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

In the Matter of the Accusation Against: **James Peter Dickens, M.D.** **Physician's & Surgeon's Certificate No A 55172** **Respondent.**	**Case No. 800-2017-030990**

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 18, 2021

IT IS SO ORDERED May 20, 2021

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **JAMES PETER DICKENS, M.D.** **701 Howe Ave.** **Bldg. H Ste. 50** **Sacramento, CA 95825** **Physician's and Surgeon's Certificate No. A 55172** Respondent.	Case No. 800-2017-030990 OAH No. 2020070833 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

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2. Respondent James Peter Dickens, M.D. (Respondent) is represented in this proceeding by attorney Nicole D. Hendrickson, whose address is: 655 University Avenue, Suite 119 Sacramento, CA 95825

3. On or about November 8, 1995, the Board issued Physician's and Surgeon's Certificate No. A 55172 to James Peter Dickens, M.D. (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. 800-2017-030990, and will expire on August 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030990 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 March 2, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-030990 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030990. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-030990, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-030990, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 55172 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 55172 issued to Respondent James Peter Dickens, M.D. shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a) (4.) This public reprimand, which is issued in connection Respondent's care and treatment of Patient A and B, as set forth in Accusation No. 800-2017-030990, is as follows:

"You failed to supervise your Physician Assistant appropriately, in that he was able to prescribe to patients without your knowledge."

A. EDUCATION COURSE Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval, educational program(s) or course(s) which shall not be less than 40 hours, in addition to the 25 hours required for license renewal. 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. Within 12 months of the effective date of this Decision, Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

Failure to successfully complete and provide proof of attendance to the Board or its

designee of the educational program(s) or course(s) within 12 months of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

B. PRESCRIBING PRACTICES COURSE

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

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later. Failure to provide proof of successful completion to the Board or its designee within twelve (12) months of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of that time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

C. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping

approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure and the coursework requirements as set forth in Condition B of this stipulated settlement.

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

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

Failure to provide proof of successful completion to the Board or its designee within twelve (12) months of the effective date of this Decision, unless the Board or its designee agrees in writing to an extension of that time, shall constitute general unprofessional conduct and may serve as the grounds for further disciplinary action.

ACCEPTANCE

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

DATED: 3/15/21

JAMES PETER DICKENS, M.D.
Respondent

I have read and fully discussed with Respondent James Peter Dickens, 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: 03/15/2021

NICOLE D. HENDRICKSON
Attorney for Respondent

ENDORSEMENT

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

DATED: 4/7/2021

Respectfully submitted,

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

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030990

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 2 20 20
BY M. Francis ANALYST

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

In the Matter of the Accusation Against: **James Peter Dickens, M.D.** **Bldg. H Ste. 50** **701 Howe Ave.** **Sacramento, CA 95825** **Physician's and Surgeon's Certificate** **No. A 55172,** Respondent.	Case No. 800-2017-030990 **A C C U S A T I O N**

PARTIES

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

2. On or about November 8, 1995, the Medical Board issued Physician's and Surgeon's Certificate No. A 55172 to James Peter Dickens, 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 August 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.

STATUTORY PROVISIONS

5. 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.

6. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

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

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

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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7. Section 2241 of the Code states:

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

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

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

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

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

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

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

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

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

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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

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

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

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

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

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

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

9. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

10. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

11. 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.

12. Section 3502 of the Code states:

(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow up care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records

review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

13. Section 3502.1 of the Code states:

(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) Drug order for purposes of this section, means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for the particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through

stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

REGULATORY PROVISIONS

14. California Code of Regulations, title 16, section 1399.545, states:

(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

(4) Other mechanisms approved in advance by the board.

(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

DEFINITIONS

15. Amphetamine salts – Generic name for the drug Adderall, which is a combination drug containing four salts of the two enantiomers of amphetamine, a Central Nervous System (CNS) stimulant of the phenethylamine class. Adderall is used to treat attention deficit hyperactivity disorder (ADHD) and narcolepsy but can be used recreationally as an aphrodisiac and euphoriant. Adderall is habit forming. Amphetamine salts are a Schedule II controlled

substance pursuant to Code of Federal Regulations Title 21 section 1308.12(d) and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent that morphine and hundreds of more times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

17. Oxycodone – Generic name for Oxycontin, Roxicodone, and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short acting opioid analgesic used to treat moderate to severe pain. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

18. Alprazolam – Generic name for the drugs Xanax and Niravam. Alprazolam is a short acting benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

19. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057.

[1] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

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

21. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Temazepam – Generic name for Restoril. Temazepam is a member of the benzodiazepine family and is a medication used to treat trouble sleeping. Temazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a transdermal patch, Butrans is used for chronic pain. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

24. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short-acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet

is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

25. Morphine – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the CNS to relieve pain. Morphine is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

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

28. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. On January 11, 2012, carisoprodol was classified a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

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[2] On October 6, 2014, hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

29. Zolpidem tartrate – Generic name for Ambien. Zolpidem tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

30. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

31. Eszopiclone – Generic name for Lunesta. Eszopiclone is a nonbenzodiazepine hypnotic agent used in the treatment of insomnia. Eszopiclone is classified as a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

32. Triazolam – Generic name for Halcion. Triazolam is a CNS depressant in the benzodiazepine class. It possesses pharmacological properties similar to those of other benzodiazepines, but it is generally only used as a sedative to treat severe insomnia. Triazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

33. Modafinil – Generic name for the drug Provigil. Modafinil is a medication to treat sleepiness due to narcolepsy, shift work sleep disorder, or obstructive sleep apnea (OSA). Modafinil is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

34. Meprobamate – Generic name for the drugs Miltown and Equanil. Meprobamate is a carbamate derivative used as an anxiolytic drug. It has largely been replaced by benzodiazepines due to their wider therapeutic index (lower risk of toxicity at therapeutically prescribed doses)

and lower incidence of serious side effects. Meprobamate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence- Patient A)

35. Respondent's license is subject to disciplinary action under sections 3527, 2234 subdivision (b), 3502, and 3502.1, of the Code and Title 16 of the California Code of Regulations sections 1399.540, 1399.541, and 1399.545, in that he committed gross negligence during the care and treatment of Patient A[3]. The circumstances are as follows:

36. Respondent is the supervising physician of physician assistant G.D. (PA GD), who, during all times alleged herein, practiced in a clinic primarily in pain management in Placerville, CA. During his interview with the Board, PA GD stated that the signatures of Respondent, his supervising physician were auto populated. PA GD affirmed that the signatures are for billing purposes and did not signify that Respondent actually saw the patient or reviewed the chart.

37. Patient A was a 33-year-old male with long history of anxiety/PTSD, chronic pain syndrome, back pain. He had pain since 1999 after a 12 gauge shotgun blast to the abdomen and a rollover accident. He suffered vertebral fractures, disc ruptures, hepatitis C with liver cirrhosis. Patient A was being referred from a pain management group in El Dorado County. Documentation from the prior provider revealed that Patient A was on methadone over 420 tablets, 10 mg, 3 tablets 4 times a day, and 2 tablets before bedtime; Xanax 1 mg, 3 times a day; and oxycodone 15 mg, 3 times a day. Patient A was being weaned off methadone by his prior provider. The CURES report from the prior provider showed that methadone was filled at around 200 tablets a month. Respondent's signature was auto-populated and PA GD documented "RTC to see [D]."

[3] Patient names and information have been removed. Percipient witness names and information have been removed. All witnesses will be fully identified in discovery.

38. On or about June 26, 2012, PA GD saw Patient A for an office visit. PA GD documented that Patient was being seen for pain management. PA GD documented that Patient A's CURES report was consistent with the drugs prescribed by his prior provider. Patient A signed a contract dated June 24, 2012, where he agreed, *inter-alia*, that losing medication, and stolen medication would mean termination of treatment. PA GD documented the treatment plan as: "To be seen by (Respondent) on RTC; Urine Drug Test; Long discussion on the side effects of Xanax with narcotics; Xanax .25mg one po q6h #120 NR; Methadone 10mg 4 tabs QID #420, NR; Oxycodone 15mg one po q8h, prn #90 for breakthrough pain." PA GD failed to ask for documentation of Patient A's prior history, old records and consultations. PA GD failed to order any diagnostic testing to confirm the sources of pain and failed to coordinate with psychiatric care. PA GD also failed to have Respondent read the chart and examine the patient to formulate Patient A's treatment plan. PA GD doubled the dose of methadone from 200 tablets to 420 without documenting the reason. PA GD failed to verify and compare the CURES report on Patient A and Patient A's medical record to determine the correct dosage of methadone.

39. During the period of June to December 2012, PA GD prescribed methadone 10 mg, at 420 tablets; Xanax .25 mg, at 180 tablets; and oxycodone 15 mg, at 90 tablets.

40. In a urine toxicology screen collected June 26, 2012, Patient A tested positive for Klonopin metabolites. Patient A tested negative for oxycodone and Xanax, which was currently prescribed to him by his prior provider. PA GD failed to address the positive and negative tests consistent with the pain contract.

41. PA GD next saw Patient A on or about July 17, 2012, August 14, 2012, September 18, 2012, October 16, 2012, November 13, 2012, and December 11, 2012. PA GD's documentation for musculoskeletal examination were identical. Respondent's signatures were all auto-populated.

42. During the period of January 2013 to December 2013, PA GD continued to prescribe methadone, oxycodone and Xanax.

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43. In a urine toxicology screen collected March 7, 2013, Patient A tested positive for Klonopin metabolites and marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

44. In a urine toxicology screen collected March 7, 2013, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

45. PA GD saw Patient A for office visits on or about January 8, 2013, February 5, 2013, March 5, 2013, April 30, 2013, May 28, 2013, June 25, 2013, August 20, 2013, September 17, 2013, October 15, 2013, and November 12, 2013. Respondent's signatures were all auto-populated. PA GD continued to incorrectly document that Patient A's CURES reports were consistent with Patient A's medications despite the inconsistent test results in Patient A's urine toxicology tests.

46. During the period of January 2014 to November 2014, PA GD continued to prescribe methadone, oxycodone and Xanax.

47. On or about December 29, 2014, PA GD documented under his Resultant PGT Treatment Plan that Patient A, "should not be placed on Methadone; Avoid using Valium; Ativan and Serax (instead use clonazepam and Xanax ok)." PA GD reduced methadone to 300 tablets, 10 mg, increased oxycodone and added fentanyl 50 mcg 10 tablets.

48. In a urine toxicology screen collected March 11, 2014, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

49. In a urine toxicology screen collected April 8, 2014, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

50. In a urine toxicology screen collected July 10, 2014, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

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51. In a urine toxicology screen collected October 8, 2014, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

52. On or about August 27, 2014, United HealthCare mailed a letter to Respondent stating that Patient A was on a high daily dose of opioids exceeding 200 mg morphine equivalent.

53. PA GD saw Patient A for office visits on or about January 7, 2014, February 11, 2014, March 11, 2014, April 8, 2014, May 6, 2014, June 10, 2014, August 5, 2014, September 10, 2014, October 5, 2014, and December 3, 2014. PA GD's documentation for musculoskeletal examination were identical. Respondent's signatures were all auto-populated. PA GD continued to incorrectly document that Patient A's CURES reports were consistent with Patient A's medications despite the inconsistent test results in Patient A's urine toxicology tests.

54. During the period of January 2015 to December 2015, PA GD continued to prescribe fentanyl, methadone, oxycodone and Xanax.

55. In a urine toxicology screen collected March 25, 2015, Patient A tested negative for fentanyl, and positive for marijuana metabolites. PA GD failed to address the negative and positive test consistent with the pain contract.

56. In a urine toxicology screen collected June 24, 2015, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

57. In a urine toxicology screen collected October 28, 2015, Patient A tested positive for marijuana metabolites. PA GD failed to address the positive test consistent with the pain contract.

58. PA GD saw Patient A monthly for office visits monthly from January 2015 to December 2015. Respondent's signatures were all auto-populated. PA GD continued to incorrectly document that Patient A's CURES reports were consistent with Patient A's medications despite the inconsistent test results in Patient A's urine toxicology tests.

59. During the period of January 2016 to December 2016, PA GD continued to prescribe fentanyl, methadone, oxycodone and Xanax.

60. In a urine toxicology screen collected May 17, 2016, Patient A tested positive for oxazepam. PA GD failed to address the positive test consistent with the pain contract.

61. PA GD saw Patient A for office visits on or about January 19, 2016, February 16, 2016, March 15, 2016, April 19, 2016, May 17, 2016, June 22, 2016, August 17, 2016, September 14, 2016, October 19, 2016 and December 14, 2016. Respondent's signatures were all auto-populated. PA GD continued to incorrectly document that Patient A's CURES reports were consistent with Patient A's medications despite the inconsistent test results in Patient A's urine toxicology tests.

62. During the period of January 2017 to September 2017, PA GD continued to prescribe fentanyl, methadone, oxycodone and Xanax.

63. On or about July 17, 2017 PA GD tapered Patient A's fentanyl prescription to 25 mcg, 15 tablets and methadone 10 mg, 270 tablets.

64. On or about September 17, 2017, PA GD further tapered Patient A's fentanyl prescription to 12mcg, 15 tablets, and eventually discontinued fentanyl.

65. On or about October 17, 2017, PA GD tapered Patient A's oxycodone prescription to 10 mg, 60 tablets and subsequently reduced to 30 tablets.

66. PA GD saw Patient A monthly for office visits monthly from January 2017 to December 2017. Respondent's signatures were all auto-populated. PA GD continued to incorrectly document that Patient A's CURES reports were consistent with Patient A's medications despite the inconsistent test results in Patient A's urine toxicology tests.

67. In a urine toxicology screen collected January 11, 2018, Patient A tested negative for oxycodone. PA GD failed to address the negative test consistent with the pain contract.

68. On or about February 6, 2018, PA GD saw Patient A for an office visit. Respondent's signatures were all auto-populated. PA GD continued to incorrectly document that Patient A's CURES reports were consistent with Patient A's medications despite the inconsistent test results in Patient A's urine toxicology tests. PA GD discontinued oxycodone. PA GD only started to consider hyperalgesia after he started to taper Patient A off and he did so well.

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69. In an interview with the Board on October 15, 2019, Respondent stated that he never saw Patient A in person. He did not recall talking to PA GD about the current management of Patient A; he was not aware that PA GD was providing 15 fentanyl patches to Patient A monthly. He was not aware that on two occasions when Patient A's urine drug screen was negative for fentanyl, PA GD continued to prescribe Fentanyl to Patient A. He does not recall anything about Patient A.

70. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to the following:

a. Respondent failed to consult with PA GD and cosign the notes within the required seven days when schedule II drugs were prescribed and 30 days in all other cases.

b. Respondent committed inaccurate recordkeeping by allowing the use of template notes by PA GD, including but not limited: physical examinations that were not performed currently; misrepresentation of his involvement in Patient A's care by auto-populating his signature; documenting that he was going to examine Patient A on the next office visit; and documenting that Patient A CURES report was compliant, despite the inconsistent urine toxicology tests.

c. Respondent allowed PA GD to prescribe opioids without reason, failing to take into consideration and/or document the rationale for prescribing opioids, ignoring multiple red flags including inconsistent urine toxicology.

d. Respondent allowed PA GD to prescribe benzodiazepines with high dose narcotics, without good reason, consultation, prescription for Narcan, or an alternative drug, and written input from him.

e. Respondent failed to adequately supervise PA GD. Respondent failed to co-sign any notes, and he failed to co-sign when controlled medication was prescribed. Respondent never met or examined Patient A. Respondent failed to audit PA GD's chart and/or look at the urine drug tests and/or review CURES. Respondent was unaware of the standard of care for prescribing opioids. Respondent failed to make appropriate referrals to specialists.

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SECOND CAUSE FOR DISCIPLINE

(Gross Negligence- Patient B)

71. Respondent's license is subject to disciplinary action under sections 3527, 2234 subdivision (b), 3502, and 3502.1, of the Code and Title 16 of the California Code of Regulations sections 1399.540, 1399.541, and 1399.545, in that he committed gross negligence during the care and treatment of Patient B. The circumstances are as follows:

72. On or about March 6, 2012, PA GD saw Patient B for an office visit. PA GD documented that Patient B was at the time a 37-year-old female being seen for pain management. Patient B was an EMT in 1995 who was lifting a patient when she experienced neck and back pain. Patient B's ambulance crashed resulting in a C6-7 and T1 ant T2 vertebral fractures. Patient later found out that she had osteogenesis imperfect (OI)[4]. Patient B has fractured several other bones and recently her pelvis. Patient B has been on pain medications since 1995. PA GD added that Patient B has been followed by Dr. M, primary care, but needed to be followed by pain management. PA GD documented Patient B's current medication as methadone 10 mg, 8 tablets, 3 times a day, Endocet 10/325, 180 tablets, morphine 30 mg, Adderall, and amphetamines, and Xanax. PA GD continued to prescribe Adderall 20 mg, at 180 tablets, methadone 10 mg, 720 tablets, morphine, 30 mg, 180 tablets, Percocet 10/325, 180 tablets. Patient B signed a contract dated March 6, 2012, where she agreed, *inter-alia*, that losing medication, and stolen medication would mean termination of treatment. Respondent's signature was auto-populated and PA GD documented "RTC to see [D]." PA GD failed to ask for documentation of Patient B's prior history, old records, and consultations. PA GD failed to order any diagnostic testing to confirm the sources of pain, the diagnosis for narcolepsy and sleepiness to support doubling the maximum dosage of Adderall. PA GD also failed to have his supervising physician read the chart and examine the patient to formulate Patient B's treatment plan. PA GD failed to verify and compare the CURES report on Patient B.

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[4] Also known as brittle bone disease, it is a group of genetic disorders that mainly result in brittle, easy to break bones.

73. In a urine toxicology screen collected March 12, 2012, Patient B tested negative for morphine. PA GD failed to address the negative test consistent with the pain contract.

74. During the period of March 12, 2012 to December 2012, PA GD saw Patient B monthly for office visits, and prescribed Adderall 20 mg, at 180 tablets, methadone 10 mg, 720 tablets, morphine, 30 mg, 180 tablets, Percocet 10/325, 180 tablets.

75. On or about April 17, 2012, PA GD saw Patient B for an office visit. PA GD documented that Patient B's CURES report was consistent with the drugs prescribed despite the March 12, 2012 urine toxicology testing negative for the prescribed morphine.

76. In a urine toxicology screen collected November 20, 2012, Patient B tested negative for morphine. PA GD failed to address the negative test consistent with the pain contract.

77. During the period of January 2013 to December 2013, PA GD saw Patient B monthly for office visits, and prescribed Adderall 20 mg, at 180 tablets, methadone 10 mg, 720 tablets, morphine, 30 mg, 180 tablets, Percocet 10/325, 180 tablets. Patient B was also getting modafinil from another provider.

78. In a urine toxicology screen collected March 12, 2013, Patient B tested negative for morphine. PA GD failed to address the negative test consistent with the pain contract.

79. On or about April 9, 2013 PA GD saw Patient B for an office visit. PA GD documented that Patient B's CURES report is consistent for medications despite the March 12, 2013 negative test for morphine.

80. In a urine toxicology screen collected July 1, 2013, Patient B tested negative for morphine. PA GD failed to address the negative test consistent with the pain contract.

81. On or about August 14, 2013, Broadspire Utilization Management (Broadspire), affiliated with Patient B's insurer, reviewed PA GD's prescription plan and wrote Respondent's office that the opioids he was prescribing were too high, well above the guidelines for pain. Broadspire also found that there was no documented medical rationale for its use.

82. On or about July 30, 2013 PA GD saw Patient B for an office visit. PA GD documented that Patient B's CURES report is consistent for medications despite the July 1, 2013 negative test for morphine.

83. During the period of January 2014 to December 2014, PA GD saw Patient B monthly for office visits, and prescribed methadone 10 mg, 720 tablets, morphine, 30 mg, 180 tablets, Percocet 10/325, 180 tablets.

84. In a urine toxicology screen collected December 9, 2014, Patient B tested negative for oxycodone, methadone and amphetamines. PA GD failed to address the negative test consistent with the pain contract.

85. On or about December 2014, Patient B was hospitalized for Afib.

86. During the period of January 2015 to December 2015, PA GD saw Patient B monthly for office visits, and prescribed methadone 10 mg, 720 tablets, morphine 30 mg, 180 tablets and Percocet 10/325, 180 tablets.

87. In a urine toxicology screen collected June 16, 2015, Patient B tested positive for cocaine. PA GD failed to address the positive test consistent with the pain contract.

88. In a urine toxicology screen collected August 11, 2015, Patient B tested positive for cocaine. PA GD failed to address the positive test consistent with the pain contract.

89. In a urine toxicology screen collected September 8, 2015, it was noted that the "OPI test" could not be performed because of an "interfering compound."

90. On or about October 21, 2015, PA GD saw Patient B for an office visit. PA GD documented "We have recommended that the patient seek another pain management provider, and a recovery center such as Azure Acres. The patient's cardiac condition does not allow any tapering of her medication..." PA GD documented "Patient was prescribed one week's worth of pain medication because of inconsistencies in her UDT. Patient CURES report 10/16/2015 is consistent for medications..."

91. On or about December 7, 2015, Broadspire wrote Respondent's clinic warning again that the dosage for opioids were too high.

92. During the period of January 2016 to December 2016, PA GD saw Patient B monthly for office visits, and prescribed methadone 10 mg, 720 tablets, morphine, 30 mg, 180 tablets, Percocet 10/325, 180 tablets.

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93. During the period of January 2017 to February 16, 2017, and July 27, 2017, PA GD prescribed methadone 10 mg, 720 tablets, morphine, 30 mg, 180 tablets, Percocet 10/325, 180 tablets. PA GD last saw Patient B on February 28, 2017. In an interview with the Board, PA GD disavowed any knowledge of the July 27, 2017 prescription.

94. In an interview with the Board on October 15, 2019, Respondent stated that he never saw Patient B in person. He was not aware that PA GD's progress notes said that Patient B's urine drug toxic screens were consistent when in fact they were not. He recalled one incident were the urine drug screen was inconsistent and Patient B threatened a lawsuit. He was not aware that Patient B's high dose medications were not appearing in her urine drug screens, and that PA GD continued to prescribe to Patient B. He was unaware that PA GD prescribed high dose amphetamines to Patient B; he was unaware of the Broadspire letters between 2013 and 2015 warning Respondent about Patient B's opioid prescriptions.

95. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to the following:

a. Respondent failed to document correct reviews of the current urine drug tests.

b. Respondent allowed PA GD to prescribe super maximal doses of opioids with negative urine drug tests.

c. Respondent allowed PA GD to prescribe super maximal doses of amphetamines.

d. Respondent failed to change the treatment plan when the urine drug tests show that Patient B was not taking the drugs prescribed.

e. Respondent failed to change the treatment plan when cocaine was seen in the urine drug tests.

f. Respondent failed to consult with PA GD and cosign the notes within the required seven days when schedule II drugs were prescribed and 30 days in all other cases.

g. Respondent committed inaccurate recordkeeping by allowing the use of template notes by PA GD, including but not limited: physical examinations that were not performed currently; misrepresentation of his involvement in Patient B's care by auto-populating his signature; documenting that he was going to examine Patient B on the next office visit; and

documenting that Patient B CURES report was compliant, despite the inconsistent urine toxicology tests.

h. Respondent allowed PA GD to prescribe opioids without reason, failing to take into consideration and/or document the rationale for prescribing opioids, ignoring multiple red flags including inconsistent urine toxicology and letters from Broadspire.

j. Respondent failed to adequately supervise PA GD. Respondent failed to co-sign any notes, and he failed to co-sign when controlled medication was prescribed. Respondent never met or examined Patient B. Respondent failed to audit PA GD's chart and/or look at the urine drug tests and/or review CURES. Respondent was unaware of the standard of care for prescribing opioids. Respondent failed to make appropriate referrals to specialists.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence- Patient C)

96. Respondent's license is subject to disciplinary action under sections 3527, 2234 subdivision (b), 3502, and 3502.1, of the Code and Title 16 of the California Code of Regulations sections 1399.540, 1399.541, and 1399.545, in that he committed gross negligence during the care and treatment of Patient C. The circumstances are as follows:

97. On or about September 24, 2014, PA GD saw Patient C for an office visit. PA GD documented that Patient C was at the time a 53-year-old female being seen for pain management. Her past medical history included surgeries for Chemonucleopsis in 1981, Anterior Lumbar Fusion L5-S1 in 1982, Posterior Lumbar Fusion L3-L5 in 2002, and Posterior Lumbar Fusion in 2004. PA GD recorded Patient C's current medication as Oxycontin, oxycodone, zolpidem tartrate, lorazapem, Keppra, Adderall and Lunesta. Patient C also had a seizure disorder. Patient C signed a contract dated September 24, 2013, where she agreed, *inter-alia*, that losing medication, and stolen medication would mean termination of treatment. PA GD continued to prescribe Patient C Oxycontin, oxycodone, zolpidem tartrate, Lorazapem, Keppra, Adderall and Lunesta. Respondent's signature was auto-populated and PA GD documented "RTC to see [D]."

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98. In a urine toxicology screen collected September 24, 2013, Patient C tested positive for tramadol, temazepam, oxazepam, Soma and meprobamate. PA GD failed to address the positive test consistent with the pain contract.

99. On or about October 1, 2013, PA GD saw Patient C for an office visit. During the office visit, PA GD documented that Patient C's CURES was consistent for medications and provider despite the September 24, 2013 urine test. Respondent's signature was auto-populated and PA GD documented "RTC to see [D]."

100. In a urine toxicology screen collected October 1, 2013, Patient C tested positive for meprobamate. PA GD failed to address the positive test consistent with the pain contract.

101. On or about October 8, 2013, PA GD saw Patient C for an office visit. During the office visit, PA GD documented that Patient C's CURES was consistent for medications and provider despite the October 1, 2013 urine test. Respondent's signature was auto-populated and PA GD documented "RTC to see [D]."

102. On or about October 29, 2013, PA GD saw Patient C for an office visit. Under his treatment plan, PA GD documented that he was prescribing Soma.

103. On or about November 12, 2013, PA GD saw Patient C for an office visit. Under his treatment plan, PA GD documented that he was discontinuing Soma. However, he issued a prescription for Soma 350 mg, 100 tablets, on the same date.

104. In a urine toxicology screen collected November 12, 2013, Patient C tested positive for temazepam and oxazepam. PA GD failed to address the positive test consistent with the pain contract.

105. On or about December 26, 2013, PA GD presented to the Sutter Roseville Medical Center Emergency Department. Triage notes indicated that Patient C "fell while walking; lost balance. The patient has had trouble walking."

106. On or about December 30, 2013, PA GD saw Patient C for an office visit. PA GD documented that "Patient was seen in the ER for a fall and hurt her left hip again. X-rays show degenerative changes with a MRI history of neurosis. Patient has ran out of pain medications early. Patient is to have left hip replacement in March. I reviewed the patient's health current

CURES report 12/30/2013 is consistent for medications and provider." PA GD failed to address the early refill consistent with the pain contract. PA GD added methadone 10 mg, and Soma 350 mg.

107. On or about January 7, 2014, PA GD saw Patient C for an office visit. PA GD documented that "Patient was put on Methadone 10mg TID. Patient states the Oxycodone works better. I explained to the patient that we need to give Methadone a longer trial. Patient admitted to taking more of her Methadone and is out. Patient admitted to drinking with her medications. The patient has a scheduled hip surgery on 3/3/2014 with Dr. [P]." PA GD failed to address the early refill, and drinking consistent with the pain contract. PA GD discontinued methadone. Patient C's current medications are Adderall, diazepam, methadone, Soma, lorazepam, oxycodone and Oxycontin.

108. During the period of January to December 2014, PA GD saw Patient C monthly and refilled her opioid medications periodically.

109. On or about March 18, 2014, PA GD saw Patient C for an office visit. PA GD documented that Patient C "had right hip replacement in March3rd by Dr. [P]. Patient was placed on several discharge pain medications; Oxycontin, baclofen, Lorazepam, OxyIR, Patient ran out of her discharge medications and her refill date isn't till next week." PA GD failed to address the early refill consistent with the pain contract.

110. On or about April 8, 2014, PA GD saw Patient C for an office visit. PA GD documented that Patient C "had right hip replacement in March3rd by Dr. [P]. Patient was placed on several discharge pain medications; Oxycontin, baclofen, Lorazepam, OxyIR, Patient ran out of her discharge medications and her refill date isn't till next week." PA GD failed to address the early refill consistent with the pain contract.

111. On or about April 14, 2014, Patient C called Respondent's office, stating that she dislocated her hip and that she needed an early refill for her discharge medication.

112. On or about June 10, 2014, PA GD saw Patient C for an office visit. PA GD documented that Patient C dislocated her left hip on June 3, 2014. PA GD also documented that Patient C's "COMM assessment for opiate misuse was +18 = high risk." PA GD continued to

prescribe lorazepam, Oxycontin, oxycodone, Soma and added Dilaudid. PA GD failed to document why he added Dilaudid.

113. In a urine toxicology screen collected July 8, 2014, Patient C tested negative for lorazepam. PA GD failed to address the negative test consistent with the pain contract.

114. On or about August 12, 2014, PA GD saw Patient C for an office visit. PA GD documented that "Patient fell at home and fractured her nose. Patient had a seizure last month and was arrested for a 'DUI' for ETOH.[5]" PA GD failed to address the falls and DUI consistent with the pain contract and signs of abuse.

115. On or about December 3, 2014, PA GD saw Patient C for an office visit. PA GD documented that "Patient is having increasing back pain. Patient was released from hospital Dec 1st for an infected hip. The patient had to have her left hip debrided and placed on antibiotics."

116. During the period of January 2015 to December 2015 PA GD saw Patient C monthly for office visits and refilled lorazepam, oxycodone, and Oxycontin. Patient C also received Soma and other controlled drugs from other providers.

117. On or about March 12, 2015, Patient C saw another provider, Dr. O. after her hip surgery. Dr. O., noted that they have advised PA GD about Patient C's frequent falls, recent overdoses. Dr. O. also advised that PA GD consider SNF placement temporarily until 24 hour help could be obtained.

118. On or about March 17, 2015, PA GD saw Patient C for an office visit. PA GD documented "After reviewing the report and discussing the results with DR. D, and the patient we have concluded that an evaluation y physical therapy concerning her balance, mechanical causes of frequent falls, and whether any of her most frequent falls can be attributed to her use of pain medications is needed."

119. On or about April 14, 2015, PA GD saw Patient C for an office visit. PA GD documented "I have reviewed the patients' health current CURES report 0/4/07/2015 is inconsistent with the patient's history for medications and provider. This patient has been given

[5] Ethyl alcohol, or ethanol. This clear substance is found in alcoholic drinks such as beer, wine and liquor. The term EtOH is commonly used in academic research and in medical circles when referring to alcohol.

about 500 oxycodone or Oxycontin both inside the hospital and through her surgeon. Patient is asking for more oxycodone until she can have her Rx refilled on 04/16/15. I instructed the patient no more early refills and DNF until 04/16/15 for both medications."

120. On or about September 2, 2015, PA GD saw Patient C for an office visit. PA GD documented that "Once patient has completed her hip rehab we plan to take the patient off of oxycodone and prescribe fentanyl patches for pain management."

121. During the period of January 2016 to December 2016, PA GD saw Patient C monthly for office visits and refilled lorazepam, oxycodone and Oxycontin. PA GD also added fentanyl patches in February 2016. Patient C also received Soma and other controlled drugs from other providers.

122. On or about February 17, 2016, PA GD saw Patient C for an office visit. PA GD documented that "Patient was release for the hospital following a lumbar laminectomy 02/01/2016. Patient has a post-operative appointment in three weeks. Patient's medications are not helping with her pain." PA GD prescribed fentanyl at 50 mcg, 10 patches.

123. On or about March 16, 2016, PA GD saw Patient C for an office visit. PA GD increased fentanyl to 75 mcg, 10 patches.

124. On or about April 7, 2016, PA GD saw Patient C for an office visit. PA GD documented that "Patient is still using a walker for her hip pain." PA GD added that he "[d]iscussed the complications of using benzodiazepines and opioids." PA GD documented that "Patient states that her fentanyl was stolen from her house."

125. On or about May 17, 2016, PA GD saw Patient C for an office visit. PA GD documented "Patient is now using a cane to ambulate. Patient fell in the bathroom and contused her left forehead. Patient was shorted her Rx for fentanyl by the pharmacist instead of 15 patches the patient received 10." PA GD's medical record indicate that his last prescription was for 10 patches. PA GD increased Patient C's fentanyl prescription to 75mcg, 15 patches.

126. In a urine toxicology screen collected May 17, 2016, Patient C tested positive for alcohol. PA GD failed to address the positive test consistent with the pain contract.

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127. In a urine toxicology screen collected June 8, 2016, Patient C tested positive for alcohol. PA GD failed to address the positive test consistent with the pain contract.

128. On or about June 8, 2016, PA GD saw Patient C for an office visit. PA GD documented "Patient states she is hallucinating with the Fentanyl Patches." PA GD documented that Patient C's "Preliminary UDT was + for oxycodone and ETOH (discussed the use of ETOH and drugs with the patient.)"

129. On or about July 6, 2016, PA GD saw Patient C for an office visit. PA GD documented "Robinson pharmacy stated that [Patient C] received over 600 tables (sic) by accident instead of 180 oxycodone 30mg at q4h by mistake. Patient C states she never received 600 tablets only 180."

130. In a urine toxicology screen collected July 6, 2016, Patient C tested negative for all opioids prescribed by PA GD. PA GD failed to address the negative test consistent with the pain contract.

131. In a urine toxicology screen collected August 4, 2016, Patient C tested positive for alcohol and oxycodone only. PA GD failed to address the positive test consistent with the pain contract.

132. During the period of January 2017 to June 2018, PA GD prescribed oxycodone, lorazepam and Oxycontin.

133. On or about January 18, 2017, Patient C went to Respondent's clinic and reported that she lost the prescription and needed a new one. PA GD issued a new prescription. At or around 2:00 p.m., Patient C called back with a story of "how her new prescription ended up being torn to shreds after it had fallen out of her pocket, into a puddle, and then her dog had gotten diarrhea all over it." PA GD "decided that she will have withdrawal medication called in for her and she will be scheduled in one week." PA GD's MA called in prescriptions for Valium, and clonidine[6].

134. In an interview with the Board on October 15, 2019, Respondent stated that he never saw Patient C in person. He did not recall ever talking to PA GD about the current management

[6] Clonidine, sold as the brand name Catapres among others, is a medication used to treat high blood pressure, attention deficit hyperactivity disorder, drug withdrawal (alcohol, opioids, or smoking), menopausal flushing, diarrhea, and certain pain conditions.

of Patient C. He was not aware that Patient C had urine drug screens that were positive for controlled drugs that were not prescribed by PA GD, despite PA GD documenting the urine drug screens were consistent. He was not aware that Patient C had an alcohol use disorder. He was not aware that PA GD was prescribing Soma to Patient C. He was not aware that a nurse practitioner had written a note in 2015, saying that Patient C had overdoses and multiple falls.

135. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to the following:

a. Respondent failed to follow his own protocols regarding the treatment of Patient C and refer Patient C for alcohol use disorder treatment. Respondent failed to document any discussion with PA GD regarding Patient C's alcohol use disorder.

b. Respondent failed to consult with PA GD and cosign the notes within the required seven days when schedule II drugs were prescribed and 30 days in all other cases.

c. Respondent committed inaccurate recordkeeping by allowing the use of template notes by PA GD, including but not limited: physical examinations that were not performed currently; misrepresentation of his involvement in Patient C's care by auto-populating his signature; documenting that he was going to examine Patient C on the next office visit; and documenting that Patient C CURES report was compliant, despite the inconsistent urine toxicology tests.

d. Respondent allowed PA GD to prescribe opioids without reason, and failing to take into consideration and/or document the rationale for prescribing opioids, ignoring multiple red flags including inconsistent urine toxicology.

e. Respondent failed to adequately supervise PA GD. Respondent failed to co-sign any notes, and he failed to co-sign when controlled medication was prescribed. Respondent never met or examined Patient C. Respondent failed to audit PA GD's chart and/or look at the urine drug tests and/or review CURES. Respondent was unaware of the standard of care for prescribing opioids. Respondent failed to make appropriate referrals to specialists.

f. Respondent allowed PA GD to prescribe Soma to a substance abuser.

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g. Respondent failed to change his treatment plan despite urine toxicology screening that show that Patient C was not taking the drugs he was prescribing; history of overdosing, and did not consider that she might need psychiatric intervention and a reduction in sedating medications.

FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence- Patient D)

136. Respondent's license is subject to disciplinary action under sections 3527, 2234 subdivision (b), 3502, and 3502.1, of the Code and Title 16 of the California Code of Regulations sections 1399.540, 1399.541, and 1399.545, in that he committed gross negligence during the care and treatment of Patient D. The circumstances are as follows:

137. On or about June 12, 2012, PA GD saw Patient D for an office visit. PA GD documented that Patient D was at the time a 55-year-old female being seen for pain management. PA GD documented her diagnosis as "Chronic pain syndrome; Right Knee pain; and Left Knee pain." In a March 9, 2012, Dr. KB faxed an oximetry report to Respondent's office concerned about Patient D's hypoxia. Patient D qualified for oxygen and had a sleep breathing disorder. Patient D entered into a pain contract on May 15, 2012 where she agreed, *inter-alia*, that losing medication, and stolen medication would mean termination of treatment. Patient D was prescribed Oxycontin, methadone and Klonopin by her prior provider. PA GD continued to prescribe Oxycontin and methadone. PA GD failed to ask for documentation of Patient D's prior history, old records and consultations. PA GD failed to order any diagnostic testing to confirm the sources of pain. PA GD also failed to have his supervising physician read the chart and examine the patient to formulate Patient D's treatment plan. PA GD failed to obtain a consultation on the abnormal oxygen test from a sleep specialist.

138. During the period of June 2012 to December 2013, PA GD prescribed Oxycontin 80 mg, 60 tablets, and methadone 10 mg, 180 tablets to Patient D. Patient D received prescriptions for other controlled substances from other providers.

139. In a urine toxicology screen collected July 3, 2013, Patient D tested positive for alcohol. PA GD failed to address the positive test consistent with the pain contract.

140. During the period of December 2013 to December 2014, PA GD prescribed Oxycontin 80 mg, 60 tablets, and methadone 10 mg, 180 tablets to Patient D.

141. On or about July 1, 2014, PA GD saw Patient D for an office visit. PA GD documented that Patient D was a high risk for opioid misuse. PA GD increased Patient D's prescription for methadone to 10 mg, 270 tablets despite the high risk for misuse.

142. In a urine toxicology screen collected December 22, 2014, Patient D tested positive for dihydrocodeinone and negative for oxycodone. PA GD failed to address the positive and negative test consistent with the pain contract.

143. During the period of December 2014 to December 2015, PA GD prescribed Oxycontin 80 mg, 60 tablets, and methadone 10 mg, 270 tablets to Patient D.

144. In a urine toxicology screen collected June 23, 2015, Patient D tested negative for oxycodone. PA GD failed to address the negative test consistent with the pain contract.

145. In a urine toxicology screen collected October 13, 2015, Patient D tested positive for oxymorphone. PA GD failed to address the positive test consistent with the pain contract.

146. During the period of December 2015 to June 2018, PA GD prescribed Oxycontin 80 mg, 60 tablets, and methadone 10 mg, 270 tablets to Patient D.

147. In a urine toxicology screen collected September 19, 2017, Patient D tested negative for methadone. PA GD failed to address the negative test consistent with the pain contract.

148. In an interview with the Board on October 15, 2019, Respondent stated that he never saw Patient D in person. He does not recall ever talking to PA GD about the current management of Patient D. He was not aware that Patient D had a sleep study showing significant oxygen desaturations, and that she was not referred to a sleep specialist and her benzodiazepines were not discontinued, and her opiates were not significantly reduced. He was not aware that Patient D had multiple urine drug toxicology screens that were inconsistent. He was not aware that PA GD was recording that the urine drug screens were consistent when in fact they were not.

149. Respondent committed gross negligence in his care and treatment of Patient D, which included, but was not limited to the following:

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a. Respondent failed to supervise PA GD and have Patient D consult with a sleep specialist.

b. Respondent allowed methadone to be used on a prn basis.

c. Respondent failed to consult with PA GD and co-sign the notes within the required seven days when Schedule II drugs were prescribed and 30 days in all other cases.

d. Respondent committed inaccurate recordkeeping by allowing the use of template notes by PA GD, including but not limited to: physical examinations that were not performed currently; misrepresentation of his involvement in Patient D's care by auto-populating his signature; documenting that he was going to examine Patient D on the next office visit; and documenting that Patient D's CURES report was compliant, despite the inconsistent urine toxicology tests.

e. Respondent allowed PA GD to prescribe opioids without reason, failing to take into consideration and/or document the rationale for prescribing opioids, ignoring multiple red flags including inconsistent urine toxicology, stolen medication, early refills and warning letters from other providers in his treatment plan.

f. Respondent failed to adequately supervise PA GD. Respondent failed to co-sign any notes, and he failed to co-sign when controlled medication was prescribed. Respondent never met or examined Patient D. Respondent failed to audit PA GD's chart and/or look at the urine drug tests and/or review CURES. Respondent was unaware of the standard of care for prescribing opioids. Respondent failed to make appropriate referrals to specialists.

g. Respondent failed to obtain a consultation with a specialist when Patient D presented with an abnormal oxygen test.

h. Respondent allowed PA GD to prescribe high dose narcotics, without good reason, consultation, and written input from his supervisor. Respondent is not following the protocol he agreed to with PA GD regarding the treatment of alcoholics needing to get coincidental alcohol treatment in order to continue their pain management.

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FIFTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

150. Respondent's license is subject to disciplinary action under sections 3527, 2234, subdivision (c), 3502, and 3502.1, of the Code and Title 16 of the California Code of Regulations sections 1399.540, 1399.541, and 1399.545, in that he committed repeated negligent acts during the care of Patient A, B, C and D as more fully described above. The circumstances are set forth in paragraphs 35 through 149, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE
(Excessive Prescribing)

151. Respondent's license is subject to disciplinary action under sections 3527, 2234, subdivision (c), 3502 and 3502.1, of the Code and Title 16 of the California Code of Regulations sections 1399.540, 1399.541, and 1399.545, in that he has excessively prescribed controlled substances and dangerous drugs to Patients A, B, C and D. The circumstances are set forth in paragraphs 35 through 149, which are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE
(Prescribing Controlled Substances Without Appropriate Examination or Medical Indication)

152. Respondent is further subject to disciplinary action under sections 2227, 2234 and 2242, in that he has prescribed controlled substances and dangerous drugs to Patients A, B, C and D. The circumstances are set forth in paragraphs 35 through 149, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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

153. Respondent's license is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C and D. The circumstances are set forth in paragraphs 35 through 149, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 55172, issued to James Peter Dickens, M.D.;

2. Revoking, suspending or denying approval of James Peter Dickens, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering James Peter Dickens, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: MAR 0 2 2020

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

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