July 22, 2014, as records indicate that three weeks prior to that visit, multiple prescriptions for substantial doses of controlled medications were written for Patient 2 under Respondent's name. It should also be noted that this case resulted from a consumer complaint filed by Patient 2's relative, who claimed that Respondent was overprescribing medications to Patient 2, and that she may have been selling the drugs prescribed by Respondent. After the case was filed, the Medical Board also discovered that Patient 2 had died on or about October 26, 2017 of acute diazepam, amphetamine, oxycodone, and oxymorphone intoxication. Per Patient 2's family's representative, she [Patient 2] was a "drug addict." Court records also show that Patient 2 may have had substance abuse issues as far back as 2007/2008, during which a Court imposed numerous restrictions on Patient 2, including ongoing drug testing, rehab, restrictions on her prescribing physician, and even requiring Patient 2 to have a "sober companion" with her [i.e. Patient 2], when she had physical custody of her minor children.

[8] Patient 2 subsequently saw a Rheumatologist on December 4, 2015, who determined that Patient 2 did not show any clinical or serologic tests which supported the diagnosis of Lupus.

[9] Most of these drugs were listed on CURES, but Respondent's notes on the first documented visit had no indication of the type of medications Patient 2 was taking, how long Patient 2 was taking those medications, no urine drug screens, no mention of location of pain/pain scales, no mention of previous treatment with prior doctors, and the like. Respondent also prescribed Spironolactone (non-habit forming) to Patient 2, without fully adequate documentation of indication, and at a very high dose.

prescribed to Patient 2 for a trip to New York and London) or other reasons.[10] Throughout this time period, Respondent also documented many orders involving her care of Patient 2, but often there was no adequate reasoning for these orders (e.g. ordering of medications for Diabetes without mention of blood sugars or Hemoglobin A1cs, etc.). There were also multiple tests documented, but some exams (e.g. multiple (8) normal pelvic exams between July 30, 2014-June 1, 2015) appeared to have been re-populated from documentation from prior visits, and some of other the other tests ordered by Respondent were not recommended/warranted.

17. Also, there is no listing of prior medications Patient 2 was taking (e.g. name of medication(s), how long Patient 2 was taking the medication(s), etc.), no pain scales/descriptions, no documentation of prior communications with previous doctors, or documentation that prior medical records were reviewed, no checking of CURES, and no documentation that Respondent adequately investigated Patient 2's past medical history.

18. Overall, Respondent's care and treatment of Patient 2, as outlined above, represented recurring simple departures from the standard of care regarding controlled substances prescribing (both habit-forming and non-habit-forming drugs), and an extreme departure for the prescribing of three additional habit-forming drugs (Fiorinal, Xanax, and Soma) in substantial quantity on November 11, 2014, in a patient who was already on multiple habit-forming medications. Respondent's care and treatment of Patient 2, as outlined above, also represents a lack of knowledge of prescription drug abuse.

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[10] These are all signs or "red flags" indicating addiction. Also, at the first documented visit, Respondent stated, among other things, that she needed to wean Patient 2 off pain medication, and that Respondent planned to obtain prior medical records. Despite this, records indicate that Respondent never followed through on this plan, but instead continued to prescribe/refill multiple controlled substances to Patient 2, sometimes at the request of Patient 2. Records also indicate that Patient 2 would reject less addictive medications (e.g. Butrans, Avinza, Lyrica) which Respondent prescribed or wanted to prescribe to Patient 2.

Patient 3

19. Patient 3 (or "patient") is a 45-year-old male who treated with Respondent from approximately July 18, 2013 through May 3, 2016.[11] Patient 3's past history included right elbow and bilateral hip pain, and anxiety. Respondent diagnosed Patient 3 with olecranon bursitis, bilateral sacroiliac joint arthritis, and ADHD, although the reasoning behind some of these diagnoses were not clear from the record.[12]

20. Respondent prescribed to Patient 3 Vyvanse (an amphetamine-like stimulator), without evidence that this was medically indicated, and Xanax (a habit-forming sedative) in 2013. There are no records of any controlled medication refills from Respondent to Patient 3 until March 2014, when the patient started filling Valium (diazepam, which is a sedative), but there is no recorded visit or other documentation explaining this prescription. After March 2014, Respondent also prescribed to Patient 3 lorazepam (another sedative), and records show that Respondent continued prescribing Valium to Patient 3 until May 3, 2016.[13]

21. Overall, Respondent's care and treatment of Patient 3, as outlined above, represented consistently recurring simple departures from the standard of care in prescribing controlled substances, which in the aggregate resulted in an extreme departure in excessive prescribing, and prescribing to someone who Respondent should have known was an addict. Respondent's care and treatment of Patient 3, as outlined above, also represents a significant lack of knowledge about substance abuse and addiction.

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[11] Again, these are approximate dates based on medical records available for review and prescription records (e.g. CURES). Respondent's notes also indicate that Patient 3 was using multiple controlled substances in the past, but the record is unclear as to the previous prescribing doctor, the indication for the previous prescriptions of controlled medications, or the current medications Patient 3 was taking.

[12] Respondent also mentions that Patient 3 is drinking, but the record is unclear whether the patient is consuming alcohol (e.g. the type of alcohol, amount, etc.).

[13] Throughout 2014 and 2015, Respondent's notes indicate that Patient 3 may be using excessive amounts of sedatives, and that the patient may have addiction issues. Despite this, records show that Respondent was continuing to prescribe habit-forming sedatives (e.g. lorazepam and Valium) to Patient 3. Interestingly, in Respondent's note, dated November 10, 2015, she discusses a conversation with Patient 3's therapist, who allegedly advised Respondent to continue prescribing Valium to Patient 3 because the patient will get it anyway. In an interview with the Board, Respondent also states that Patient 3 may have been in rehab for substance use around November 2012. However, Respondent asserts that she was unaware of this fact at the time of the first visit.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – 5 Patients)

22. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligent acts in her care of Patients 1, 2, 3, above, and 4, and 5. The circumstances are as follows:

23. The facts and circumstances in paragraphs 11 through 21, above, are incorporated by reference as if set forth in full herein.

24. Respondent also committed repeated negligent acts in her care of Patients 4 and 5. The circumstances are as follows:

Patient 4

25. Patient 4 (or "patient") is a 75-year-old female who treated with Respondent from approximately April 3, 2014 through September 2016. Patient 4 had various maladies including a very long history of insomnia, but there is no entry in Respondent's notes mentioning chronic insomnia. Respondent prescribed temazepam and diazepam to Patient 4, but Respondent's notes do not discuss these medications which were prescribed to Patient 4 until February 2018, during the Board's investigation of Respondent.[14]

26. Respondent's medical record regarding Patient 4 also included a listing of other medications Patient 4 was taking, but it is unclear whether these medications were old or current. The record for Patient 4 also included many inaccuracies such as a pelvic exam with a "normal cervix" in a patient who had a hysterectomy, and a physical exam which said genitals "not examined," but also indicating that the "scrotum" in Patient 4 (who is a female) was normal.

27. Overall, Respondent's care and treatment of Patient 4, as outlined above, represented a simple departure from the standard of care for not adequately monitoring the use of controlled

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[14] Respondent stated, among other things, in an interview with Board investigators that she [Respondent] was unaware that Patient 4 was taking temazepam and diazepam simultaneously, despite multiple refills in her name. The records also did not indicate why both these medications were prescribed simultaneously. Respondent also admitted during the Board interview that her medical record-keeping was poor.

substances for insomnia, and a recurrent simple departure from the standard of care for medical record-keeping.

Patient 5

28. Patient 5 (or "patient") is a 68-year-old male who treated with Respondent from approximately November 1, 2013 through June 25, 2014.[15] Patient 5 had bladder cancer and was homebound. Respondent's record is unclear as to whether some of the prescriptions to Patient 5 were made in the office, or whether Patient 5 was being prescribed controlled substances over the phone because he was homebound. The record is also unclear as to whether Respondent was prescribing to Patient 5 as a covering physician for another doctor, or whether Respondent had actually met the patient. In the initial visit, the medication list is not verified as to what is current. Also, there are prior prescriptions which are not explained.

29. Overall, Respondent's care and treatment of Patient 5, as outlined above, represented two[16] simple departures in documentation, in not listing the patient's active medications, and in not providing appropriate information during a pre-op visit.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing – 3 Patients)

30. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to Patients 1, 2, and 3, above.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate Records – 5 patients)

31. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in

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[15] As with the other patients mentioned herein, these are approximate dates, as prescription records show that the prescribing of opioids and sedatives by Respondent to Patient 5 continues to at least December 28, 2015.

[16] The additional discovery belatedly provided by Respondent appears to document a pre-op visit.

that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1, 2, 3, 4, and 5, above.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing to an Addict – 3 Patients)

32. Respondent is subject to disciplinary action under section 2241 of the Code in that Respondent prescribed controlled substances to Patients 1, 2 and 3, who had signs of addiction/substance abuse.

33. The facts and circumstances in paragraphs 11 through 21, above, are incorporated by reference as if set forth in full 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 G76535, issued to Patricia Jeh-Yee Chang, M.D.;

2. Revoking, suspending or denying approval of Patricia Jeh-Yee Chang, M.D.'s authority to supervise physician assistants and advance practice nurses;

3. Ordering Patricia Jeh-Yee Chang, 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: MAR 10 2020

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