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

In the Matter of the Accusation Against: Terrance James Foster, M.D. Physician's and Surgeon's Certificate No. G 38904 Respondent.	Case No.: 800-2018-043590

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 August 27, 2021.

IT IS SO ORDERED: July 30, 2021.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Vice Chair
Panel A

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
VERONICA VO
Deputy Attorney General
State Bar No. 230698
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7508
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **TERRANCE JAMES FOSTER, M.D.** **274 Cohasset Rd., Ste. 100** **Chico, CA 95926-2236** **Physician's and Surgeon's Certificate No. G 38904** Respondent.	Case No. 800-2018-043590 OAH No. 2020090966 **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 Veronica Vo, Deputy Attorney General.

2. Respondent Terrance James Foster, M.D. ("Respondent") is represented in this proceeding by attorney Jeffrey S. Kravitz, Esq., whose address is: 1851 Heritage Lane, Suite 128 Sacramento, CA 95815.

3. On or about March 12, 1979, the Board issued Physician's and Surgeon's Certificate No. G 38904 to Terrance James Foster, 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. 800-2018-043590, and will expire on July 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-043590 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 August 25, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-043590 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. 800-2018-043590. 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.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the First Amended Accusation No. 800-2018-043590, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2018-043590, a true and correct copy of which is attached as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certification No. G 38904 to disciplinary action.

11. 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.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or 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.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2018-043590 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California. Upon adoption of this Decision and Order by the Board, this paragraph shall be fully incorporated as part of the terms and conditions of the Disciplinary Order below.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 38904 issued to Respondent Terrance James Foster, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION.

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act in Schedules II, III, and IV, except for those drugs listed in Schedule V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use

of marijuana.

These restrictions shall be deemed fully satisfied and no longer in effect upon the Board's receipt and acceptance of a certificate of completion from a Board-approved prescribing practices course *and* medical record-keeping course. A prescribing practices course and medical record-keeping course taken after the acts that gave rise to the charges in the original 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 the Decision.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES.

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

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

3. 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.

4. MEDICAL RECORD KEEPING COURSE.

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

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

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

15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE.

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which

includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

6. NOTIFICATION.

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

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

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7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES.

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

8. OBEY ALL LAWS.

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

9. QUARTERLY DECLARATIONS.

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

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

license.

Travel or Residence Outside California

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

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

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE.

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION.

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

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

Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

13. COMPLETION OF PROBATION.

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

14. VIOLATION OF PROBATION.

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

15. LICENSE SURRENDER.

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

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

16. PROBATION MONITORING COSTS.

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

17. FUTURE ADMISSIONS CLAUSE.

If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2018-043590 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Jeffrey S. Kravitz, Esq.. 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: 04/01/2021

TERRANCE JAMES FOSTER, M.D.
Respondent

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

DATED: 4-1-2021

JEFFREY S. KRAVITZ, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: April 1, 2021

Respectfully submitted,

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

Veronica Vo

VERONICA VO
Deputy Attorney General
Attorneys for Complainant

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Stipulated Settlement.docx

Exhibit A

Accusation No. 800-2018-043590

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
VERONICA VO
Deputy Attorney General
State Bar No. 230698
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7508
Facsimile: (916) 327-2247
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 800-2018-043590
Terrance James Foster, M.D. **274 Cohasset Rd., Ste. 110** **Chico, CA 95926-2236** **Physician's and Surgeon's Certificate No. G 38904,** Respondent.	**ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about March 12, 1979, the Medical Board issued Physician's and Surgeon's Certificate No. G 38904 to Terrance James Foster, 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 July 31, 2022, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code, states:

"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.

". . ."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. 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.

". . ."

8. Section 4021 of the Code states: "'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

9. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self use, except veterinary drugs that are labeled as such, and includes the following:

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

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar

import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

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

DEFINITIONS

10. **Alprazolam** (generic name for the drug Xanax) is a short-acting benzodiazepine used to treat anxiety, and 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, subdivision (d).

11. **Carisoprodol** (generic name for the drug Soma) 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.

12. **Clonazepam** (generic name for the drug Klonopin) is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks and seizures, among others. It is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. **Codeine** is an opioid pain reliever used to treat moderately severe pain. It is also used, usually in combination with other medications, to reduce coughing. It 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).

14. **Diazepam** (generic name for the drug Valium) is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Meniere's disease. It is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. **Fentanyl** (generic name for the drug Duragesic) 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 than morphine and hundreds of 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, subdivision (c).

16. **Hydrocodone bitartrate with acetaminophen** (generic name for the drugs Vicodin, Norco, and Lortab) is 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). On October 6, 2014, hydrocodone combination products were reclassified as Schedule II controlled substances. 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).

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

18. **Lorazepam** (generic name for Ativan) 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

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

21 section 1308.14(c) and California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. **Methadone** (generic name for the drug Symoron) 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 California Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. **Morphine sulfate** (generic name for the drugs Kadian, MS Contin, and MorphaBond ER) 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 central nervous system (CNS) to relieve pain. Morphine sulfate dissolves readily in water and body fluids, creating an immediate release. Morphine sulfate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine Sulfate is a Schedule II controlled substance pursuant to California Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. **Oxycodone** (generic name for Oxycontin, Roxicodone, and Oxecta) is a short acting opioid analgesic used to treat moderate to severe pain. It is a high risk drug 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 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, subdivision (b).

22. **Zohydro ER** is an extended release capsule of hydrocodone bitartrate, an opioid analgesic, indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment. Hydrocodone bitartrate 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).

23. **Zolpidem tartrate** (generic name for Ambien): 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patients A, B, C, D, and E.[2] The circumstances are as follows:

25. Respondent is a physician and surgeon, board certified in family medicine, who at all times relevant to the charges brought herein worked at his own clinic in Chico, California.

Patient A

26. Patient A is a 59-year old male who first sought treatment from Respondent in or around the early 2000's with lumbar and cervical spondylosis and signs and symptoms of radiculopathy. Patient A continued to see Respondent as a primary care physician and for regular and ongoing pain management. Patient A's diagnoses included: chronic pain; lumbar and cervical spondylosis; radiculopathy; anxiety; and cervicalgia.

27. Available patient records from May 2014 through January 2019 indicate that Respondent treated Patient A for pain management and prescribed very high dosages of opioids throughout that time, frequently in combination of benzodiazepines. Respondent would typically see Patient A every one to three months for medication refills.

28. During an interview with Board investigators on June 20, 2019 (the "Board Interview"), Respondent recalled that he gradually increased Patient A's opioid dosages over time as Patient A's tolerance also increased. By the time of May 2014—the earliest available medical

[2] Patient names are redacted to protect privacy.

record—Respondent was prescribing Patient A short-acting and long-acting opioids (Norco and morphine sulfate, respectively) with a daily morphine milligram equivalent (MME) of approximately 2,300 mg.[3] That is roughly **25 times greater** than the **maximum** daily dosage recommended by the CDC. Respondent was also prescribing Xanax to Patient A around that time.

29. In the several years following May 2014, despite very modest and gradual efforts to taper, Respondent continued to prescribe extremely high dosages of opioids, sometimes in combination with a benzodiazepine (such as Xanax). Indeed, Respondent periodically calculated the MME in his visit summaries for Patient A, which included the following estimates ranging from 930 mg to 1,920 mg. In other words, during the relevant course of treatment, Respondent prescribed Patient A between 10 and 25 times more than the maximum MME recommended by the CDC. Further, Respondent did not document (and failed to articulate at the Board Interview) any reason why Patient A should receive such extraordinarily high dosages.

30. On or around October 26, 2015, Patient A submitted to a urine toxicology screen that was positive for clonazepam metabolites, which Respondent had not prescribed. Available patient records indicate that Respondent did not document any discussion with Patient A regarding this toxicology screen or take any action as a result. During the Board Interview, Respondent did not recall taking any action related to the inconsistent result in Patient A's toxicology screen. The same toxicology screen also showed a positive result for THC. At the Board Interview, Respondent said that he was aware of Patient A's marijuana use but did not counsel him against it.

31. On or around June 7, 2016, Patient A again provided a urine sample that tested positive for clonazepam metabolites and THC. Available patient records indicate that, once again, Respondent did not document any discussion with Patient A regarding this toxicology screen or take any action as a result. Respondent admitted to Board investigators that he did not recall taking any steps to address Patient A's second inconsistent drug screen in less than a year.

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[3] The Centers for Disease Control and Prevention (CDC) recommends that clinicians avoid increasing prescribed opiates beyond 90 MME per day. Doses above 50 MME per day confer an increased risk of overdose of at least twice that of a dose less than 20 MME per day. The CDC states that higher dosages have not been shown to reduce pain over the long-term and that higher opioid dosages place the patient at higher risk of overdose death.

32. On or around September 13, 2017, Respondent referred Patient A to a pain specialist. On or around September 25, 2017, the pain specialist faxed a message to Respondent, denying the referral. The denial explained that Patient A "needs to be seen by [an] opioid addiction program. [Patient A] is a severe respiratory risk." (Emphasis in original.)

33. Available patient records show that Patient A signed pain management contracts in December 2017 and January 2018. Neither copy provided to the Board is signed by Respondent. Prior to December 2017, Respondent either did not enter into a pain management contract with Patient A or he failed to maintain records of any such agreement.

34. During the period of February 12, 2016 through February 1, 2019, Respondent prescribed and Patient A filled the following controlled substances:

Date Filled	Drug Name	Dosage	Quantity	Schedule
February 12, 2016	Morphine sulfate	100 MG	180	II
February 27, 2016	Morphine sulfate	60 MG	120	II
March 3, 2016	Morphine sulfate	200 MG	150	II
March 9, 2016	Alprazolam	2 MG	90	IV
March 12, 2016	Morphine sulfate	100 MG	180	II
March 28, 2016	Morphine sulfate	60 MG	120	II
April 1, 2016	Morphine sulfate	200 MG	150	II
April 11, 2016	Alprazolam	2 MG	90	IV
April 11, 2016	Morphine sulfate	100 MG	180	II
April 27, 2016	Morphine sulfate	60 MG	120	II
April 29, 2016	Morphine sulfate	200 MG	150	II
May 9, 2016	Alprazolam	2 MG	90	IV
May 9, 2016	Morphine sulfate	100 MG	180	II
May 26, 2016	Morphine sulfate	60 MG	120	II
May 27, 2016	Morphine sulfate	200 MG	150	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
June 7, 2016	Alprazolam	2 MG	90	IV
June 7, 2016	Morphine sulfate	100 MG	180	II
June 25, 2016	Morphine sulfate	60 MG	60	II
June 27, 2016	Morphine sulfate	200 MG	150	II
July 5, 2016	Alprazolam	2 MG	90	IV
July 6, 2016	Morphine sulfate	100 MG	180	II
July 25, 2016	Morphine sulfate	60 MG	60	II
July 25, 2016	Morphine sulfate	200 MG	150	II
August 3, 2016	Alprazolam	2 MG	90	IV
August 4, 2016	Morphine sulfate	100 MG	180	II
August 24, 2016	Morphine sulfate	200 MG	150	II
August 24, 2016	Morphine sulfate	60 MG	60	II
September 5, 2016	Alprazolam	2 MG	90	IV
September 5, 2016	Morphine sulfate	100 MG	180	II
October 3, 2016	Alprazolam	2 MG	90	IV
October 3, 2016	Morphine sulfate	100 MG	180	II
October 20, 2016	Morphine sulfate	200 MG	150	II
November 1, 2016	Alprazolam	2 MG	90	IV
November 1, 2016	Morphine sulfate	100 MG	180	II
November 18, 2016	Morphine sulfate	200 MG	150	II
November 29, 2016	Alprazolam	2 MG	90	IV
November 30, 2016	Morphine sulfate	100 MG	180	II
December 16, 2016	Morphine sulfate	200 MG	150	II
December 28, 2016	Alprazolam	2 MG	90	IV
December 28, 2016	Morphine sulfate	100 MG	180	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
January 14, 2017	Morphine sulfate	200 MG	150	II
January 26, 2017	Alprazolam	2 MG	90	IV
January 26, 2017	Morphine sulfate	100 MG	180	II
February 13, 2017	Morphine sulfate	200 MG	150	II
February 24, 2017	Alprazolam	2 MG	90	IV
February 24, 2017	Morphine sulfate	100 MG	180	II
March 13, 2017	Morphine sulfate	200 MG	150	II
March 24, 2017	Alprazolam	2 MG	90	IV
March 24, 2017	Morphine sulfate	100 MG	180	II
April 11, 2017	Morphine sulfate	200 MG	150	II
April 22, 2017	Alprazolam	2 MG	90	IV
April 22, 2017	Morphine sulfate	100 MG	180	II
May 10, 2017	Morphine sulfate	200 MG	150	II
May 22, 2017	Alprazolam	2 MG	90	IV
May 22, 2017	Morphine sulfate	100 MG	180	II
June 8, 2017	Morphine sulfate	200 MG	150	II
June 21, 2017	Alprazolam	2 MG	90	IV
June 21, 2017	Morphine sulfate	100 MG	180	II
July 7, 2017	Morphine sulfate	200 MG	150	II
July 7, 2017	Morphine sulfate	60 MG	30	II
July 20, 2017	Alprazolam	2 MG	90	IV
July 20, 2017	Morphine sulfate	100 MG	150	II
August 5, 2017	Morphine sulfate	200 MG	150	II
August 5, 2017	Morphine sulfate	60 MG	30	II
August 18, 2017	Alprazolam	2 MG	90	IV

Date Filled	Drug Name	Dosage	Quantity	Schedule
August 18, 2017	Morphine sulfate	100 MG	150	II
September 4, 2017	Morphine sulfate	200 MG	150	II
September 4, 2017	Morphine sulfate	30 MG	30	II
September 16, 2017	Alprazolam	2 MG	90	IV
September 16, 2017	Morphine sulfate	100 MG	150	II
October 3, 2017	Morphine sulfate	200 MG	150	II
October 3, 2017	Morphine sulfate	30 MG	30	II
October 14, 2017	Alprazolam	2 MG	90	IV
October 16, 2017	Morphine sulfate	100 MG	150	II
November 1, 2017	Morphine sulfate	30 MG	30	II
November 1, 2017	Morphine sulfate	200 MG	150	II
November 11, 2017	Alprazolam	2 MG	90	IV
November 14, 2017	Morphine sulfate	100 MG	150	II
November 30, 2017	Morphine sulfate	30 MG	30	II
November 30, 2017	Morphine sulfate	200 MG	150	II
December 12, 2017	Alprazolam	2 MG	90	IV
December 13, 2017	Morphine sulfate	100 MG	150	II
December 29, 2017	Morphine sulfate	200 MG	150	II
January 11, 2018	Alprazolam	2 MG	90	IV
January 11, 2018	Morphine sulfate	100 MG	120	II
January 27, 2018	Morphine sulfate	200 MG	150	II
February 3, 2018	Morphine sulfate	100 MG	30	II
February 9, 2018	Alprazolam	2 MG	90	IV
February 9, 2018	Morphine sulfate	100 MG	150	II
February 24, 2018	Morphine sulfate	200 MG	150	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
March 10, 2018	Alprazolam	2 MG	90	IV
March 10, 2018	Morphine sulfate	100 MG	150	II
March 24, 2018	Morphine sulfate	200 MG	150	II
April 7, 2018	Alprazolam	2 MG	90	IV
April 7, 2018	Morphine sulfate	100 MG	150	II
April 25, 2018	Morphine sulfate	200 MG	150	II
May 5, 2018	Alprazolam	2 MG	90	IV
May 8, 2018	Morphine sulfate	100 MG	140	II
May 24, 2018	Morphine sulfate	200 MG	150	II
June 2, 2018	Alprazolam	2 MG	90	IV
June 6, 2018	Morphine sulfate	100 MG	140	II
June 25, 2018	Morphine sulfate	200 MG	150	II
July 3, 2018	Alprazolam	2 MG	90	IV
July 7, 2018	Morphine sulfate	100 MG	130	II
July 24, 2018	Morphine sulfate	200 MG	150	II
August 1, 2018	Alprazolam	2 MG	90	IV
August 6, 2018	Morphine sulfate	100 MG	120	II
August 22, 2018	Morphine sulfate	200 MG	150	II
August 30, 2018	Alprazolam	2 MG	90	IV
September 5, 2018	Morphine sulfate	100 MG	110	II
September 20, 2018	Morphine sulfate	200 MG	150	II
September 28, 2018	Alprazolam	2 MG	90	IV
October 5, 2018	Morphine sulfate	100 MG	100	II
October 19, 2018	Morphine sulfate	200 MG	150	II
October 27, 2018	Alprazolam	2 MG	90	IV

Date Filled	Drug Name	Dosage	Quantity	Schedule
November 5, 2018	Morphine sulfate	100 MG	90	II
November 19, 2018	Morphine sulfate	200 MG	150	II
November 28, 2018	Alprazolam	2 MG	90	IV
December 4, 2018	Morphine sulfate	100 MG	80	II
December 18, 2018	Morphine sulfate	200 MG	150	II
December 28, 2018	Alprazolam	2 MG	90	IV
January 3, 2019	Morphine sulfate	100 MG	75	II
January 16, 2019	Morphine sulfate	200 MG	150	II
January 26, 2019	Alprazolam	2 MG	90	IV
February 1, 2019	Morphine sulfate	100 MG	60	II

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

A. Respondent prescribed excessive amounts of controlled substances to Patient A, including short-acting and long-acting opioids, frequently in combination with a benzodiazepine;

B. Respondent failed to document a discussion or take any action related to multiple testing irregularities when Patient A submitted to toxicology screens; and

C. Respondent's records for Patient A do not include a pain management contract prior to December 2017 even though Respondent treated Patient A since the early 2000's.

Patient B

36. Patient B is a 65-year old male treated by Respondent for chronic pain for approximately 20 years. Patient B's diagnoses included: chronic pain; chronic pancreatitis, type I diabetes; peripheral neuropathy; autonomic neuropathies; peripheral vascular disease; chronic viral hepatitis C; and major depression.

37. Available patient records from April 2014 through January 2019 indicate that Respondent treated Patient B for pain management and prescribed very high dosages of opioids in combination of zolpidem tartrate throughout that time. Respondent would typically see Patient B

every one to three months and prescribe multiple long-acting opioids (morphine sulfate and fentanyl patches), a short-acting opioid (hydromorphone), and a hypnotic (zolpidem tartrate).

38. During the Board Interview, Respondent recalled that he gradually increased Patient B's opioid dosages over time. For example, on or around June 30, 2014, Respondent prescribed approximately 1600 mg of morphine sulfate per day, in addition to significant amounts of oxycodone and fentanyl patches. These prescriptions amounted to an MME of approximately 2,130, more than **23 times greater** than the **maximum** daily dosage recommended by the CDC.

39. As of June 15, 2015, Respondent was prescribing approximately 900 mg of morphine sulfate per day, in addition to 80 mg of oxycodone and 125 mcg/hour of fentanyl. This represents an MME of 1,320, approximately **14 times greater** than the **maximum** daily dosage recommended by the CDC. Respondent continued prescribing a similar pain medication regimen through at least February 2017, swapping hydromorphone for oxycodone. From February 2017 to January 2019, Respondent made very modest and gradual efforts to taper Patient B's pain medications; however, he continued to prescribe extremely high dosages of opioids in combination with a hypnotic. Indeed, Respondent periodically calculated the MME, beginning in May 2017, which exceeded 1,000 MME in all but two instances. Throughout Respondent's treatment of Patient B, he prescribed between 9 and at least 14 times more than the maximum MME recommended by the CDC. Further, Respondent did not document any reason why Patient B should receive such extraordinarily high dosages.

40. After Patient B visited Respondent for a medication refill on August 8, 2016, Respondent's medical records do not show any visit summaries for Patient B until May 1, 2017, which is described as a three-month follow-up despite a 9-month gap in records. The CURES report indicates that Patient B continued to fill (some) monthly prescriptions written by Respondent during that timeframe. Oddly, however, Patient B filled only one prescription for morphine sulfate between February 28, 2017 and January 1, 2018, even though Respondent regularly wrote prescriptions for morphine sulfate during that time. Respondent did not document that Patient B had not been using morphine sulfate or did not need it. And as suddenly as he stopped filling those prescriptions, Patient B began filling them again in January 2018. In other

words, Patient B went from taking 900 mg of morphine sulfate per day to 0 mg per day for almost an entire year—without any corresponding increase in other pain medications or documentation of withdrawals from the sudden and dramatic decrease—and then went back to taking 900 mg of morphine sulfate per day.

41. In addition to physical ailments, Respondent documented that Patient B suffered from major depression. For example, on a June 15, 2015 visit summary, Respondent wrote, "Not suicidally depressed but fatalistic about current situation. Memory still bad but doesn't want referral." A month later, Respondent noted "[o]ngoing depression" and listed "Depression (Type: Acute)" as a diagnosis. Indeed, at the Board Interview, Respondent admitted that Patient B had "indicated a few times that . . . he's not sure if his life was worth living." Respondent indicated that Patient B declined psychiatric or social treatment, yet Respondent continued to treat Patient B with very high doses of opioids and zolpidem tartrate even though it created an extra risk factor for suicide.

42. In addition to documenting major depression, Respondent also documented that Patient B has a history of viral hepatitis C, which suggests a prior substance abuse problem. Respondent did not document a specific substance abuse history in Patient B's medical records. Nor did he recommend or make a referral for a current specialty consultation.

43. Available patient records indicate that Respondent ordered only one toxicology screen from April 2014 through January 2019. That one toxicology screen occurred on December 10, 2018.

44. During the period of February 18, 2016 through January 18, 2019, Respondent prescribed and Patient B filled the following controlled substances:

Date Filled	Drug Name	Dosage	Quantity	Schedule
February 18, 2016	Hydromorphone hcl	4 MG	120	II
February 25, 2016	Zolpidem tartrate	10 MG	30	IV
February 29, 2016	Morphine sulfate	200 MG	90	II
February 29, 2016	Morphine sulfate	100 MG	90	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
March 26, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
March 26, 2016	Hydromorphone hcl	4 MG	120	II
March 26, 2016	Zolpidem tartrate	10 MG	30	IV
April 2, 2016	Morphine sulfate	100 MG	90	II
April 2, 2016	Morphine sulfate	200 MG	90	II
April 26, 2016	Zolpidem tartrate	10 MG	30	IV
May 2, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
May 2, 2016	Hydromorphone hcl	4 MG	120	II
May 2, 2016	Morphine sulfate	100 MG	90	II
May 2, 2016	Morphine sulfate	200 MG	90	II
May 26, 2016	Zolpidem tartrate	10 MG	30	IV
June 1, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
June 1, 2016	Hydromorphone hcl	4 MG	120	II
June 1, 2016	Morphine sulfate	200 MG	90	II
June 1, 2016	Morphine sulfate	100 MG	90	II
June 24, 2016	Zolpidem tartrate	10 MG	30	IV
July 1, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
July 1, 2016	Hydromorphone hcl	4 MG	120	II
July 1, 2016	Morphine sulfate	100 MG	90	II
July 1, 2016	Morphine sulfate	200 MG	90	II
July 26, 2016	Zolpidem tartrate	10 MG	30	IV
July 29, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
July 29, 2016	Hydromorphone hcl	4 MG	120	II
July 29, 2016	Morphine sulfate	200 MG	90	II
July 29, 2016	Morphine sulfate	100 MG	90	II
August 26, 2016	Zolpidem tartrate	10 MG	30	IV
August 29, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
August 29, 2016	Morphine sulfate	200 MG	90	II
August 29, 2016	Morphine sulfate	100 MG	90	II
August 30, 2016	Hydromorphone hcl	4 MG	100	II
September 23, 2016	Zolpidem tartrate	10 MG	30	IV
September 26, 2016	Hydromorphone hcl	4 MG	100	II
September 28, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
September 28, 2016	Morphine sulfate	100 MG	90	II
September 28, 2016	Morphine sulfate	200 MG	90	II
October 21, 2016	Hydromorphone hcl	4 MG	100	II
October 24, 2016	Zolpidem tartrate	10 MG	30	IV
October 28, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
October 28, 2016	Morphine sulfate	200 MG	90	II
October 28, 2016	Morphine sulfate	100 MG	90	II
November 22, 2016	Hydromorphone hcl	4 MG	90	II
November 22, 2016	Zolpidem tartrate	10 MG	30	IV
November 25, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
November 25, 2016	Morphine sulfate	100 MG	90	II
November 25, 2016	Morphine sulfate	200 MG	90	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
December 20, 2016	Hydromorphone hcl	4 MG	90	II
December 24, 2016	Zolpidem tartrate	10 MG	30	IV
December 26, 2016	Fentanyl transdermal system	100 MCG/1 HR	15	II
December 26, 2016	Morphine sulfate	200 MG	90	II
December 26, 2016	Morphine sulfate	100 MG	90	II
January 19, 2017	Hydromorphone hcl	4 MG	90	II
January 25, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
January 25, 2017	Morphine sulfate	200 MG	90	II
January 25, 2017	Morphine sulfate	100 MG	90	II
January 25, 2017	Zolpidem tartrate	10 MG	30	IV
February 24, 2017	Zolpidem tartrate	10 MG	30	IV
February 27, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
February 27, 2017	Hydromorphone hcl	4 MG	80	II
February 27, 2017	Morphine sulfate	200 MG	90	II
February 27, 2017	Morphine sulfate	100 MG	90	II
March 24, 2017	Zolpidem tartrate	10 MG	30	IV
March 28, 2017	Hydromorphone hcl	4 MG	80	II
March 29, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
April 24, 2017	Hydromorphone hcl	4 MG	80	II
April 25, 2017	Zolpidem tartrate	10 MG	30	IV
April 28, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
May 23, 2017	Hydromorphone hcl	4 MG	80	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
May 25, 2017	Zolpidem tartrate	10 MG	30	IV
May 26, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
June 21, 2017	Hydromorphone hcl	4 MG	80	II
June 23, 2017	Zolpidem tartrate	10 MG	30	IV
June 27, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
July 24, 2017	Hydromorphone hcl	4 MG	80	II
July 24, 2017	Zolpidem tartrate	10 MG	30	IV
July 27, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
August 21, 2017	Hydromorphone hcl	4 MG	80	II
August 23, 2017	Zolpidem tartrate	10 MG	30	IV
August 25, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
August 25, 2017	Morphine sulfate	200 MG	90	II
September 21, 2017	Zolpidem tartrate	10 MG	30	IV
September 25, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
September 25, 2017	Hydromorphone hcl	4 MG	80	II
October 16, 2017	Hydromorphone hcl	4 MG	80	II
October 20, 2017	Zolpidem tartrate	10 MG	30	IV
October 24, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
November 20, 2017	Zolpidem tartrate	10 MG	30	IV
November 22, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
December 20, 2017	Zolpidem tartrate	10 MG	30	IV

Date Filled	Drug Name	Dosage	Quantity	Schedule
December 22, 2017	Fentanyl transdermal system	100 MCG/1 HR	15	II
January 2, 2018	Morphine sulfate	100 MG	90	II
January 9, 2018	Morphine sulfate	200 MG	90	II
January 19, 2018	Zolpidem tartrate	10 MG	30	IV
January 22, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
February 8, 2018	Morphine sulfate	200 MG	90	II
February 21, 2018	Fentanyl transdermal system	100 MCG/1 HR	10	II
February 21, 2018	Morphine sulfate	100 MG	90	II
February 21, 2018	Zolpidem tartrate	10 MG	30	IV
March 12, 2018	Morphine sulfate	200 MG	90	II
March 19, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
March 23, 2018	Zolpidem tartrate	10 MG	30	IV
April 4, 2018	Morphine sulfate	100 MG	90	II
April 11, 2018	Morphine sulfate	200 MG	90	II
April 18, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
April 20, 2018	Zolpidem tartrate	10 MG	30	IV
May 8, 2018	Morphine sulfate	100 MG	80	II
May 17, 2018	Morphine sulfate	200 MG	90	II
May 18, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
May 18, 2018	Zolpidem tartrate	10 MG	30	IV
June 11, 2018	Morphine sulfate	100 MG	70	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
June 15, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
June 15, 2018	Morphine sulfate	200 MG	90	II
June 19, 2018	Zolpidem tartrate	10 MG	30	IV
July 17, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
July 17, 2018	Morphine sulfate	200 MG	90	II
July 17, 2018	Morphine sulfate	100 MG	60	II
July 20, 2018	Zolpidem tartrate	10 MG	30	IV
August 17, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
August 17, 2018	Zolpidem tartrate	10 MG	30	IV
September 10, 2018	Morphine sulfate	60 MG	15	II
September 10, 2018	Morphine sulfate	100 MG	45	II
September 10, 2018	Morphine sulfate	200 MG	90	II
September 14, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
September 17, 2018	Zolpidem tartrate	10 MG	30	IV
October 10, 2018	Hydromorphone hcl	4 MG	60	II
October 11, 2018	Morphine sulfate	60 MG	15	II
October 11, 2018	Morphine sulfate	200 MG	90	II
October 11, 2018	Morphine sulfate	100 MG	30	II
October 17, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
October 17, 2018	Zolpidem tartrate	10 MG	30	IV
November 5, 2018	Hydromorphone hcl	4 MG	60	II
November 5, 2018	Morphine sulfate	30 MG	20	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
November 14, 2018	Morphine sulfate	100 MG	30	II
November 14, 2018	Morphine sulfate	200 MG	90	II
November 19, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
December 19, 2018	Fentanyl transdermal system	100 MCG/1 HR	15	II
December 19, 2018	Morphine sulfate	200 MG	90	II
December 19, 2018	Morphine sulfate	100 MG	30	II
January 18, 2019	Fentanyl transdermal system	100 MCG/1 HR	15	II
January 18, 2019	Morphine sulfate	100 MG	60	II
January 18, 2019	Morphine sulfate	200 MG	60	II
January 18, 2019	Zolpidem tartrate	10 MG	30	IV

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

A. Respondent prescribed excessive amounts of controlled substances to Patient B, including short-acting and long-acting opioids in combination with a hypnotic sedative;

B. Respondent failed to perform periodic urine toxicology screens during chronic opioid treatment;

C. Respondent failed to refer Patient B for a current specialty consultation despite being on extremely high doses of opiates, having major depression and hepatitis C consistent with a prior substance abuse problem; and

D. Respondent continued to treat Patient B with chronic opioid medications after Patient B refused treatment for major depression.

Patient C

46. Patient C is an 84-year old, morbidly obese female treated by Respondent for chronic low back and knee pain for approximately 12 years or longer. Respondent treated Patient C for

regular and ongoing pain management over that time. Patient C's diagnoses included: low back and knee pain; atrial fibrillation with heart failure; and headaches.

47. Available patient records from September 2015 through January 2019 indicate that Respondent treated Patient C for pain management and prescribed a risky level of opioids in combination with benzodiazepines throughout that time. Respondent would typically see Patient C every one to three months and prescribe butalbital-acetaminophen-caffeine for headaches, a long-acting opioid (Zohydro ER), a short-acting opioid (hydrocodone bitartrate-acetaminophen), and a benzodiazepine (alprazolam and/or lorazepam).

48. For example, on July 21, 2016, Respondent summarized Patient C's chief complaint as "pain medication refill would like to discuss increasing her dosage of norco so she can 'do things like camping. . . . [C]omplains of knee and shoulder pain; pain scale today 0/10." Respondent increased Patient C's prescription for hydrocodone bitartrate-acetaminophen from 100 to 120 tablets per month, but he did not document the reason or medical need for this adjustment other than Patient C's request. Respondent also prescribed 60 capsules of Zohydro ER 40 mg and 90 tablets of alprazolam 0.25 mg. These prescriptions amounted to an MME of 120.

49. Following the July 21, 2016 visit, Respondent continued to prescribe the same or similar drugs and dosages through May 2018. On June 14, 2018, Respondent began to very slowly taper Patient C's prescription of hydrocodone bitartrate-acetaminophen, typically reducing it by 5 tablets per month. Respondent continued to calculate the MME in excess of 100 until November 1, 2018, when he calculated an MME of 90. Throughout the relevant period, Respondent prescribed Patient C an opioid regimen that was at or above the maximum recommended by the CDC—in combination with benzodiazepines—even though she was an elderly, morbidly obese woman with mobility problems.

50. On or around February 27, 2017, Respondent saw Patient C after she went to the hospital for a fall-related accident. Patient C reported that she fell twice, slipping off the bed, and that she was unable to get up. One month later, on or about March 27, 2017, Patient C returned to Respondent for a follow-up visit on her knee pain and to fill her prescriptions. Despite the recent falls, Respondent prescribed Patient C her usual prescription regimen with an MME of 120.

Respondent also prescribed alprazolam even though it is contraindicated in a patient of her age due to its accumulation in the body and increased risk of falling. Apparently, Patient C had another severe fall in November 2015.

51. In addition to prescribing opioids and benzodiazepines, Respondent prescribed 120 to 180 tablets of butalbital-acetaminophen-caffeine 325 mg – 50 mg – 40 mg per month for the vast majority of the relevant period. At the Board Interview, Respondent admitted that this prescription—as well as the opioid prescriptions—likely caused or contributed to her rebound headaches.

52. Available patient records indicate that Respondent alternated between prescribing alprazolam and lorazepam to Patient C in 2016 and 2017. On April 12, 2016, Patient C filled prescriptions for both of these benzodiazepines on the same day. Patient C also filled prescriptions for both medications in October 2016, December 2016, and May 2017.

53. Available patient records for Patient C, which cover September 2015 to January 2019, indicate that Respondent did not order any toxicology screens for her during that time period.

54. During the period of February 12, 2016 through January 15, 2019, Respondent prescribed and Patient C filled the following controlled substances:

Date Filled	Drug Name	Strength	Quantity	Schedule
February 12, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	90	II
February 12, 2016	Zohydro ER	30 MG	60	II
February 18, 2016	Lorazepam	1 MG	90	IV
March 10, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	90	III
March 10, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	90	II
March 10, 2016	Zohydro ER	30 MG	60	II
April 4, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	90	III
April 7, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	90	II

Date Filled	Drug Name	Strength	Quantity	Schedule
April 7, 2016	Zohydro ER	30 MG	60	II
April 12, 2016	Alprazolam	0.25 MG	90	IV
April 12, 2016	Lorazepam	1 MG	90	IV
April 28, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	100	II
May 2, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
May 2, 2016	Zohydro ER	40 MG	60	II
May 23, 2016	Alprazolam	0.25 MG	90	IV
June 2, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	100	II
June 2, 2016	Zohydro ER	40 MG	60	II
June 20, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
June 24, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	100	II
June 25, 2016	Zohydro ER	40 MG	60	II
July 21, 2016	Alprazolam	0.25 MG	90	IV
July 21, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
July 21, 2016	Zohydro ER	40 MG	60	II
August 12, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
August 18, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
August 18, 2016	Zohydro ER	40 MG	60	II
September 8, 2016	Alprazolam	0.25 MG	90	IV
September 15, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
September 15, 2016	Zohydro ER	40 MG	60	II

Date Filled	Drug Name	Strength	Quantity	Schedule
September 27, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
October 5, 2016	Lorazepam	1 MG	90	IV
October 13, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
October 13, 2016	Zohydro ER	40 MG	60	II
October 28, 2016	Alprazolam	0.25 MG	90	IV
October 31, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
November 11, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
November 11, 2016	Zohydro ER	40 MG	60	II
December 7, 2016	Alprazolam	0.25 MG	90	IV
December 8, 2016	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
December 8, 2016	Zohydro ER	30 MG	60	II
December 12, 2016	Zohydro ER	40 MG	60	II
December 12, 2016	Zohydro ER	40 MG	60	II
December 16, 2016	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
December 19, 2016	Lorazepam	1 MG	90	IV
January 5, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
January 5, 2017	Zohydro ER	40 MG	60	II
January 9, 2017	Alprazolam	0.25 MG	90	IV
January 30, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
February 2, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
February 2, 2017	Zohydro ER	40 MG	60	II

Date Filled	Drug Name	Strength	Quantity	Schedule
February 14, 2017	Lorazepam	1 MG	90	IV
March 2, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
March 2, 2017	Zohydro ER	40 MG	60	II
March 6, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
March 27, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
March 27, 2017	Zohydro ER	40 MG	60	II
April 10, 2017	Alprazolam	0.25 MG	90	IV
April 17, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	120	III
April 27, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
April 27, 2017	Zohydro ER	40 MG	60	II
May 1, 2017	Lorazepam	1 MG	90	IV
May 23, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	120	III
May 26, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
May 26, 2017	Zohydro ER	40 MG	60	II
May 30, 2017	Alprazolam	0.25 MG	90	IV
June 22, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
June 22, 2017	Zohydro ER	40 MG	60	II
June 30, 2017	Alprazolam	0.25 MG	90	IV
July 7, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	120	III
August 2, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
August 2, 2017	Zohydro ER	40 MG	60	II

Date Filled	Drug Name	Strength	Quantity	Schedule
August 16, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	120	III
August 30, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
August 30, 2017	Zohydro ER	40 MG	60	II
September 7, 2017	Alprazolam	0.25 MG	90	IV
September 25, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	120	III
September 28, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
September 28, 2017	Zohydro ER	40 MG	60	II
October 4, 2017	Alprazolam	0.25 MG	90	IV
October 25, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	120	III
October 26, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
October 26, 2017	Zohydro ER	40 MG	60	II
November 13, 2017	Alprazolam	0.25 MG	90	IV
November 21, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
November 21, 2017	Zohydro ER	40 MG	60	II
November 30, 2017	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
December 16, 2017	Alprazolam	0.25 MG	90	IV
December 26, 2017	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
December 26, 2017	Zohydro ER	40 MG	60	II
January 12, 2018	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
January 15, 2018	Alprazolam	0.25 MG	90	IV

Date Filled	Drug Name	Strength	Quantity	Schedule
January 23, 2018	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	120	II
January 23, 2018	Zohydro ER	40 MG	60	II
February 17, 2018	Alprazolam	0.25 MG	90	IV
February 20, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	120	II
February 20, 2018	Zohydro ER	40 MG	60	II
February 28, 2018	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
March 22, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	120	II
March 22, 2018	Zohydro ER	40 MG	60	II
March 26, 2018	Alprazolam	0.25 MG	90	IV
April 19, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	120	II
April 19, 2018	Zohydro ER	40 MG	60	II
April 25, 2018	Alprazolam	0.25 MG	90	IV
May 17, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	120	II
May 17, 2018	Zohydro ER	40 MG	60	II
June 4, 2018	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
June 8, 2018	Alprazolam	0.25 MG	90	IV
June 14, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	115	II
June 14, 2018	Zohydro ER	40 MG	60	II
July 9, 2018	Alprazolam	0.25 MG	90	IV
July 12, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	110	II
July 12, 2018	Zohydro ER	40 MG	60	II
August 9, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	100	II

Date Filled	Drug Name	Strength	Quantity	Schedule
August 9, 2018	Zohydro ER	40 MG	60	II
August 13, 2018	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
August 14, 2018	Alprazolam	0.25 MG	90	IV
September 14, 2018	Alprazolam	0.25 MG	90	IV
October 4, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	100	II
October 4, 2018	Zohydro ER	40 MG	60	II
November 1, 2018	Butalbital- acetaminophen-caffeine	325 MG-50 MG-40 MG	180	III
November 1, 2018	Acetaminophen- hydrocodone bitartrat	325 MG-10 MG	90	II
November 1, 2018	Alprazolam	0.25 MG	90	IV
November 1, 2018	Zohydro ER	30 MG	60	II
December 6, 2018	Alprazolam	0.25 MG	90	IV
December 11, 2018	Zohydro ER	30 MG	60	II
December 14, 2018	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	85	II
January 14, 2019	Hydrocodone bitartrate-acetaminophen	325 MG-10 MG	85	II
January 14, 2019	Zohydro ER	30 MG	60	II
January 15, 2019	Alprazolam	0.25 MG	90	IV

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

A. Respondent engaged in polypharmacy—including a high level of opioids in combination with benzodiazepines and butalbital-acetaminophen-caffeine—in this elderly patient with balance and gait problems and congestive heart failure; and

B. Respondent failed to perform periodic urine toxicology screens during chronic opioid treatment.

Patient D

56. Patient D is a 68-year old male who first sought treatment from Respondent in or around 2000 related to lumbar spondylosis. Patient D continued to see Respondent for regular and ongoing pain management. Over time, Patient D developed painful conditions in addition to lumbar spondylosis and required replacement of both hips and additional surgery. Patient D's diagnoses included: lumbar spondylosis; hypertension; chronic obstructive pulmonary disease; back and hip pain. Patient D was a regular smoker and would very regularly complain of shortness of breath at his visits with Respondent. He also reported to Respondent that he used alcohol and marijuana. For example, a visit summary from August 2014 notes that Patient D had previously been drinking six beers per day; although, according to the note, Patient D had scaled back to two beers per day.

57. Available patient records from December 2013 through March 2019 indicate that Respondent treated Patient D for pain management and prescribed very high dosages of opioids throughout that time. Respondent would typically see Patient D every one to three months for medication refills. At each visit, Respondent prescribed extraordinarily high amounts of methadone, a long-acting opioid, as well as oxycodone. For example, from the earliest available patient record in December 18, 2013, up until April 2018, Respondent prescribed 800 tablets of methadone 10 mg per month, typically with instructions to take 27 to 33 tablets per day. On April 25, 2018, Respondent began to taper Patient D's methadone usage by initially reducing the total tablets to 750 per month, and eventually down to 740 per month by March 8, 2019. Respondent also prescribed a substantial amount of oxycodone. For example, on March 23, 2016, Patient D filled a monthly prescription for 180 tablets of oxycodone 30 mg. Respondent continued to prescribe the same amount until June 2017, when he tapered the dosage, eventually down to 125 tablets of oxycodone 20 mg per month.

58. Despite the very modest and gradual efforts to taper, Respondent continued to prescribe extremely high dosages of opioids. Indeed, Respondent periodically calculated the

MME in his visit summaries for Patient D, which included estimates ranging from 3,000 to 3,360. That is roughly **33 to 37 times greater** than the **maximum** daily dosage recommended by the CDC. Further, Respondent did not document any reason why Patient D should receive such extraordinarily high dosages.

59. Methadone is a very dangerous narcotic to take at high dosages for several reasons: there is a thin line between the effective dose and the lethal dose; there is also a difference between the effective dose for pain which is in spaced portions during the day and the effective dose for preventing withdrawal symptoms which is one small dose daily; it has a very long half-life and cumulates in the body; and the cumulated dose does not affect pain very much but adds to the likelihood of respiratory depression. Further, methadone can cause lethal cardiac arrhythmias. Despite the latter risk, Patient D's medical records do not include an electrocardiogram (EKG). While there is a mention of an EKG, it does not appear that it was done to look for the long Q-T interval which would contra-indicate the further use of methadone.

60. On several occasions, Patient D ran out of his opioid pain medications and/or requested refills early, and Respondent provided them to Patient D each time. For example, on or around November 21, 2013, Patient D spoke to Respondent's staff, saying that he needed a refill of methadone because he was "flying out on December 4 to work in mines." Respondent approved the request for an early refill the next day. A few weeks later, on or around December 18, 2013, Patient D reported that he had been taking about six extra methadone tablets per day due to cold weather. Although Patient D reported increased pain between the spine and right scapula, Respondent reported no tenderness when examining Patient D's back.

On or around July 14, 2014, Respondent provided an early methadone refill because Patient D was traveling. And, on or around February 2, 2016, Patient D requested refills on methadone and oxycodone "even though he just filled them on the 19th of January" because he did not "want to come back in a week or two because of his situation and limitations." Respondent provided the early refill prescriptions.

61. Available patient records indicate that Respondent ordered only one toxicology screen from December 2013 through March 2019. That one toxicology screen occurred on December 14, 2018.

62. On multiple occasions, Respondent discussed referring Patient D to a pain specialist. Patient D declined such a referral. Nonetheless, Respondent continued to treat Patient D and prescribe extremely high dosages of opioids.

63. Patient D signed one pain contract in March 2015.

64. During the period of March 23, 2016 through January 11, 2019, Respondent prescribed and Patient D filled the following controlled substances:

Date Filled	Drug Name	Dosage	Quantity	Schedule
March 23, 2016	Methadone hcl	10 MG	800	II
March 28, 2016	Oxycodone hcl	30 MG	180	II
April 21, 2016	Methadone hcl	10 MG	800	II
April 21, 2016	Oxycodone hcl	30 MG	180	II
May 13, 2016	Methadone hcl	10 MG	800	II
May 20, 2016	Oxycodone hcl	30 MG	180	II
June 9, 2016	Methadone hcl	10 MG	800	II
June 17, 2016	Oxycodone hcl	30 MG	180	II
July 15, 2016	Carisoprodol	350 MG	10	IV
July 15, 2016	Oxycodone hcl	15 MG	60	II
July 15, 2016	Zolpidem tartrate	10 MG	3	IV
July 18, 2016	Methadone hcl	10 MG	800	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
July 18, 2016	Oxycodone hcl	15 MG	175	II
July 18, 2016	Zolpidem tartrate	10 MG	30	IV
August 31, 2016	Methadone hcl	10 MG	800	II
August 31, 2016	Oxycodone hcl	30 MG	180	II
September 29, 2016	Methadone hcl	10 MG	800	II
September 29, 2016	Oxycodone hcl	30 MG	180	II
November 1, 2016	Methadone hcl	10 MG	800	II
November 1, 2016	Oxycodone hcl	30 MG	180	II
December 5, 2016	Methadone hcl	10 MG	800	II
December 5, 2016	Oxycodone hcl	30 MG	180	II
January 2, 2017	Methadone hcl	10 MG	800	II
January 2, 2017	Oxycodone hcl	30 MG	180	II
January 26, 2017	Methadone hcl	10 MG	800	II
February 23, 2017	Methadone hcl	10 MG	800	II
February 23, 2017	Oxycodone hcl	30 MG	180	II
April 3, 2017	Methadone hcl	10 MG	800	II
April 3, 2017	Oxycodone hcl	30 MG	180	II
May 8, 2017	Methadone hcl	10 MG	800	II
May 8, 2017	Oxycodone hcl	30 MG	180	II
June 23, 2017	Methadone hcl	10 MG	800	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
June 23, 2017	Oxycodone hcl	20 MG	180	II
July 21, 2017	Methadone hcl	10 MG	800	II
July 21, 2017	Oxycodone hcl	20 MG	180	II
August 17, 2017	Methadone hcl	10 MG	800	II
August 17, 2017	Oxycodone hcl	20 MG	180	II
September 18, 2017	Methadone hcl	10 MG	800	II
September 18, 2017	Oxycodone hcl	20 MG	180	II
October 23, 2017	Methadone hcl	10 MG	800	II
October 23, 2017	Oxycodone hcl	20 MG	180	II
November 27, 2017	Methadone hcl	10 MG	800	II
November 27, 2017	Oxycodone hcl	20 MG	180	II
December 29, 2017	Methadone hcl	10 MG	800	II
December 29, 2017	Oxycodone hcl	20 MG	175	II
January 23, 2018	Methadone hcl	10 MG	800	II
January 23, 2018	Oxycodone hcl	20 MG	175	II
February 28, 2018	Methadone hcl	10 MG	800	II
February 28, 2018	Oxycodone hcl	20 MG	175	II
May 1, 2018	Methadone hcl	10 MG	750	II
May 1, 2018	Oxycodone hcl	20 MG	150	II
June 1, 2018	Diazepam	2 MG	4	IV

Date Filled	Drug Name	Dosage	Quantity	Schedule
June 1, 2018	Methadone hcl	10 MG	750	II
June 1, 2018	Oxycodone hcl	20 MG	145	II
June 29, 2018	Methadone hcl	10 MG	745	II
July 25, 2018	Methadone hcl	10 MG	745	II
July 25, 2018	Oxycodone hcl	20 MG	145	II
August 23, 2018	Methadone hcl	10 MG	745	II
August 23, 2018	Oxycodone hcl	20 MG	140	II
September 21, 2018	Methadone hcl	10 MG	745	II
September 21, 2018	Oxycodone hcl	20 MG	140	II
October 17, 2018	Methadone hcl	10 MG	740	II
October 17, 2018	Oxycodone hcl	20 MG	135	II
November 15, 2018	Methadone hcl	10 MG	740	II
November 15, 2018	Oxycodone hcl	20 MG	135	II
December 14, 2018	Methadone hcl	10 MG	740	II
December 14, 2018	Oxycodone hcl	20 MG	130	II
January 11, 2019	Methadone hcl	10 MG	740	II
January 11, 2019	Oxycodone hcl	20 MG	125	II

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

A. Respondent prescribed excessive amounts of controlled substances to Patient D, including short-acting and long-acting opioids;

B. Respondent prescribed excessive amounts of methadone without an EKG analysis of the Q-T interval; and

C. Respondent failed to perform periodic urine toxicology screens during chronic opioid therapy.

Patient E

66. Patient E is a 44-year old male treated by Respondent for approximately 18 years. Patient E has had multiple surgeries and experiences pain in several areas. Patient E's diagnoses included chronic pain in the low back, right knee, and shoulders.

67. Available patient records from June 2015 through December 2018 indicate that Respondent treated Patient E for pain management and prescribed very high dosages of opioids. Respondent would typically see Patient E every month and prescribe multiple long-acting opioids (morphine sulfate and fentanyl patches) and a short-acting opioid (hydrocodone bitartrate-acetaminophen).

68. During the Board Interview, Respondent recalled that he gradually increased Patient E's opioid dosages over time. For example, on or around July 18, 2016, Respondent prescribed 360 tablets of morphine sulfate 200 mg, 120 tablets of morphine sulfate 100 mg, 10 fentanyl patches 75 mcg, and 100 tablets of hydrocodone bitartrate with acetaminophen 10 mg – 325 mg. These prescriptions amounted to an MME of approximately 3,013, more than **33 times greater** than the **maximum** daily dosage recommended by the CDC. Respondent prescribed a similar opioid pain regimen until at least February 2017. He did not document anyone reason why Patient E should receive such extraordinarily high dosages.

69. On or around June 22, 2015, Patient E submitted to a urine toxicology screen that was positive for codeine, which Respondent had not prescribed. Available patient records indicate that Respondent did not document any discussion with Patient E regarding this toxicology screen or take any action as a result. During the Board Interview, Respondent did not recall taking any

action related to the inconsistent result in Patient E's toxicology screen. The same toxicology screen also showed a positive result for THC.

70. During the period of February 19, 2016 through February 8, 2019, Respondent prescribed and Patient E filled the following controlled substances:

Date Filled	Drug Name	Dosage	Quantity	Schedule
February 19, 2016	Fentanyl transdermal system	50 MCG/1 HR	10	II
February 19, 2016	Morphine sulfate	100 MG	150	II
February 20, 2016	Morphine sulfate	200 MG	360	II
February 22, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	90	II
March 16, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	90	II
March 17, 2016	Fentanyl transdermal system	50 MCG/1 HR	10	II
March 17, 2016	Morphine sulfate	200 MG	360	II
March 28, 2016	Morphine sulfate	100 MG	150	II
April 20, 2016	Fentanyl transdermal system	50 MCG/1 HR	10	II
April 20, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	120	II
April 20, 2016	Morphine sulfate	100 MG	150	II
April 26, 2016	Morphine sulfate	200 MG	360	II
May 19, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	100	II
May 20, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
May 20, 2016	Morphine sulfate	100 MG	120	II
May 26, 2016	Morphine sulfate	200 MG	360	II
June 21, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
June 21, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	100	II
June 21, 2016	Morphine sulfate	100 MG	120	II
June 27, 2016	Morphine sulfate	200 MG	360	II
July 18, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
July 18, 2016	Morphine sulfate	200 MG	360	II
July 18, 2016	Morphine sulfate	100 MG	120	II
July 19, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	100	II
August 17, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
August 17, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	90	II
August 20, 2016	Morphine sulfate	100 MG	120	II
August 20, 2016	Morphine sulfate	200 MG	360	II
September 19, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
September 19, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	90	II
September 21, 2016	Morphine sulfate	200 MG	360	II
September 21, 2016	Morphine sulfate	100 MG	90	II
September 27, 2016	Morphine sulfate	30 MG	90	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
October 21, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
October 21, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	85	II
October 21, 2016	Morphine sulfate	200 MG	360	II
October 21, 2016	Morphine sulfate	100 MG	90	II
October 27, 2016	Morphine sulfate	30 MG	90	II
November 19, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
November 19, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	85	II
November 19, 2016	Morphine sulfate	30 MG	90	II
November 19, 2016	Morphine sulfate	100 MG	90	II
November 19, 2016	Morphine sulfate	200 MG	360	II
December 19, 2016	Fentanyl transdermal system	75 MCG/1 HR	10	II
December 19, 2016	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	75	II
December 19, 2016	Morphine sulfate	30 MG	90	II
December 19, 2016	Morphine sulfate	200 MG	360	II
December 19, 2016	Morphine sulfate	100 MG	90	II
January 19, 2017	Fentanyl transdermal system	75 MCG/1 HR	10	II
January 19, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	75	II
January 19, 2017	Morphine sulfate	100 MG	90	II
January 19, 2017	Morphine sulfate	200 MG	360	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
January 19, 2017	Morphine sulfate	30 MG	90	II
February 18, 2017	Fentanyl transdermal system	75 MCG/1 HR	10	II
February 18, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	70	II
February 18, 2017	Morphine sulfate	100 MG	90	II
February 18, 2017	Morphine sulfate	200 MG	360	II
February 18, 2017	Morphine sulfate	30 MG	90	II
February 20, 2017	Plo/Gabapentin/Ketamine/Clonidine/Lidocaine	120 G	7.2	III
March 20, 2017	Fentanyl transdermal system	75 MCG/1 HR	10	II
March 20, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	75	II
March 20, 2017	Morphine sulfate	30 MG	90	II
March 20, 2017	Morphine sulfate	100 MG	90	II
April 19, 2017	Morphine sulfate	200 MG	60	II
April 20, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
April 20, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	60	II
April 20, 2017	Morphine sulfate	100 MG	90	II
May 17, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
May 17, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	60	II
May 17, 2017	Morphine sulfate	100 MG	90	II
May 17, 2017	Morphine sulfate	200 MG	60	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
May 17, 2017	Morphine sulfate	30 MG	60	II
May 30, 2017	Plo/Gabapentin/Ketamine/Clonidine/Lidocaine	120 G	7.2	III
June 19, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
June 19, 2017	Morphine sulfate	200 MG	60	II
June 19, 2017	Morphine sulfate	30 MG	90	II
June 19, 2017	Morphine sulfate	100 MG	90	II
June 20, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	60	II
July 25, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
July 25, 2017	Morphine sulfate	30 MG	90	II
July 25, 2017	Morphine sulfate	200 MG	60	II
July 25, 2017	Morphine sulfate	100 MG	90	II
July 26, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	45	II
August 25, 2017	Morphine sulfate	200 MG	60	II
August 28, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
August 28, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	45	II
August 28, 2017	Morphine sulfate	30 MG	90	II
August 28, 2017	Morphine sulfate	100 MG	90	II
September 27, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
September 27, 2017	Plo/Gabapentin/Ketamine/Clonidone/Lidocaine	120 G	7.2	III

Date Filled	Drug Name	Dosage	Quantity	Schedule
September 27, 2017	Morphine sulfate	30 MG	60	II
September 27, 2017	Morphine sulfate	200 MG	60	II
September 27, 2017	Morphine sulfate	100 MG	90	II
September 28, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	45	II
September 30, 2017	Morphine sulfate	200 MG	60	II
October 27, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
October 27, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	40	II
October 27, 2017	Morphine sulfate	30 MG	60	II
October 27, 2017	Morphine sulfate	100 MG	90	II
November 1, 2017	Morphine sulfate	200 MG	60	II
November 1, 2017	Morphine sulfate	200 MG	60	II
November 25, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
November 25, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	30	II
November 25, 2017	Morphine sulfate	30 MG	60	II
November 28, 2017	Morphine sulfate	200 MG	60	II
November 28, 2017	Morphine sulfate	100 MG	90	II
November 28, 2017	Morphine sulfate	200 MG	60	II
December 27, 2017	Fentanyl transdermal system	50 MCG/1 HR	10	II
December 27, 2017	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	30	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
December 27, 2017	Morphine sulfate	200 MG	60	II
December 27, 2017	Morphine sulfate	15 MG	60	II
December 27, 2017	Morphine sulfate	200 MG	60	II
December 27, 2017	Morphine sulfate	100 MG	90	II
January 4, 2018	Plo/Gabapentin/Ketamine/Clonidone/Lidocaine	120 G	7.2	III
January 27, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
January 27, 2018	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	20	II
January 27, 2018	Morphine sulfate	200 MG	60	II
January 27, 2018	Morphine sulfate	200 MG	60	II
January 27, 2018	Morphine sulfate	15 MG	60	II
January 27, 2018	Morphine sulfate	100 MG	90	II
February 28, 2018	Morphine sulfate	15 MG	60	II
February 28, 2018	Morphine sulfate	100 MG	90	II
February 28, 2018	Morphine sulfate	200 MG	60	II
March 8, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
March 8, 2018	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	15	II
March 8, 2018	Morphine sulfate	200 MG	60	II
April 3, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
April 3, 2018	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	15	II
April 3, 2018	Morphine sulfate	200 MG	60	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
April 3, 2018	Morphine sulfate	15 MG	60	II
April 3, 2018	Morphine sulfate	200 MG	60	II
April 3, 2018	Morphine sulfate	100 MG	90	II
May 4, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
May 4, 2018	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	6	II
May 4, 2018	Morphine sulfate	15 MG	60	II
May 4, 2018	Morphine sulfate	200 MG	60	II
May 4, 2018	Morphine sulfate	200 MG	60	II
May 8, 2018	Morphine sulfate	100 MG	90	II
June 8, 2018	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	6	II
June 11, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
June 11, 2018	Morphine sulfate	200 MG	60	II
June 11, 2018	Morphine sulfate	15 MG	30	II
July 11, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
July 11, 2018	Hydrocodone bitartrate- acetaminophen	325 MG-10 MG	6	II
July 11, 2018	Morphine sulfate	15 MG	30	II
July 11, 2018	Morphine sulfate	200 MG	60	II
August 10, 2018	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	6	II
August 10, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II

Date Filled	Drug Name	Dosage	Quantity	Schedule
August 10, 2018	Morphine sulfate	200 MG	60	II
September 10, 2018	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	6	II
September 10, 2018	Fentanyl transdermal system	50 MCG/1 HR	10	II
September 10, 2018	Morphine sulfate	200 MG	60	II
October 10, 2018	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	6	II
October 10, 2018	Fentanyl transdermal system	25 MCG/1 HR	10	II
October 10, 2018	Morphine sulfate	200 MG	60	II
November 8, 2018	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	6	II
November 8, 2018	Fentanyl transdermal system	25 MCG/1 HR	10	II
November 8, 2018	Morphine sulfate	200 MG	60	II
December 10, 2018	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	6	II
December 10, 2018	Fentanyl transdermal system	12 MCG/1 HR	10	II
December 10, 2018	Morphine sulfate	200 MG	60	II
January 8, 2019	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	6	II
January 9, 2019	Morphine sulfate	200 MG	60	II
February 8, 2019	Acetaminophen- hydrocodone bitartrate	325 MG-10 MG	5	II
February 8, 2019	Morphine sulfate	200 MG	60	II

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

A. Respondent prescribed excessive amounts of controlled substances to Patient E, including short-acting and long-acting opioids; and

B. Respondent failed to document a discussion or take any action related to a testing irregularity in urine toxicology screen of Patient E.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

72. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 24 through 71, above, which are hereby incorporated by reference and realleged as if fully set forth herein

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

73. Respondent's license is subject to disciplinary action under sections 2227, 2234, and 725, of the Code, in that he engaged in excessive prescribing of controlled substances and dangerous drugs to Patients A, B, C, D, and E, as more particularly alleged in paragraphs 24 through 71, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

74. 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, D, and E, as more particularly alleged in paragraphs 24 through 71, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

75. Respondent's license is subject to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 24 through 71, 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. G 38904, issued to Terrance James Foster, M.D.;

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

3. Ordering Terrance James Foster, 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: AUG 25 2020

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

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