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

In the Matter of the Accusation Against: Kalpana Amarendra Phadnis, M.D. Physician's and Surgeon's Certificate No. A120572 Respondent	Case No. 800-2019-057135

DECISION

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

This Decision shall become effective at 5:00 p.m. on May 26, 2021.

IT IS SO ORDERED: April 26, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **KALPANA AMARENDRA PHADNIS, M.D.** 2081 Bronze Star Dr Woodland, CA 95776-5423 Physician's and Surgeon's Certificate No. A 120572 Respondent.	Case No. 800-2019-057135 OAH No. 2020050732 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

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2. Respondent Kalpana Amarendra Phadnis, M.D. ("Respondent") is represented in this proceeding by attorney John Quincy Brown III, whose address is:

Hardy, Erich, Brown & Wilson
455 Capitol Mall, Suite 200
Sacramento, CA 95814

3. On or about March 16, 2012, the Board issued Physician's and Surgeon's Certificate No. A 120572 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-057135, and will expire on November 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-057135 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 9, 2020. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-057135 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-057135. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-057135, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a factual basis with respect to the charges and allegations in Accusation No. 800-2019-057135, a true and correct copy of which is attached hereto as Exhibit A, and that she has subjected her Physician's and Surgeon's Certificate, No. A 120572, to disciplinary action.

11. Respondent agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

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

13. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2019-057135 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 120572 issued to Respondent Kalpana Amarendra Phadnis, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) III-V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

This restriction shall be deemed fully satisfied upon the Board's receipt and acceptance of a certificate of completion from a Board approved prescribing practices course. 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.

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

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

3. 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.

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

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

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

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

complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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, 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, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

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7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place

of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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

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

period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards'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; and Quarterly Declarations.

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

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

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate

and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

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ACCEPTANCE

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

DATED: 01/11/2021

KALPANA AMARENDRA PHADNIS, M.D.
Respondent

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

DATED: Jan 11, 2021

JOHN QUINCY BROWN III
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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DATED: 01/11/2021

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Respondent

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DATED: Jan 11, 2021

JOHN QUINCY BROWN III
Attorney for Respondent

ENDORSEMENT

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DATED: Jan 11, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Kalpana Amarendra Phadnis, M.D.** 2081 Bronze Star Dr. Woodland, CA 95776-5423 Physician's and Surgeon's Certificate No. A 120572, Respondent.	Case No. 800-2019-057135 **A C C U S A T I O N**

PARTIES

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

2. On or about March 16, 2012, the Medical Board issued Physician's and Surgeon's Certificate Number A 120572 to Kalpana Amarendra Phadnis, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2021, unless renewed.

JURISDICTION

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

4. 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.

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

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

6. Section 2266 of the Code, states in pertinent part:

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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PERTINENT DRUG DEFINITIONS

7. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride ("hcl") is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

8. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

9. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[1] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

10. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of

[1] Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

11. Alprazolam – Generic name for Xanax. Alprazolam is a benzodiazepine that is commonly used in short-term management to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam can increase the risk of respiratory depression when taken in combination with opiate and opioid medications. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

13. Respondent is a family practice physician in Woodland, California. On November 26, 2013, Patient A[2] presented at Respondent's clinic to establish new care. According to the history of present illness documented in the medical record, Patient A presented with, "a history of MS[3], RA[4], hypertension, CAD[5], neuropathy, DM[6], PAD[7], hypothyroidism, hyperlipidemia, shingles twice in the past, narcolepsy, chronic pain. She also uses 2 L of oxygen at night by nasal cannula." The medical record documented that another physician in Colusa, California, was previously both Patient A's primary care physician, and had also provided chronic pain management care. According to Respondent, the prior physician's clinic was, "shut down by the

[2] Patient's name has been omitted to protect confidentiality. All witnesses will be fully identified in discovery.
[3] Multiple sclerosis
[4] Rheumatoid arthritis
[5] Coronary artery disease
[6] Diabetes mellitus
[7] Peripheral artery disease

narcotics squad and so the patient has transferred care here." According to the progress note, Patient A's medical records from the other physician's clinic were not available. Respondent documented that Patient A requested refills of some of her medications.

14. On November 26, 2013, medical records documented that a PHQ-9[8] questionnaire was completed and Patient A presented with a score of 17, indicating a moderately severe problem with depression. Respondent documented that Patient A was currently taking hydromorphone, methadone, and tramadol for pain. Respondent documented that Patient A was also taking alprazolam for anxiety. Respondent documented a brief physical examination but failed to document the physical issues that generated Patient A's pain, failed to specify what physical functions were altered by pain, and failed to state how Patient A's past chronic pain treatments had affected her physical function. Respondent also failed to document in Patient A's medical history whether non-opioid treatments and/or low dose opioid treatments had failed in treating Patient A's pain. Respondent failed to document whether Patient A had a history of substance abuse. According to Patient A's certified pharmacy profile, Dr. L had prescribed and Patient A had received a three-month supply of methadone and hydromorphone on October 29, 2013.[9] Assuming Patient A was taking a daily dose of 4 tablets of 10 mg methadone, 7 tablets of 8 mg hydromorphone, 1 tablet of 100 mg tramadol, and 3 mg of alprazolam, under the prior physician's care, Patient A had a daily MED[10] of 554 in combination with benzodiazepines.

15. Respondent documented in Patient A's treatment plan for chronic pain that Patient A would bring all of her medication bottles at her next visit in two weeks and that Respondent would get Patient A's "medication history from Davison drug house in Colusa." Respondent prescribed Patient A 30 tablets of 100 mg tramadol and a 30 tablets of 1 mg alprazolam, but did nor prescribe hydromorphone or methadone. Respondent did not order any medical imaging, nor

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[8] The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.

[9] 360 tablets of 10 mg. methadone, 630 tablets of 8 mg. hydromorphone.

[10] Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day. http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17.

did she have Patient A provide a urine drug test. Respondent did not have Patient A sign a controlled drug agreement on November 26, 2013.

16. Respondent next saw Patient A on December 10, 2013, in her clinic for a two-week follow-up. Respondent documented under history of physical illness that Patient A was there for follow-up regarding diabetes, hyperlipidemia, and chronic pain. Respondent documented Patient A's chronic pain as follows that:

> "she is on Diluadid 8 mg 4 tablets daily along with methadone 10 mg 4 tablets daily for chronic pain. She is complaining of 10/10 pain today because she has run out of medications. She is requesting a refill of her pain medications. She has not established care with pain management."

Respondent also documented that Patient A suffered from coronary artery disease, narcolepsy, rheumatoid arthritis, and was a current every day smoker. Respondent documented that she did a minimal general physical examination but failed to document the physical issues that generated Patient A's pain, failed to specify what physical functions were altered by chronic pain, and failed to state how Patient A's past chronic pain treatments had affected her physical function. Respondent did not have Patient A sign a controlled drug agreement on December 10, 2013. Respondent also did not perform and/or document performing an EKG[11] and did not document that she provided Patient A with a specific informed consent regarding the dangers of prescribing methadone to a patient with a known history of cardiac disease. While Respondent documented that she ordered a drug abuse screen in Patient A's medical records, the first urine drug screen result actually documented in Patient A's chart is dated December 22, 2014.

17. Respondent documented in Patient A's plan for chronic pain therapy that she would refill Patient A's methadone and Dilaudid and make a referral to pain management to establish care. Assuming Patient A took the prescriptions as Respondent prescribed, Patient A was taking a daily prescription of 4 tablets of 10 mg methadone, 4 tablets of 8 mg hydromorphone, and 1 tablet of 100 mg tramadol, for chronic pain while also taking 1 tablet of 2 mg alprazalom for

[11] Electrocardiogram

anxiety.[12] Respondent documented that Patient A would receive a referral to pain management and that she would be contacted within 3 to 5 business days.

18. On December 23, 2013, Patient A was admitted to Enloe Medical Center in Chico, California for symptoms related to a cardiac event after being transferred from the Colusa Hospital emergency department. That same day Patient A underwent a quintuple bypass of her heart vessels. Patient A's methadone prescription was stopped following the hospital admission for the cardiac event. Respondent next saw Patient A on January 13, 2014, in office. Respondent documented Patient A's hospital admission from December 23, 2013, and noted that Patient A was in severe pain due to her recent surgery and her chronic pain conditions. Respondent noted that Patient A's chronic pain was a result of three abdominal hernias, which were operated on multiple times. Respondent noted that Patient A had 10 surgeries over ten years. Respondent noted that Patient A was out of all of her pain medications and that a referral to pain management was still pending authorization.

19. On January 13, 2014, Respondent began prescribing a monthly total of 120 tablets of 8 mg hydromorphone, which if taken as prescribed would mean Patient A was taking 32 mg per day.[13] Patient A had received 30 tablets of 1 mg alprazolam and 30 tablets of 2 mg alprazolam on January 9, 2014, from a prior prescription from Respondent. Respondent discontinued both methadone and tramadol. Respondent documented that she would order a urine toxology screen at the next visit but, as noted above, the first urine drug screen did not occur until December 22, 2014. On January 13, 2014, Respondent had Patient A enter a controlled substances agreement with Respondent. Respondent failed to document a comprehensive physical examination related to Patient A's chronic pain issues.

20. On February 4, 2014, Respondent next saw Patient A in her clinic. Respondent refilled Patient A's hydromorphone and noted that the pain management referral was still pending and that the patient was waiting for an appointment. Respondent noted that the office would need to follow-up on Patient A's pain management referral. On March 4, 2014, Respondent next saw

[12] An MED of 458 in combination with a benzodiazepine.
[13] An MED of 128 in combination with a benzodiazepine.

Patient A in clinic. Respondent documented that Patient A's pain was not controlled on hydromorphone and that Patient A reported that she had a lot anxiety despite being on 2 tablets of 1 mg alprazolam. Respondent documented again that the referral to pain management was still pending. Respondent noted that Patient A stated she had severe pain in her right leg all the way down to her foot, and stated that, "her leg feels like a dead weight." Respondent documented a brief physical examination and that Patient A was in moderate distress due to pain, but failed to specifically document Patient A's sources of pain or a more complete physical examination geared to chronic pain. Respondent documented under the treatment plan that Patient A would continue to be prescribed 32 mg of hydromorphone per day and would be prescribed 20 mg of hydrocodone with acetaminophen for breakthrough pain.[14] Respondent also documented that she continued Patient A on 2 tablets of 1 mg alprazolam per day but that Patient A could take a third pill of alprazolam if she felt her anxiety was not controlled. On March 27, 2020, at an investigative interview with the Board, Respondent was asked why she managed Patient A's chronic pain with two short-acting opiates, Dilaudid and Norco. Respondent stated, "(w)ell, I do not have experience in pain management and I would – I would not be (inaudible) if I needed to transition the patient on such high doses of opiates (inaudible) –uh—that is not within my –uh—you know (inaudible) and I don't think (inaudible) to that competently."

21. On April 4, 2014, Respondent next saw Patient A in clinic. Respondent documented Patient A was taking 3 tablets of 1 mg alprazolam per day and that Patient A's anxiety was under improved control. Respondent also documented that Patient A was having shooting pain from her right groin to her right toe. Respondent documented that Patient A's referral to pain management was still pending. Respondent documented that Patient A reported that the Norco prescription for breakthrough pain was, "not adequate to control her pain." Respondent noted that Patient A remained on hydromorphone. Respondent refilled Patient A's 60-tablet prescription for 5/325 mg hydrocodone with acetaminophen and her 120-tablet prescription for 8 mg hydromorphone. Respondent also prescribed 60 tablets of 50 mg Lyrica to Patient A.[15]

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[14] An MED of 148.

[15] Lyrica, generically known as pregabalin, is a Schedule V controlled substance designed to treat neuropathic pain.

22. On May 2, 2014, Respondent next saw Patient A in clinic. Respondent documented that Patient A reported that her pain was not well controlled and that she was taking 4 to 6 tablets of 5/325 mg Norco per day. Respondent documented that she increased Patient A's Lyrica to 50 mg tablet three times daily, and that she advised Patient A to not take more than four Norco tablets per day. Respondent continued Patient A on hydromorphone and Norco. Respondent also continued Patient A on 3 tablets of 1 mg alprazolam.[16]

23. On May 30, 2014, Respondent next saw Patient A in clinic for chronic pain and anxiety. Respondent documented that Patient A stated that her pain was reasonably well controlled but that the Patient wanted to change from 5/325 mg Norco tablets to stronger 10/325 mg Norco tablets in order reduce her Tylenol intake. Respondent documented that 3 tablets of 1 mg alprazolam kept Patient A's anxiety well controlled. Respondent documented a brief physical exam and noted that Patient A was alert and oriented and not in distress. However, Respondent did not document a more comprehensive physical examination of Patient A's chronic pain complaints. Respondent documented in the treatment plan that she was now prescribing 90 tablets of 10/325 mg hydrocodone with acetaminophen and continuing Patient A's 90 tablet prescription of 1 mg alprazolam and 120 tablet prescription of 8 mg hydromorphone.[17] Despite documenting that Patient A's pain was "reasonably well controlled," Respondent failed to document why she was increasing Patient A's MED from 148 to 158.

24. Between June 27, 2014, and October 22, 2014, Respondent prescribed hydromorphone, hydrocodone with acetaminophen, and alprazolam to Patient A. On or about October 22, 2014, Respondent increased Patient A's hydrocodone with acetaminophen prescription to 120 tablets of 10/325 mg per month. Respondent noted that she had discontinued Lyrica due to cost and had started Patient A on gabapentin and that she was increasing Norco. Between October 22, 2014, and March 30, 2017, on a recurring monthly basis, Respondent

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[16] Respondent incorrectly documented the benzodiazepine as lorazepam (Ativan) in Patient A's chart rather than the alprazolam which was actually prescribed.

[17] MED of 158 in combination with a benzodiazepine.

prescribed 120 tablets of 10/325 mg Norco, 120 tablets of 8 mg hydromorphone, and 90 tablets of 1 mg alprazolam to Patient A.[18]

25. A review of the progress notes between October 22, 2014, and March 30, 2017, shows that Respondent documented a treatment plan from visit to visit but did not set forth any objectives for Patient A to reach while on chronic pain therapy. Between October 22, 2014, and March 30, 2017, Respondent often documented that Patient A's pain was 10/10 and that the medications were not effective, yet there was no change in Patient A's chronic pain therapy. Respondent often documented that she referred Patient A to a pain specialist for chronic therapy management but there was never any follow-up with this referral, and Patient A was not seen by a pain specialist during that period of time. Similarly, a review of the progress notes between October 22, 2014, and March 30, 2017, reveals a lack of documentation of Patient A's progress on controlled substances. Respondent failed to document a change in Patient A's chronic pain treatment plan despite Patient A being either unable and/or unwilling to go to see a pain management specialist. Finally, between October 22, 2014, and March 30, 2017, Respondent failed to document any comprehensive physical examination findings or medical imaging that would have supported the continued prescribing of controlled substances.

26. Between June 27, 2014, and March 30, 2017, Respondent did not document whether she ever suspected that Patient A was abusing her pain management therapy despite an indication that Patient A was at risk of abuse. For example, on June 2, 2014, Patient A was admitted to Enloe Medical Center following a fall in her garage when she tried to feed her cat. According to the hospitalization summary from the hospital stay, Patient A's presentation was consistent with narcotic abuse in terms of hypotension, respiratory acidosis, and improvement in the conditions with time in the hospital. It was noted that on June 3, 2014, Patient A left Enloe Medical Center against medical advice while pending an MRI[19] to rule out other neurological defects because Patient A wanted to take "all her pain medications at her usual dose." The physician at Enloe Medical Center stated that prior to Patient A leaving against medical advice, she advised Patient

[18] MED of 168 in combination with a benzodiazepine.
[19] Magnetic resonance imaging.

A that she should only take her pain medications at reasonable dosages or she would be at risk of sedation and hypotension. The discharge summary from Enloe Medical Center is located in Respondent's medical chart and dated July 7, 2014. Despite this record from Enloe Medical Center, Respondent continued to prescribe controlled substances to Patient A.

27. On April 3, 2017, a podiatrist saw Patient A regarding concerns with ulcers plantar and posterior to both heels. The podiatrist debrided Patient A's heels. On April 17, 2017, a physician assistant that is supervised by Respondent saw Patient A in clinic. At that time, Patient A had last received 120 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 8 mg hydromorphone, and 90 tablets of 1 mg alprazolam on March 30, 2017, from Respondent. The physician assistant noted that Patient A presented with complaints of bilateral foot pain and that her pain level was 10 out of 10. The physician assistant noted that Patient A was extremely defensive when confronted with the fact that she smoked 6-10 cigarettes per day, and told the physician assistant to "stop this shit" in reference to the physician assistant telling her to quit smoking. The physician assistant documented in regards to Patient A's chronic pain therapy that Patient A stated, "(s)he's been on Dilaudid for over 15 years and feels that her body is somewhat immune to this because it does not help her pain."

28. In the treatment plan, the physician assistant documented that Patient A was in severe pain and that because she had been taking her medications every four hours, that she was due to run out of her controlled medications in a few days. The physician assistant noted that Patient A was not due for a refill of her pain medication until April 27 or April 29, at least 10 days later. The physician assistant noted that Patient A wanted a referral to pain management (despite Respondent documenting that she had referred Patient A to pain management over the last two and half years of progress notes) and she wanted a refill or increase of her chronic pain medications. The physician assistant stated she was unable to increase Patient A's chronic pain medications and that she would speak with Respondent about the medication regimen. Respondent counter-signed the physician assistant's note on April 23, 2017.

29. On April 20, 2017, Respondent prescribed and Patient A received 90 tablets of 1 mg alprazolam and 84 tablets of 8 mg hydromorphone. This represented an early refill of Patient A's

medications. Respondent failed to author a progress note in the medical record that set forth the reason or basis for this early refill. Respondent next prescribed to Patient A on May 5, 2017. Respondent failed to verify that Patient A had run out of opioid medication prior to issuing new prescriptions. Assuming that Patient A had in fact run out of all opioid medication by April 20, 2017, 84 tablets of hydromorphone over 15 days would mean that Patient A was now taking at least five pills of 8 mg hydromorphone a day, but could take as many as six pills per day.[20]

30. On May 3, 2017, Patient A presented at Enloe Medical Center. According to the history of present illness, Patient A had fallen on the afternoon of May 2, 2017, and her caregiver had found her in a confused mental state. According to the Enloe Medical Center note, her caregiver brought Patient A to the hospital but the caregiver dropped Patient A off at the hospital and left. According to the Enloe Medical Center note, Patient A was confused and unable to provide any information whatsoever; specifically, her answer to most of the questions was, "I have heel problems." The note mentioned that Patient A had previously been admitted to Enloe Medical Center in June 2014 and mentioned Patient A's history of excessive narcotic use. In the assessment and plan, the physician at Enloe Medical Center noted that Patient A had "Acute encephalopathy and quite likely opiate and benzodiazepine related, I will hold those. In fact, I will hold all patient's outpatient medications, as patient is drowsy. She will be on bowel rest until she is more awake and prove that she can eat and swallow." The note from Enloe Medical Center also mentioned that Patient A would be placed on "p.r.n. Narcan[21]" and that she was somewhat hypotensive. On the bottom of the Enloe Medical Center note, there was writing which indicated the report was for Respondent's clinic and the note was stamped May 3, 2017, in the upper right hand corner of the chart.

31. On May 5, 2017, Respondent prescribed and Patient A received a 28-day supply of controlled substances which included 112 tablets of 10/325 mg hydrocodone with acetaminophen and 168 tablets of 8 mg hydromorphone. Assuming these medications were taken as prescribed,

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[20] Five pills of 8 mg hydromorphone per day as an MED of 160. Six pills of 8 mg hydromorphone has an MED of 192. This was in combination with a benzodiazepine.

[21] Naloxone, sold under the brand name Narcan

Patient A would be taking 4 tablets of 10/325 mg hydrocodone with acetaminophen and 6 tablets of 8 m. hydromorphone in combination with three tablets of 1 mg alprazolam per day.[22] There is no documentation in Patient A's medical record that explains why the prescriptions were dispensed to Patient A on May 5, 2017.

32. On May 9, 2017, Respondent next saw Patient A in clinic for follow-up. Respondent documented that Enloe Medical Center had recently admitted Patient A for concerns of confusion and difficulty in arousal by her caregiver. Respondent documented that Patient A's narcotic prescriptions were withheld while she was in the hospital and that Patent A had left the hospital "AGAINST MEDICAL ADVICE" the next day. Respondent did not document why she provided Patient A an early refill of controlled substances on April 20, 2017. Respondent noted that Patient A's diabetes was uncontrolled. Respondent noted that Patient A was taking 6 tablets of 8 mg hydromorphone daily and 3-4 tablets of 10/325 mg Norco daily as well as 3 tablets of 1 mg alprazolam daily. Respondent noted that Patient A reported that Norco does not really help much with her pain control. Respondent noted that Patient A was noncompliant with her Lyrica prescription, only taking 100 mg daily when she should have been taking 150 mg daily. Under the treatment plan, Respondent documented that Patient A had drowsiness/difficulty in arousal and attributed that to either controlled drug prescriptions or her uncontrolled diabetes. Under the treatment plan for chronic pain, Respondent documented that she would discontinue Norco and advised Patient A to "use only" 6 tablets of 8 mg hydromorphone daily. Respondent noted that, "[p]atient unwilling to reduce the dose of Dilaudid." Respondent documented that she discussed, "[s]top Norco" with Patient A but there is no documentation on what would happen to the 112 tablets of 10/325 mg hydrocodone with acetaminophen that had been dispensed to Patient A only four days earlier. Respondent also reduced Patient A's prescription of alprazolam to 1 mg tablet taken twice daily.

33. Between May 10, 2017, and July 10, 2017, Respondent did not see Patient A in clinic for chronic pain management. On May 24, 2017, an individual in Respondent's practice authored a progress note which stated that Patient A's diabetes was out of control, and that her medication

[22] MED of 232 in combination with a benzodiazepine.

was non-compliant. According to the May 24, 2017, progress note, Patient A had been hospitalized twice in 2017 and had been to the emergency room three times in 2017. The May 24, 2017, progress note documented that Respondent was updated regarding Patient A's current status. On May 25, 2017, Patient A received a prescription of 90 tablets of 1 mg alprazolam from Respondent, despite Respondent reducing the prescription to two pills daily on May 9, 2017. On June 2, 2017, Patient A received a prescription of 168 tablets of 8 mg hydromorphone. On June 19, 2017, a telephone note was entered in Patient A's medical record regarding follow-up with medication compliance. According to the telephone note, Patient A had cancelled follow-up appointments with Respondent on June 5, 2017, June 7, 2017, and June 14, 2017. According to the telephone note, Patient A stated she cancelled the appointments because she was "feeling good" and that it was difficult to travel to Respondent's clinic. According to the note, Patient A agreed to schedule a follow-up visit with Respondent in June. Patient A never attended a follow-up visit with Respondent in June 2017.

34. On July 6, 2017, a telephone call was documented with Patient A's caregiver who stated that Patient A was not doing well. According to Patient A's caregiver, Respondent was sleeping most of the time and was bed bound. According to the Patient's caregiver, when she last took Patient A to the emergency department, the caregiver had been informed that Patient A was over-medicated. According to Patient A's caregiver, she was providing Lyrica, hydromorphone, and alprazolam twice daily to Patient A instead of three times a day. Finally, Patient A's caregiver noted that she would work hard to have Patient A attend a July 11, 2017, appointment with Respondent. On June 30, 2017, Patient A received a prescription of 90 tablets of 1 mg alprazolam from Respondent, despite Respondent having previously reduced the prescription to two pills daily on May 9, 2017.

35. On July 11, 2017, Respondent next saw Patient A in clinic for follow-up regarding her diabetes and chronic pain management. Respondent documented that Patient A was on Dilaudid and was using six 8 mg tablets a day. Respondent documented that Patient A was getting over sedated and difficult to arouse. Respondent noted that she had Patient A's caregiver previously give Patient A two Dilaudid tablets in the morning and two tablets in the afternoon and

that Patient A was more alert and interactive. Respondent noted that Patient A reported her pain was not controlled on four tablets of 8 mg Dilaudid and she requested that her dose of Dilaudid be increased. Respondent documented that Patient A was receiving two tablets of 1 mg alprazolam daily and that was working for her. This statement was not supported by the pharmacy records, which showed that Patient A was still receiving three tablets of 1 mg alprazolam daily. Respondent noted that Patient reported she was more depressed since her husband passed away. Respondent documented under the treatment plan that she wanted Patient A to continue to use 2 tablets of 8 mg Dilaudid twice daily, plus use an additional tablet midday if her pain was worse. Respondent documented that she would continue Patient A on two tablets of 1 mg alprazolam. Respondent provided Patient A with a prescription for 140 tablets of 8 mg hydromorphone and Patient A received the prescription on July 12, 2017.

36. Following this visit with Respondent, Patient A was hospitalized in early August 2017 and it was determined that she would be transferred to hospice care. Respondent did not prescribe controlled substances to Patient A following the July 11, 2017, appointment. Patient A died on October 25, 2017, from multiple health complications. Between November 16, 2013, and July 12, 2017, Respondent only had Patient A provide two urine toxicology screens, which were collected on December 22, 2014, and March 20, 2015, respectively. The December 22, 2014, test was negative for hydrocodone and hydromorphone despite Patient A receiving a prescription from Respondent for 120 tablets of 10/325 mg hydrocodone with acetaminophen and 120 tablets of 8 mg hydromorphone on November 26, 2014. The December 22, 2014, test was positive for alprazolam. The March 20, 2015, test was positive for hydrocodone, hydromorphone and alprazolam.

37. Between November 16, 2013, and July 12, 2017, Patient A often reported that her pain was uncontrolled and ten out of ten despite being on high dose opioids. During that time, Respondent failed to evaluate and/or document evaluating whether or not Patient A was abusing her controlled pain medication. Between April 17, 2017, and July 12, 2017, Patient A required more and more opioids and continued to have intolerable pain. Between November 16, 2013, and July 12, 2017, Respondent failed to consider and/or document considering a referral of Patient A

to a substance abuse program. Between November 16, 2013, and July 12, 2017, aside from stopping methadone in early 2014 following Patient A's cardiac event, Respondent failed to consider and/or document considering whether she should reduce Patient A's opioid dosages. Between November 16, 2013, and July 12, 2017, despite Respondent repeatedly stating that Patient A would be referred to a pain management specialist, Respondent failed to follow through and/or document following through and ensure that Patient A was actually seen by a pain management specialist. Between November 16, 2013, and July 12, 2017, Respondent did not consider and/or document considering terminating Patient A as a patient for violating the pain contract.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

38. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she committed gross negligence during the care and treatment of Patient A. The circumstances are set forth in paragraphs 13 through 37, and those paragraphs are incorporated by reference as if fully set forth herein. Additional circumstances are as follows:

39. Respondent's license is subject to disciplinary action because she committed gross negligence during the care and treatment of Patient A in the following distinct and separate ways:

a. By improperly prescribing high dose opioids from January 2015 to July 2017 without documenting a comprehensive treatment plan for chronic pain management which set forth goals and objectives for treatment and without performing a periodic review of that treatment plan when it became apparent that Patient A was unable and/or unwilling to go to a pain management specialist.

b. By continuing to prescribe high dose opioids over a three-year period between January 2014 and July 2017 in conjunction with benzodiazepines to Patient A without obtaining any prior records, any new evaluations, any new pain management consultations or transfer Patient A's chronic pain therapy to a specialist;

c. By improperly prescribing a high morphine equivalent dose of opioids on December 10, 2013, to Patient A, which included methadone, without doing an independent

evaluation of Patient A's chronic pain, without ordering appropriate medical imaging, without following through on appropriate pain management referrals, without documenting a separate informed consent for methadone, and without ordering an EKG;

d. By failing to consider and/or document considering whether Patient A was suffering from abuse disorder between November 16, 2013, and July 12, 2017, while Respondent continued to prescribe high dose opioids to Patient A;

e. By failing to consider and/or document considering whether Patient A was suffering from hyperalgesia between November 16, 2013, and July 12, 2017, and either reduce Patient A's opioid prescriptions and/or refer her to a substance abuse program; and

f. By improperly continuing to prescribing high dose opioids to Patient A despite repeated hospital documentation which indicated that Patient A was somnolent and had repeatedly fallen in her residence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

40. Respondent's license is subject to disciplinary action under Section 2234, subdivision (c), of the Code in that she committed repeated negligent acts during the care and treatment of Patient A. The circumstances are set forth in paragraphs 13 through 39, which are incorporated by reference as if fully set forth herein. Each of the instances of gross negligence are also considered separate and distinct negligent acts. Additional negligent acts are as follows:

a. By failing to order and/or document ordering Patient A to undergo urine drug testing more than twice over a three and a half year period between November 16, 2013, and July 12, 2017.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

41. Respondent's license is subject to disciplinary action under Section 2266 of the Code in that she kept inaccurate and inadequate medical records during her care and treatment of Patient A. The circumstances are set forth in paragraphs 13 through 40, which are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 120572, issued to Kalpana Amarendra Phadnis, M.D.;

2. Revoking, suspending or denying approval of Kalpana Amarendra Phadnis, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Kalpana Amarendra Phadnis, 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: APR 09 2020

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

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