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

In the Matter of the Accusation Against: Ildiko C. Gerbatsch-Bornemisza, M.D. Physician's and Surgeon's Certificate No. A 63645 Respondent	Case No. 800-2017-033931

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 June 4, 2021.

IT IS SO ORDERED: May 7, 2021.

MEDICAL BOARD OF CALIFORNIA

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

MATTHEW RODRIQUEZ
Acting Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
State Bar No. 231195
600 West Broadway, Suite 1800
San Diego, California 92101
P.O. Box 85266
San Diego, California 92186-5266
Telephone: (619) 738-9417
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **ILDIKO C. GERBATSCH-BORNEMISZA, M.D.** **12565 Carmel Canyon Road** **San Diego, California 92130-3191** **Physician's and Surgeon's Certificate No. A 63645,** Respondent.	Case No. 800-2017-033931 OAH No. 2021010548 **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 Matthew Rodriquez, Acting Attorney General of the State of California, and by Joseph F. McKenna III, Deputy Attorney General.

2. Ildiko C. Gerbatsch-Bornemisza, M.D. (Respondent) is represented in this proceeding by attorney D. Scott Barber, Esq., whose address is: 12555 High Bluff Drive, Suite 270, San Diego, California, 92130.

3. On or about October 10, 1997, the Board issued Physician's and Surgeon's Certificate No. A 63645 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-033931, and will expire on May 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-033931 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 June 17, 2020. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2017-033931 is attached hereto as Exhibit A and hereby incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations contained in Accusation No. 800-2017-033931. Respondent has also carefully read, discussed with her counsel, and fully 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 contained 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, having been fully advised of same by her counsel.

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

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CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2017-033931 and that she has thereby subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action.

10. 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 Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2017-033931 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.

CONTINGENCY

11. This Stipulated Settlement and Disciplinary Order shall be subject to approval of the Board. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that she may not withdraw her agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the

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

ADDITIONAL PROVISIONS

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 63645 issued to Respondent Ildiko C. Gerbatsch-Bornemisza, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years from the effective date of the Decision on the following terms and conditions:

1. CONTROLLED SUBSTANCES – SURRENDER OF DEA PERMIT.

Respondent shall immediately surrender her current Drug Enforcement Administration (DEA) permit to the DEA for cancellation and may reapply for a new DEA permit limited to those Schedules not restricted by this Disciplinary Order. Respondent is prohibited from practicing medicine until Respondent submits documentary proof to the Board or its designee that she has surrendered her DEA permit to the DEA for cancellation. Within fifteen (15) calendar days after the effective date of issuance of a new DEA permit limited to those Schedules

not restricted by this Disciplinary Order, Respondent shall submit to the Board or its designee a true copy of the new DEA permit. If Respondent fails to submit to the Board or its designee a true copy of the new DEA permit within the time prescribed, Respondent will be prohibited from practicing medicine until a true copy of the new DEA permit has been submitted to the Board or its designee.

2. 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 Schedules IV and 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.

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3. 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, 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.

4. EDUCATION COURSE.

Within sixty (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 forty (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 sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

5. PRESCRIBING PRACTICES COURSE.

Within sixty (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 twelve (12) 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 contained in Accusation No. 800-2017-033931, 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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

6. MEDICAL RECORD KEEPING COURSE.

Within sixty (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 twelve (12) 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 contained in Accusation No. 800-2017-033931, 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.

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

7. PROFESSIONALISM PROGRAM (ETHICS COURSE).

Within sixty (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 twelve (12) 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 contained in Accusation No. 800-2017-033931, 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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

8. MONITORING – PRACTICE.

Within thirty (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 and Disciplinary Order and Accusation No. 800-2017-033931, and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision and Disciplinary Order, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Disciplinary Order and Accusation, 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 sixty (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 sixty (60) calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. 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 ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (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 fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (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.

9. PROHIBITED PRACTICE.

During probation, Respondent is prohibited from practicing, performing, or treating any patients in the area of pain management, which shall be defined as utilizing pharmacological approaches to prevent, reduce, or eliminate pain of a recurrent or chronic nature. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from practicing, performing, or treating any patients in the area of pain management, which shall be defined as utilizing pharmacological approaches to prevent, reduce, or eliminate pain of a recurrent or chronic nature. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for

immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

10. NOTIFICATION.

Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Disciplinary Order and Accusation No. 800-2017-033931 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 fifteen (15) calendar days.

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

11. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES.

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

12. 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.

13. 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 ten (10) calendar days after the end of the preceding quarter.

14. 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 thirty (30) calendar days prior to the dates of departure and return.

15. 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.

16. NON-PRACTICE WHILE ON PROBATION.

Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (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 forty (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 eighteen (18) calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

17. COMPLETION OF PROBATION.

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

18. 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.

19. 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 fifteen (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.

20. 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.

21. FUTURE ADMISSIONS CLAUSE.

If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-033931 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, D. Scott Barber, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 63645. 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: 04/16/2021

ILDIKO C. GERBATSCH-BORNEMISZA, M.D.
Respondent

I have read and fully discussed with Respondent Ildiko C. Gerbatsch-Bornemisza, 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: 4/19/21

D. SCOTT BARBER, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: April 19, 2021

Respectfully submitted,

MATTHEW RODRIQUEZ
Acting Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-033931

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
State Bar No. 231195
600 West Broadway, Suite 1800
San Diego, California 92101
P.O. Box 85266
San Diego, California 92186-5266
Telephone: (619) 738-9417
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **ILDIKO C. GERBATSCH-BORNEMISZA, M.D.** **12565 Carmel Canyon Road** **San Diego, California 92130** **Physician's and Surgeon's Certificate** **No. A 63645,** Respondent.	Case No. 800-2017-033931 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about October 10, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. A 63645 to Ildiko C. Gerbatsch-Bornemisza, 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 May 31, 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 states:

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

5. Section 2234 of the Code states, in relevant 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.

(d) Incompetence.

...

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. 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 the patient's 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.

8. 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.

9. Section 725 of the Code states:

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

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

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

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

10. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent has subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in her care and treatment of Patients A, B, C, D, and E,[1] as more particularly alleged hereinafter:

[1] To protect the privacy of the patients involved in this matter, patient names have not been included in this pleading. Respondent is aware of the identities of Patients A, B, C, D, and E.

12. **Patient A**

(a) On or about January 2, 2014, Patient A, a then-60-year-old male, presented for medication refills at the clinic where Respondent practiced general medicine.[2] Respondent issued prescriptions for long-acting Oxycontin[3] (80mg) (#150), immediate-release oxycodone[4] (30 mg) (#240), Soma[5] (350 mg) (#120), and Xanax[6] (2mg) (#90). Significantly, this combined prescription equaled a daily Morphine Milligram Equivalent[7] (MME) of approximately 960 MME/day.

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[2] Respondent completed an internship year in Family Medicine but she did not complete the residency. She applied for other Family Medicine residencies but she was not accepted. Respondent was never Board Certified nor is she eligible to sit for the Family Medicine Board Certification. Respondent has no specialty training in the field of Pain Medicine.

[3] OxyContin, an opioid, is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. Oxycontin is a brand name for oxycodone. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.)

[4] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Soma, a muscle relaxant, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short term treatment (1-3 weeks) of acute musculoskeletal pain and/or muscle spasms. Soma is a brand name for carisoprodol. According to the DEA, Office of Diversion Control, published comment on carisoprodol, dated March 2014, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

[6] Xanax, a benzodiazepine, is a Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short term treatment (4-6 weeks) of severe anxiety, panic attacks or muscle spasms when other modalities have failed. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) Xanax is a brand name for Alprazolam. The risk of respiratory depression and intentional and unintentional overdose and death is increased with the concomitant use of benzodiazepines, opioids and muscle relaxants.

[7] For a comparison of opioid doses, MME was developed to equate the many different opioids into one standard value. This standard value is based on morphine and its potency,

Respondent documented in the chart note that the amount of oxycodone would need to be "cut down" while Patient A was taking Oxycontin 80 mg.

(b) At this same visit, Respondent did not document specific symptoms or conditions suffered by Patient A justifying the need for the large amount of controlled pain medication she had prescribed. Vital signs were documented, but Respondent did not perform and/or document performing a review of systems nor physical examination at this visit. Significantly, the chart note did not include any notations regarding anxiety, panic attacks, or muscle spasms. Finally, Respondent did not counsel Patient A at this visit about the serious health risks associated with the concomitant use of high-dose opioids, benzodiazepines, and Soma.

(c) On or about January 31, 2014, Patient A returned to Respondent's clinic for medication refills. Patient A's vital signs were documented. Respondent refilled the same pain medication regimen equaling a daily MME of approximately 960 MME/day. Respondent did not document specific symptoms or conditions justifying the need for the large amount of controlled pain medication she had prescribed; she did not perform and/or document performing a review of systems nor physical examination at this visit; she did not document symptoms of anxiety, panic attacks or muscle spasms; and she did not counsel Patient A about the serious health risks associated with the concomitant use of high-dose opioids, benzodiazepines, and Soma.

(d) On or about February 27, 2014, Patient A returned to Respondent's clinic for medication refills. Respondent added Dilaudid[8] (8 mg) (#30) to Patient A's pain

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referred to as morphine equivalent doses. The Centers for Disease Control and Prevention (CDC) states, "Higher dosages of opioids are associated with higher risk of overdose and death – even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk."

[8] Dilaudid, a short-acting opioid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. Dilaudid is a brand name for hydromorphone. The DEA has identified opioids, such as Dilaudid, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.)

medication regimen but did not document in the chart note any reasons justifying the need for an additional opioid. The chart note also lacks the same critical information that was missing in Patient A's earlier chart notes in 2014.

(e) Patient A's charted visits in March, April, May and June of 2014 documented that Respondent continued Patient A on virtually the same pain medication regimen of high-dose opioids, Xanax, and Soma. And, consistent with the prior clinical visits, Respondent did not document the same critical information that was missing from Patient A's earlier chart notes in 2014.

(f) On or about July 24, 2014, Respondent saw Patient A for a follow-up visit for prescription refills. The chart note does not document any information about pain medications being prescribed at this visit. Significantly, however, a Controlled Substance Utilization Review and Evaluation System[9] (CURES) report shows that Patient A indeed filled prescriptions issued by Respondent for multiple opioids, Xanax, and Soma, on or about July 24, 2014.

(g) For the remainder of 2014 and 2015, Respondent charted approximately twelve (12) more visits with Patient A: on or about September 18, October 16, November 14, and on or about December 12, 2014; February 5, March 5, April 3, May 4, June 4, July 2, August 3, and September 1, 2015.

(h) Between in or around 2014 and 2015, Respondent routinely prescribed the concomitant use of immediate-release oxycodone, long-acting Oxycontin, and short-acting Dilaudid; and the doses ranged between approximately 700–800 MME/day. Respondent never documented medical justification for prescribing opioids in such

[9] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

high doses over a twenty (20) month period; nor did she document the indicated use of prescribing two (2) different short-acting opioids to this patient.

(i) Between in or around 2014 and 2015, aside from the documentation of vital signs, Respondent did not perform and/or document performing a review of systems and physical examination at each visit; she did not document symptoms of anxiety, panic attacks, or muscle spasms; and she did not counsel Patient A about the serious health risks associated with the concomitant use of high-dose opioids, benzodiazepines, and Soma.

(j) Between in or around 2014 and 2015, Respondent routinely refilled prescriptions for high-dose opioids, notwithstanding multiple "red flags" of aberrant drug behavior including, but not limited to, Patient A's use of different pharmacies to fill duplicate prescriptions and his inconsistent urine drug screen (UDS).[10] Patient A also objected multiple times to having his opioid prescriptions reduced, which had been documented by Respondent in the chart notes. Respondent also documented that Patient A smoked a lot of marijuana and exhibited signs of sedation during clinical visits.

(k) Between in or around 2014 and 2015, Respondent did not review a single CURES report for Patient A; she did not screen Patient A for Opioid Use Disorder; she did not obtain a signed controlled substances agreement with Patient A; and she did not discuss the risks and benefits of long-term high-dose opioid drug therapy with Patient A.

(l) Multiple chart notes for Patient A's clinical visits in 2015 (February 5, March 5, and August 3) bear Respondent's electronic signature with a date of "March 26, 2019." The chart notes for Patient A's clinical visits in 2014 do not contain any medical provider signatures.

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[10] A UDS obtained on or about October 15, 2014 was negative for benzodiazepines, despite the fact that Respondent had been prescribing benzodiazepines twice daily to Patient A. Respondent failed to document any follow-up discussion with Patient A regarding the inconsistent UDS results.

(m) On February 12, 2020, Respondent was interviewed at the Health Quality Investigation Unit (HQIU) San Diego field office regarding the care and treatment she had provided to Patient A. During the subject interview, Respondent stated that she began treating Patient A in 2012.[11] She admitted during the interview that she was not calculating MME levels for drugs at the time she was prescribing them to Patient A, but that she did consider the doses of opioids and Xanax to be high. Respondent was not able to explain why she had added Dilaudid to the pain medication regimen after reviewing the medical records for Patient A. Respondent also stated that she had had several arguments with Patient A about reducing his medication dosages. Significantly, these arguments were not documented because she "didn't have very much time to write the chart notes," according to Respondent during the transcribed interview.

13. Respondent committed gross negligence in her care and treatment of Patient A including, but not limited to, the following:

(a) Respondent prescribed high-dose opioids to Patient A without a clear medical indication;

(b) Respondent failed to appropriately monitor Patient A's use of controlled substances;

(c) Respondent failed to perform a physical examination of Patient A; and

(d) Respondent's documentation of chart notes is scant including, but not limited to, failed to document performing physical examinations; failed to document identifying patient information on most pages; multiple unsigned chart notes; and, chart notes electronically signed several years after the patient encounter.

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[11] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

14. **Patient B**

(a) On or about January 16, 2014, Patient B, a then-58-year-old female, presented for medication refills at the clinic where Respondent practiced general medicine. Respondent issued prescriptions for oxycodone (30 mg) (#300), Dilaudid (8 mg) (#150), Soma (350 mg) (#120), and Xanax (2mg) (#90). Significantly, this combined prescription equaled approximately 610 MME/day. Respondent documented that Patient B had reported her daughter's medication had been stolen. Respondent refilled the daughter's oxycodone prescription with no further counseling on the issue of lost or stolen medications. The only notation about Patient B's pain was that she hurt her right knee helping her sister.

(b) At this same visit, Respondent did not document specific symptoms or conditions suffered by Patient B justifying the need for the large amount of controlled pain medication she had prescribed. Vital signs were documented, but Respondent did not perform and/or document performing a review of systems nor physical examination at this visit. Significantly, the chart note did not include any notations regarding anxiety, panic attacks, or muscle spasms. Finally, Respondent did not counsel Patient B at this visit about the serious health risks associated with the concomitant use of high-dose opioids, benzodiazepines, and Soma.

(c) On or about March 15, 2014, Patient B was seen by Respondent for a medication refill. Respondent issued prescriptions for oxycodone (30 mg) (#300), Dilaudid (8 mg) (#120), Soma (350 mg) (#120), and Xanax (2mg) (#90). The chart note documented an elevated blood pressure for Patient B, but it does not show whether a physical examination and/or review of systems was actually performed. Significantly, the chart note did not include any notations regarding anxiety, panic attacks, or muscle spasms; nor an informed consent regarding the risks associated with the concomitant use of high-dose opioids, benzodiazepines, and Soma.

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(d) On or about April 15, 2014, Patient B was seen by Respondent for a medication refill. Respondent issued prescriptions for the same pain medication regimen, but increased the Dilaudid from #120 to #150 pills per month without documenting a rationale for the increase in medication. And, consistent with the prior clinical visits, Respondent did not document the same critical information that was missing from Patient B's earlier chart notes in 2014.

(e) On or about August 18, 2014, Respondent documented that Patient B "cannot keep up her activity level and has withdrawals" and that she could "not get through the month without #10 pills per day of oxycodone."

(f) On or about October 9, 2014, Respondent documented that Patient B "does not want to go down on her meds." Significantly, per CURES report, Respondent increased the Dilaudid prescription and continued the oxycodone prescription for #300 pills per month. Respondent did not document any justification for the increase of Dilaudid at this visit.

(g) On or about November 7, 2014, Respondent refilled Patient B's prescriptions for oxycodone (30 mg) (#300), Dilaudid (8 mg) (#150), Soma (350 mg) (#120), and Xanax (2mg) (#90).[12] Patient B used up her entire pain medication regimen in less than three (3) weeks. Significantly, Respondent, on or about November 25, 2014, issued an early refill of all prescription medications. Respondent documented that Patient B had "used up all of her medication. She went to Seattle and it was cold and rainy there and she took more medication than usual." Respondent did not counsel the patient on the need to take her pain medications as prescribed.

(h) After the November 25, 2014 visit, Respondent did not document a single clinical visit with Patient B until on or about March 18, 2015. Significantly, however, according to CURES, Patient B had continued refilling her pain medication prescriptions issued by Respondent during this 3 ½ month gap in clinical visits.

[12] This combined prescription equaled approximately 610 MME/day.

(i) On or about May 12, 2015, Respondent documented that Patient B had "lost all her meds." Without any further documentation in the chart note, Respondent refilled Patient B's prescriptions for oxycodone, Dilaudid, Soma, and Xanax.

(j) On or about July 13, 2015, a UDS was obtained from Patient B. The results showed the presence of morphine and marijuana. Respondent had not been prescribing morphine to Patient B. Significantly, Respondent did not document any discussion with Patient B regarding the inconsistent UDS results.

(k) Between in or around 2014 and 2015, Respondent routinely prescribed the concomitant use of two short-acting opioids (oxycodone and Dilaudid); and the doses ranged between approximately 550–610 MME/day. Respondent never documented medical justification for prescribing opioids in such high doses over a twenty (20) month period; nor documented the indicated use of two (2) different short-acting opioids for this patient.

(l) Between in or around 2014 and 2015, aside from the documentation of vital signs, Respondent did not perform and/or document performing a review of systems and physical examination at each visit; she did not document symptoms of anxiety, panic attacks, or muscle spasms; and she did not counsel Patient B about the serious health risks associated with the concomitant use of high-dose opioids, benzodiazepines, and Soma. Finally, Respondent never documented a definitive pain diagnosis for Patient B other than charting "chronic lumbar pain."

(m) Between in or around 2014 and 2015, Respondent routinely refilled prescriptions for high-dose opioids, notwithstanding multiple "red flags" of aberrant drug behavior including, but not limited to, Patient B losing her medications, her request for an early refill, and her inconsistent UDS results. Patient B also consistently objected to having her opioid prescriptions reduced, which had been documented by Respondent in the chart notes.

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(n) Between in or around 2014 and 2015, Respondent did not review a single CURES report for Patient B; she did not screen Patient B for Opioid Use Disorder; she did not obtain a signed controlled substances agreement with Patient B; she did not discuss the risks and benefits of long-term high-dose opioid drug therapy with Patient B; and she only ordered a single UDS for this patient during this timeframe.

(o) Between in or around 2014 and 2015, Respondent never addressed any preventive health care measures involving Patient B including, but not limited to, she did not recommend or order colon cancer screening, mammography, Pap smears, flu shots, pneumonia vaccination, Hepatitis C screening, or cholesterol testing.

(p) Multiple chart notes for Patient B's clinical visits in 2014 are inaccurate including, but not limited to, they do not contain a current medication list, and most of them are not signed by a medical provider.

(q) Multiple chart notes for Patient B's clinical visits in 2015 are inaccurate including, but not limited to, they do not include oxycodone, Dilaudid, and Xanax in the current medication list, and most of them are not signed by a medical provider. Significantly, chart notes for clinical visits on or about March 18, May 12, and August 13, 2015, bear Respondent's electronic signature with a date of "March 26, 2019."

(r) During the majority of clinical visits in 2014 and 2015, it was documented that Patient B's blood pressure had been elevated, but there was no documentation in the medical record that this issue was addressed. Respondent never ordered an EKG, lab work, and rarely documented a heart or lung examination.

(s) On February 12, 2020, Respondent was interviewed at the HQIU San Diego field office regarding the care and treatment she had provided to Patient B. During the subject interview, Respondent stated that she had been treating Patient B

for approximately a decade, and that she considered herself to be Patient B's primary care physician.[13] Respondent stated that Patient B "sometimes had swelling in her knees," but she agreed that the opioid dosages were extremely high. She also admitted that she should not have combined Soma and Xanax. Respondent also stated that it was very difficult to reduce Patient B's medications because she did not want them reduced.

15. Respondent committed gross negligence in her care and treatment of Patient B including, but not limited to, the following:

(a) Respondent prescribed high-dose opioids to Patient B without a clear medical indication;

(b) Respondent failed to appropriately monitor Patient B's use of controlled substances; and

(c) Respondent's documentation of chart notes is scant including, but not limited to, failed to document performing physical examinations and review of systems; failed to document identifying patient information on most pages; multiple unsigned chart notes; and, chart notes electronically signed several years after the patient encounter.

16. **Patient C**

(a) In 2015, Respondent charted twelve (12) visits with Patient C: on or about March 25, April 13, April 21, May 18, May 26, June 4, June 12, July 20, July 29, August 26, September 3, and September 9.

(b) On or about March 25, 2015, Patient C, a then-51-year-old female, was seen for medications and wanted to quit smoking. Patient C complained of pain in her left knee and ankle. Respondent documented some swelling of the left ankle and diagnosed left ankle pain, knee arthritis, hypertension, and ankylosing spondylitis. Respondent referred patient to an orthopedic surgeon and a pain

[13] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

specialist noting, "chronic back pains since 19-years-old diagnosed with ankylosing spondylitis; has been on opiates for many years and has a high tolerance, need to change meds and find a better regimen."

(c) At this same visit, Respondent prescribed immediate-release oxycodone (30 mg), 3 pills every 4-6 hours, 12-15 pills per day. However, Respondent did not document the quantity of the prescription of oxycodone in the chart note. CURES showed that Patient C filled Respondent's prescription with #450 pills of oxycodone (30 mg) between the March 25 visit and the next clinic visit, 19 days later on April 13. Significantly, Respondent's prescription equaled an extraordinarily high daily dose of 1,065 MME/day. Patient C also filled a prescription issued by Respondent for Soma (350 mg) (#100).

(d) On or about April 13, 2015, Respondent documented that Patient C was seen in an emergency department due to nausea, and that she had vomited her medications. Respondent documented warning the patient that she was taking too many pills too many times during the day. Nonetheless, Respondent refilled Patient C's pain medications at this visit.

(e) CURES reports showed that Patient C filled prescriptions issued by Respondent for oxycodone at three (3) different pharmacies for a total of 1,050 pills. In the month of April, Patient C had access to thirty-five (35) oxycodone pills per day, which equaled an extraordinarily high daily dose of 1,575 MME/day.

(f) CURES showed that in May 2015, Patient C filled prescriptions issued by Respondent at 2 different pharmacies for oxycodone (30 mg) (#1190) and Soma (350 mg) (#230). Significantly, Respondent's prescription equaled an extraordinarily high daily dose of 1,800 MME/day.

(g) CURES showed that in June 2015, Patient C filled prescriptions issued by Respondent for oxycodone (30 mg) (#720) and Soma (350 mg) (#100). Significantly, Respondent's prescription equaled an extraordinarily high daily dose of 1,080 MME/day.

(h) CURES showed that in July 2015, Patient C filled prescriptions issued by Respondent for oxycodone (30 mg) (#720) and Soma (350 mg) (#140). For the remainder of the clinical visits in 2015, Respondent routinely prescribed high dosages of oxycodone that were combined with high dosages of Soma.

(i) In 2015, Respondent did not document specific symptoms or conditions suffered by Patient C justifying a need for the large amount of controlled pain medication she had been prescribing. There were no referrals for a rheumatologist found in the medical record for addressing Patient C's diagnosis of ankylosing spondylitis.

(j) In 2015, Respondent did not review a single CURES report for Patient C; she did not screen Patient C for Opioid Use Disorder; she did not obtain a signed controlled substances agreement with Patient C; she did not discuss the risks and benefits of long-term high-dose opioid drug therapy with Patient C; and she was unaware of Patient C's use of multiple pharmacies and filling duplicate prescriptions within days of each other.

(k) In 2015, Respondent did not counsel Patient C about the serious health risks associated with the concomitant use of high-dose opioids and Soma.

(l) Documentation of clinical visits in 2015 showed a number of medical issues including, but not limited to, elevated blood pressure and glycohemoglobin levels that were consistent with diabetes. Respondent noted that she had planned for an EKG to be performed, but there was no record of one ever being done in 2015. There was also no mention in Patient C's medical record of any vaccinations, Pap smears, mammograms, or colon cancer screening.

(m) Chart notes for clinical visits that took place on or about March 25, June 12, July 29, August 26, September 3, and September 9, 2015, bear Respondent's electronic signature with a date of "March 26, 2019."

(n) On February 12, 2020, Respondent was interviewed at the HQIU San Diego field office regarding the care and treatment she had provided to Patient C.

During the subject interview, Respondent stated that she began treating Patient C in 2012, and that she considered herself to be Patient C's primary care physician.[14] Respondent stated that she did not consider Patient C's vomiting to be related to her medications. Respondent admitted that she had never reviewed a CURES report for Patient C, despite knowing that the patient had been taking high amounts of pain medications. In response to a question about the patient filling multiple refills each month, Respondent stated that at one point she was refilling her prescriptions every two (2) weeks and that "I lost track because she was always coming and saying that she needed more medication, she ran out, and all different kinds of problems happened."

17. Respondent committed gross negligence in her care and treatment of Patient C including, but not limited to, the following:

(a) Respondent prescribed high-dose opioids to Patient C without a clear medical indication; and

(b) Respondent failed to appropriately monitor Patient C's use of controlled substances.

18. **Patient D**

(a) In 2015, Respondent charted nineteen (19) visits with Patient D: on or about February 12, March 10, March 19, March 31, April 13, April 23, May 7, May 12, May 26, May 27, June 3, June 19, June 24, July 1, July 20, July 30, August 10, August 31, and September 10.

(b) On or about February 12, 2015, Patient D, a then-48-year-old female, was seen for a fever and swollen lymph nodes. Patient D had a history of chronic pain "due to left hip fracture and several PE and DVTs" [blood clots] and she was taking Coumadin.[15] Patient D reported being unable to take morphine because of

[14] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[15] Coumadin, a brand name for warfarin, is prescription medicine used to treat blood clots and to lower the chance of blood clots forming in the body.

nightmares, that oxycodone did not work well, and that she could not afford Oxycontin. Respondent diagnosed Patient D with hypertension, but there was no discussion documented in the chart note regarding her elevated blood pressure reading of 196/129; nor any documentation about her blood clots and taking Coumadin, which was also not included on the medication list in the chart note for this visit. A physical examination was not performed. Respondent issued prescriptions for Dilaudid, oxycodone, and morphine.[16]

(c) In February 2015, CURES showed that Patient D filled Respondent's prescriptions for Dilaudid (4 mg) (#60), oxycodone (30 mg) (#240), morphine (30 mg) (#60), morphine (15 mg) (#90), Xanax (2 mg) (#60), Xanax (1 mg) (#90), and clonazepam[17] (2 mg) (#90). Significantly, Respondent's prescriptions equaled a daily dose of 497 MME/day.

(d) On or about March 10, 2015, Patient D presented with an elevated blood pressure reading of 125/138. The chart note does not document any discussion about her blood pressure. Patient D reported that the Dilaudid did not help with her pain.

(e) On or about March 19, 2015, Patient D presented with an elevated blood pressure reading of 216/111. The chart note does not document any discussion about her blood pressure. Patient D reported that she was "not seeing a psychiatrist yet." Respondent refilled prescriptions for Dilaudid, oxycodone, and Xanax.

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[16] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022

[17] Clonazepam, a benzodiazepine, is a Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat panic attacks, certain types of seizures, and the short-term relief of the symptoms of anxiety. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) Klonopin is a brand name for clonazepam. The risk of respiratory depression and intentional and unintentional overdose and death is increased with the concomitant use of multiple benzodiazepines and opioids.

(f) On or about March 22, 2015, Patient D was hospitalized for left-side weakness and a possible stroke. The Emergency Department physician documented "severe narcotic dependency" as a diagnosis. MRI and CT scans were normal. Patient D reported being "raped by a piece of wood," according to a notation made in the chart during this admission.

(g) On or about March 31, 2015, Respondent saw Patient D for a hospital follow up. The chart note documented that Patient D had been diagnosed with "somatoform vs. Munchausen disorder" and that she had been assaulted. Again, Patient D reported that Dilaudid did not help with her pain. Respondent changed the patient's medications, but she did not document any reasons for the change in the chart note for this visit. No physical examination was documented related to the alleged assault of Patient D, and there was no notation regarding her elevated blood pressure taken at that visit.

(h) In March 2015, CURES showed that Patient D filled Respondent's prescriptions for Dilaudid (4 mg) (#90), oxycodone (30 mg) (#240), morphine (30 mg) (#180), Percocet[18] (10/325 mg) (#90), Xanax (2 mg) (#150), and Xanax (1 mg) (#90). Significantly, Respondent's prescriptions equaled a daily dose of 633 MME/day.

(i) On or about April 13, 2015, Respondent issued an early refill because Patient D reported that she had ran out of her medications. She presented with an elevated blood pressure reading of 240/131. There was no documentation of discussion regarding blood pressure/hypertension diagnosis, blood clots and use of Coumadin, nor mental health issues faced by the patient.

(j) In April 2015, CURES showed that Patient D filled Respondent's prescriptions for Dilaudid (4 mg) (#30), oxycodone (30 mg) (#77), morphine IR

[18] Percocet, an opioid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022. Percocet is a brand name for the drug combination of oxycodone-acetaminophen, which is commonly prescribed under the generic name of oxycodone/APAP.

(30 mg) (#257), morphine ER (60 mg) (#60), Xanax (2 mg) (#120), and clonazepam (1 mg) (#90).

(k) In May 2015, CURES showed that Patient D filled Respondent's prescriptions for Dilaudid (4 mg) (#170), oxycodone (30 mg) (#240), Oxycontin (40 mg) (#40), morphine IR (30 mg) (#180), morphine ER (15 mg) (#140), Xanax (2 mg) (#60), Xanax (1 mg) (#152), and lorazepam[19] (1 mg) (#10). Significantly, Respondent's prescriptions equaled a daily dose of 750 MME/day.

(l) On or about June 19, 2015, Respondent refilled Patient D's medications. A physical examination was not performed.

(m) On or about June 24, 2015, Patient D presented at the clinic requesting an early refill of her pain medications. Respondent refilled prescriptions for Dilaudid, oxycodone, morphine, Xanax, and Nirvam. However, there was no documentation about reasons for the early refill. The patient was told that there would be no refills for 3-4 weeks. She also presented with an elevated blood pressure reading of 186/125, but no other physical examination was performed. Again, there was no documentation of discussion regarding blood pressure/hypertension diagnosis, blood clots and use of Coumadin, nor mental health issues faced by the patient.

(n) On or about August 31, 2015, Patient D presented at the clinic and stated her concern that someone in a "white van" was watching her, and she also showed a photograph of the white van to Respondent. Respondent diagnosed the patient with Lupus, anxiety, depression, and chronic pain. Aside from vitals and an elevated blood pressure reading of 215/126, no other physical examination was

[19] Lorazepam, a benzodiazepine, is a Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat panic attacks, certain types of seizures, and the short-term relief of the symptoms of anxiety. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) Ativan is a brand name for lorazepam. The risk of respiratory depression and intentional and unintentional overdose and death is increased with the concomitant use of multiple benzodiazepines and opioids.

performed at this visit. Again, there was no documentation of discussion regarding blood pressure/hypertension diagnosis, blood clots and use of Coumadin, nor mental health issues faced by the patient.

(o) CURES reports for June, July, August, and September 2015, show that Respondent continued to prescribe high dosages of multiple opioids and multiple benzodiazepines to Patient D.

(p) In 2015, Respondent routinely prescribed for concomitant use multiple short-acting high-dose opioids and multiple benzodiazepines. Significantly, Respondent did not document specific symptoms or conditions suffered by Patient D justifying the need for such a large amount of opioids, together with multiple benzodiazepines having similar mechanisms of action.

(q) In 2015, Respondent did not review a single CURES report for Patient D; she did not screen Patient D for Opioid Use Disorder; she did not obtain a signed controlled substances agreement with Patient D; she did not discuss the risks and benefits of long-term high-dose opioid drug therapy with Patient D; and she never obtained a UDS from Patient D to confirm that she was taking the medications as prescribed.

(r) In 2015, Respondent did not counsel Patient D about the serious health risks associated with the concomitant use of high-dose opioids and benzodiazepines.

(s) Documentation of clinical visits in 2015 showed Patient D had a number of medical issues including, but not limited to, elevated blood pressure/hypertension, blood clots, and mental health issues. The chart notes for these 2015 visits showed that Respondent did not address these medical issues.

(t) Chart notes for clinical visits that took place on or about February 12, March 10, March 19, May 7, May 12, July 20, and September 10, 2015, bear Respondent's electronic signature with a date of "March 26, 2019."

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(u) On February 12, 2020, Respondent was interviewed at the HQIU San Diego field office regarding the care and treatment she had provided to Patient D. During the subject interview, Respondent said that she had been treating Patient D for at least 10 years.[20] Respondent stated that she was not aware that she could have had Patient D evaluated for a psychiatric hold at the time. She further stated that she tried to refer this patient to a mental health provider but offered no other evidence in support of this claim. Respondent said that she did not know of an addictionologist to whom she could refer the patient. She also said that she did not have access to CURES at the time. Respondent was unable to explain why she prescribed a combination of multiple benzodiazepines for concomitant use.

19. Respondent committed gross negligence in her care and treatment of Patient D including, but not limited to, the following:

(a) Respondent prescribed high-dose opioids to Patient D without a clear medical indication;

(b) Respondent failed to appropriately monitor Patient D's use of controlled substances;

(c) Respondent prescribed multiple chronic benzodiazepines to Patient D without a clear medical justification;

(d) Respondent failed to perform a physical examination of Patient D; and

(e) Respondent's documentation of chart notes is scant including, but not limited to, failed to document performing physical examinations; inaccurate medication lists; and, chart notes electronically signed several years after the patient encounter.

20. **Patient E**

(a) In 2015, Respondent charted eight (8) visits with Patient E: on or about March 24, April 21, May 20, June 12, July 6, August 4, August 6, and September 2.

[20] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

(b) On or about March 24, 2015, Patient E, a then-27-year-old female, was seen for medication refills. Vital signs were recorded (elevated blood pressure reading of 148/91) but no physical examination was performed. Blood pressure was not addressed in the chart note. Patient E told Respondent that her purse and medications had been stolen. No UDS was obtained at the visit. However, Respondent issued prescriptions for Dilaudid (8 mg) (chart note does not indicate quantity), oxycodone (30 mg) (#210), Soma (350 mg) (#120), and Xanax (2 mg) (#45). Significantly, Respondent's prescriptions equaled a daily dose of 364 MME/day. Finally, Respondent gave the patient a referral to pain management and physical therapy at this visit.

(c) On or about April 21, 2015, Patient E returned to the clinic for medication refills. Vital signs were recorded (elevated blood pressure reading of 151/105) but again, no physical examination was performed. And, again, Respondent did not document any discussion regarding the patient's current pain levels or issue of hypertension. Respondent refilled Patient E's pain medication regimen, which equaled a daily dose of 350 MME/day. Finally, Respondent did not document any follow-up in the chart regarding referrals to pain management and physical therapy.

(d) CURES reports in 2015 show that Respondent continued to prescribe the concomitant use of high dosages of multiple opioids, benzodiazepines, and Soma to Patient E.

(e) In 2015, Respondent routinely prescribed high-dose opioids, in dosages that ranged from 317 to 364 MME/day, without documenting any specific symptoms or conditions suffered by Patient E justifying a need for such a large amount of opioids.

(f) In 2015, Respondent did not review a single CURES report for Patient E; she did not screen Patient E for Opioid Use Disorder; she did not obtain a signed controlled substances agreement with Patient E; she did not discuss the risks and

benefits of long-term high-dose opioid drug therapy with Patient E; she did not document any specific symptoms or side effects, nor the efficacy of the pain medication treatment plan; and she never obtained a UDS from Patient E to confirm that she was taking the medications as prescribed.

(g) In 2015, aside from recording vital signs, Respondent did not perform a physical examination of Patient E.

(h) In 2015, despite multiple elevated blood pressure readings, Respondent did not make the diagnosis of hypertension, did not intervene to help lower the blood pressure, nor document evaluation of secondary causes of elevated blood pressure in a patient under thirty (30) years old.

(i) In 2015, Respondent did not document with any specificity the reasons for prescribing benzodiazepines to Patient E, including but not limited to, there were no diagnoses of anxiety, panic attacks, and/or muscle spasms. In addition, Respondent did not obtain an informed consent from Patient E regarding the risks associated with the concomitant use of benzodiazepines, high-dose opioids, and Soma.

(j) Chart notes for clinical visits that took place on or about May 20, August 4, August 6, and September 2, 2015, bear Respondent's electronic signature with a date of "April 24, 2019."

(k) On February 12, 2020, Respondent was interviewed at the HQIU San Diego field office regarding the care and treatment she had provided to Patient E. During the subject interview, Respondent said that she began treating Patient E in 2012.[21] She stated that she was aware Patients' A, B, C, and E were related in some way and that they were all taking very high doses of opioids. She "thought" that they were all "highly tolerant to the medications" but did not appear to consider whether these patients may have been sharing or diverting their pain

[21] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

medications. She also admitted that she did not know (in 2014 or 2015) that opioids had a significant street value; that there was a high street demand for Soma; and that opioid addicts liked to take Soma in conjunction with opioids and benzodiazepines. When Respondent was asked questions regarding the requirements related to the supervision of physician assistants, her answers indicated that she was not aware or knowledgeable of the requirements. Significantly, she was not familiar with a delegation of services agreement.

21. Respondent committed gross negligence in her care and treatment of Patient E including, but not limited to, the following:

(a) Respondent failed to appropriately monitor Patient E's use of controlled substances; and

(b) Respondent failed to perform a physical examination of Patient E.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

22. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in her care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter:

23. **Patient A**

(a) Paragraphs 12 and 13, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent prescribed an average of 2-3 pills of Xanax, per day, to Patient A for over a year with no discussion of any anxiety symptoms or mention of panic attack in any of the chart notes; and

(c) Respondent prescribed 4 pills of Soma, per day, to Patient A for over a year in combination with high-dose opioids and daily benzodiazepines, with no mention of muscle spasms in any of the chart notes.

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24. **Patient B**

(a) Paragraphs 14 and 15, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent prescribed an average of 2-3 pills of Xanax, per day, to Patient B for over a year with no discussion of any anxiety symptoms or mention of panic attack in any of the chart notes;

(c) Respondent prescribed 4 pills of Soma, per day, to Patient B for over a year in combination with high-dose opioids and daily benzodiazepines, with no mention of muscle spasms in any of the chart notes;

(d) Respondent, acting as Patient B's primary care physician, failed to address or recommend any preventive health care measures between in or around 2014 and 2015; and

(e) Respondent failed to address Patient B's hypertension between in or around 2014 and 2015.

25. **Patient C**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent prescribed 4 pills of Soma, per day, to Patient C in combination with high-dose opioids, with no mention of muscle spasms in the history and no physical examination demonstrating spasm; and

(c) Respondent, acting as Patient C's primary care physician, failed to address or recommend any preventive health care measures.

26. **Patient D**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to closely monitor Patient D's blood clot diagnosis and use of Coumadin;

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(c) Respondent failed to properly address Patient D's mental health issues; and

(d) Respondent failed to properly address Patient D's hypertension.

27. **Patient E**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent prescribed high-dose opioids to Patient E without a clear medical indication;

(c) Respondent prescribed chronic benzodiazepines to Patient E without a clear medical justification;

(d) Respondent prescribed 4 pills of Soma, per day, to Patient E in combination with high-dose opioids and daily benzodiazepines, with no mention of muscle spasms in any of the chart notes; and

(e) Respondent failed to address Patient E's hypertension.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

28. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (d), of the Code, in that Respondent demonstrated incompetence in her care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter:

29. **Patient A**

(a) Paragraph 12, subsections (a), (b), (c), (d), (e), (i), (j), (k), and (m), above, are hereby incorporated by reference and realleged as if fully set forth herein.

30. **Patient B**

(a) Paragraph 14, subsections (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), and (s), above, are hereby incorporated by reference and realleged as if fully set forth herein.

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31. **Patient C**

(a) Paragraph 16, subsections (c), (d), (e), (f), (g), (h), (i), (j), (k), and (n), above, are hereby incorporated by reference and realleged as if fully set forth herein.

32. **Patient D**

(a) Paragraph 18, subsections (c), (e), (f), (g), (h), (i), (j), (k), (m), (n), (o), (q), and (u), above, are hereby incorporated by reference and realleged as if fully set forth herein.

33. **Patient E**

(a) Paragraph 20, subsections (a), (b), (c), (d), (e), (f), (i), and (k), above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without an Appropriate Prior Examination and Medical Indication)

34. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234, as defined in sections 2242 and 4022, of the Code, in that Respondent prescribed, dispensed, or furnished dangerous drugs without an appropriate prior examination and medical indication to Patients A, B, and D, as more particularly alleged hereinafter:

35. **Patient A**

(a) Paragraph 12, subsections (b), (c), (d), (e), (h), and (i), above, are hereby incorporated by reference and realleged as if fully set forth herein.

36. **Patient B**

(a) Paragraph 14, subsections (a), (b), (c), (d), (h), (k), (l), and (s), above, are hereby incorporated by reference and realleged as if fully set forth herein.

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37. **Patient D**

(a) Paragraph 18, subsections (a), (b), (c), (g), (h), (j), (k), (l), (m), (n), (o), and (p), above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

38. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs to Patients A, B, C, and D, as more particularly alleged hereinafter:

39. **Patient A**

(a) Paragraph 12, subsections (a), (b), (c), (d), (e), (f), and (m), above, are hereby incorporated by reference and realleged as if fully set forth herein.

40. **Patient B**

(a) Paragraph 14, subsections (a), (c), (d), (e), (f), (g), (h), (i), (k), (m), and (s), above, are hereby incorporated by reference and realleged as if fully set forth herein.

41. **Patient C**

(a) Paragraph 16, subsections (c), (e), (f), (g), (h), and (n), above, are hereby incorporated by reference and realleged as if fully set forth herein.

42. **Patient D**

(a) Paragraph 18, subsections (a), (c), (h), (j), (k), (o), (p), and (u), above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

43. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the

Code, in that Respondent failed to maintain adequate and accurate records in connection with her care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter:

44. **Patient A**

(a) Paragraphs 12 and 13, above, are hereby incorporated by reference and realleged as if fully set forth herein.

45. **Patient B**

(a) Paragraphs 14 and 15, above, are hereby incorporated by reference and realleged as if fully set forth herein.

46. **Patient C**

(a) Paragraphs 16 and 17, above, are hereby incorporated by reference and realleged as if fully set forth herein.

47. **Patient D**

(a) Paragraphs 18 and 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

48. **Patient E**

(a) Paragraphs 20 and 21, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

49. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 63645 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 11 through 48, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 63645, issued to Respondent Ildiko C. Gerbatsch-Bornemisza, M.D.;

2. Revoking, suspending or denying approval of Respondent Ildiko C. Gerbatsch-Bornemisza, M.D.'s, authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Ildiko C. Gerbatsch-Bornemisza, M.D., to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

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

DATED: June 17, 2020

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

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