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

In the Matter of the Accusation Against: Hari Om Goyal, M.D. Physician's and Surgeon's Certificate No. A 65439 Respondent.	Case No. 800-2016-021321

DECISION

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

This Decision shall become effective at 5:00 p.m. on September 24, 2021.

IT IS SO ORDERED August 25, 2021.

MEDICAL BOARD OF CALIFORNIA

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

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HARI OM GOYAL, M.D., Respondent

Case No. 800-2016-021321

OAH No. 2019060800

PROPOSED DECISION

Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on March 15 through 19, 2021, from Sacramento, California.

Ryan Yates, Deputy Attorney General, represented and appeared on behalf of William J. Prasifka (complainant) in his official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department).

Dominique Pollara, Attorney at Law, represented Hari Goyal, M.D. (respondent), who was present.

Evidence was received, the record closed, and the matter submitted for decision on March 19, 2021.

FACTUAL FINDINGS

1. On June 5, 1998, the Board issued petitioner Physician's and Surgeon's Certificate No. A 65439 (license). The license will expire on July 31, 2021, unless renewed or revoked.

Complaint

2. In March 2016, the Board received a patient complaint against respondent and Physician Assistant (PA) Anthony Kelly, whom respondent supervised. The complaint primarily alleged PA Kelly regularly prescribed controlled substances without making a proper evaluation or following other safeguards. The complaint did not include any allegations regarding respondent's prescribing practices, or his care and treatment of patients.

3. The Board conducted separate investigations for respondent and PA Kelly. As part of the investigation into respondent, a Board medical consultant reviewed respondent's Controlled Substances Utilization Review and Evaluation System (CURES) history, and identified five patients for further review. The Board then obtained respondent's medical records and pharmacy prescription profiles for those five patients. Respondent was also interviewed.

4. The Board submitted the records for the five patients to Anthony Sacks, M.D., for expert review. Dr. Sacks found no departure from the standard of care with respect to one patient. Regarding the other four patients (Patients A through D), Dr. Sacks found simple departures from the standard of care in the area of medical recordkeeping. He further found a simple departure from the standard of care with respect to Patient C regarding respondent's failures to address an inconsistent drug

screen and to acknowledge or respond to a CURES report showing Patient C had been receiving a controlled substance from another provider. Lastly, Dr. Sacks found a simple departure from the standard of care regarding Patient D, noting an inadequate assessment of the patient's headache pain and migraine/headache management.

Respondent's Education, Experience, and Background

5. Respondent was born and raised in Punjab, India. He grew up in a large family with eight siblings. He attended medical school in Punjab, which included a one-year internship in general surgery, and graduated in 1974. After graduating, he practiced family medicine for approximately eight years, followed by 10 years in general surgery. In February 1994, he immigrated to the United States where he took and passed the United States Medical Licensing Examination. He then completed a one-year residency in neurology at Long Island Hospital in Buffalo, New York, followed by a three-year residency in internal medicine at Kingsbrook Jewish Medical Center in New York. Respondent has been board-certified in internal medicine since 1998.

6. In July 1998, respondent relocated to Yuba City, California, and worked for two years with another private physician. He then practiced at a federally-funded facility, Del Norte Clinic, for 10 years. In 2010, he purchased an internal medicine practice from Dr. Nguyen[1] in Yuba City. At that time, respondent was treating approximately 500 to 600 patients total, most of whom followed him from Del Norte Clinic. Respondent's daughter, Shalini Gupta, M.D., later joined respondent's practice.

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[1] Dr. Nguyen's first name was not provided in the record.

7. In addition to his private practice, respondent has also served as the medical director for three nursing homes in the Yuba City/Marysville area, including The Fountains owned by Adventist Health Rideout Hospital (Adventist Rideout). When respondent began as medical director for The Fountains in early 2016, the facility had a three-star rating. After one year, its rating climbed to four stars. By the time respondent resigned in the summer of 2019, its rating was close to five stars.

8. In August 2019, respondent began winding down his private practice, gave his office space to Adventist Rideout, and worked to find his patients new primary care providers. He officially stopped private practice in January 2020.

9. Since January 2020, respondent has worked as a hospitalist for Adventist Rideout, covering the emergency room and conducting hospital rounds as needed. He also serves as the hospital's chief of medicine and sits on its medical executive committee.

Accusation[2]

10. On May 30, 2019, a former Executive Officer for the Board made and served the instant Accusation in her official capacity. The Accusation seeks to discipline respondent's license based on allegations of repeated negligent acts, general unprofessional conduct, and improper recordkeeping concerning Patients A through D, all chronic pain patients, over a six-year period. Respondent timely filed a Notice of Defense. This hearing followed.

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[2] At hearing, complainant amended the Accusation on the record to strike Paragraph 25 in its entirety.

PATIENT A

11. Patient A is a 54-year-old female suffering from chronic low back pain, anxiety, cervical disc disease, obesity, hypertension, and peptic ulcer. Respondent began treating Patient A in the mid-2000s while at the Del Norte Clinic; she followed respondent to his new practice in 2010. The Board reviewed respondent's medical records for Patient A for the period of December 29, 2010, through August 24, 2018. During this time, respondent saw Patient A on a monthly basis, for a total of 94 visits. Respondent routinely prescribed opioids to Patient A, including oxycodone,[3] Norco,[4]and lorazepam.[5]

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[3] Oxycodone is an opioid analgesic used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. Common brand names for oxycodone are OxyContin, Roxicodone, and Oxecta.

[4] Norco is the brand name for hydrocodone bitartrate with acetaminophen, an opioid analgesic used to treat moderate to moderately severe pain. It was previously a Schedule III controlled substance. On October 6, 2014, it was reclassified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug under Business and Professions Code section 4022.

[5] Lorazepam is the generic name for Ativan, a benzodiazepine used to treat severe anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug under Business and Professions Code section 4022.

12. Patient A's chart during the review period showed respondent made periodic increases in narcotic dosages without documenting the reason for the increase. On April 9, 2012, the oxycodone dosage was increased from 120 milligram (mg) per day to 180 mg per day; the chart did not include an explanation for the increase. Rather, under "Chief Complaint," the chart listed "pain is controlled," a note which respondent had copied from prior visits. On September 6, 2012, the number of Norco tablets increased from 60 per month to 90 per month; however, the chart did not reflect a change in the daily dosage and indicated the patient's "neck and back pain [were] better."

13. On September 6, 2012, respondent saw Patient A for a routine monthly visit. The "Current Medication" and "Care Plan" portions of the patient chart for this visit listed, in pertinent part:

> Current Medications: . . . Lorazepam 1mg Tab, 1 tablet by mouth TID; Qty 90; Refills 0. Norco 5 mg-325 mg Tab; 1 tablet by mouth BID; Qty 60; Refills 0. Oxycodone 30 mg Tab; 2 tablet by mouth BID; Qty 60; Refills 0.[6]
>
> Care Plan: . . . I will continue oxycodone 30 mg 2 [by mouth] Tid #180 given. I will added [*sic*] NORCO 5/325 mg [by mouth] bid for breakthrough pain #90 for a month. With [*sic*] pain control she can do AODL no side effects of any meds seen no aberrant behavior.

[6] TID stands for three times per day; BID stands for twice daily.

Additionally, the CURES report for Patient A reflects that, on September 6, 2012, respondent prescribed oxycodone 30 mg (180 quantity), Norco 5 mg/325 mg (90 quantity), and lorazepam 1 mg (90 quantity).

14. The patient charts for subsequent monthly visits from January 28, 2013, through October 22, 2013, contain the same notations under "Current Medications" and "Care Plan" However, in the October 22, 2013 chart note, the "Care Plan" also states: "PATIENT IS ADVISED TO CUT DOWN ON SUGARS AND FATTY FOOD AND START DOING EXERCISE." (Capitalization in original.)

PATIENT B

15. Patient B is a 68-year-old man with degenerative arthritis in the cervical and lumbar spine, hips, knees, and shoulders. He is paralyzed in his left arm, and suffers from severe pain, anxiety, and vascular necrosis of the hips.[7] Patient B has had three back surgeries, bilateral hip replacements, arthroscopic knee surgery, and two left shoulder replacements. Respondent began treating Patient B at the Del Norte Clinic in 2000. Patient B eventually followed respondent to his private practice. Respondent continued Patient B's regiment of narcotics and pain medication, which began with a prior provider, including OxyContin, clonazepam, diazepam, and Norco.

16. The Board reviewed respondent's medical records for Patient B for the period of December 2, 2011, through September 2018. During this time, respondent saw Patient B on a monthly basis, for a total of 88 visits.

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[7] Death of bone tissue caused by loss of blood supply.

17. On December 2, 2011, respondent saw Patient B for a routine monthly visit. The "Current Medication" and "Care Plan" portions of the patient chart listed, in pertinent part:

> Current Medications: . . . Oxycontin 80 mg [by mouth] tid. Norco 10/325 mg [by mouth] 6 h. Diazepam 10 mg [by mouth] tid. [¶] . . . [¶]
>
> Care Plan: Refill on oxycontin 80 mg q tid #90 given and diazepam 10 mg po q tid #90. Pain is well controlled. Given option for refferal [*sic*] to pain clinic[.] patient will think it over. Patient dont [*sic*] want to go to pain clinic. Refill on norco will be refilled. For acute pain patient does not want any injection. He is told to apply heat pad. Refuses to go to psychiatrist. Zoloft is helping depression. I will decrease diazepam to 5 mg po q tid and monitor closely his symptoms. [¶] . . . [¶]

18. The patient chart did not include a reason for decreasing the diazepam. The patient charts for monthly visits on December 30, 2011, and January 27, 2012, included a "Care Plan" identical to the one above, inclusive of spelling and grammar mistakes, and repeated the "Current Medications" with no change to the diazepam amount. The patient chart for February 27, 2012, under "Current Medications," correctly lists "diazepam 5 mg Tab; 1 tablet by mouth TID; Qty: 90; Refills: 0."[8] The

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[8] In his report, Dr. Sacks incorrectly stated that this language was not corrected in the patient record until January 18, 2013.

"Care Plan" in patient charts for subsequent monthly visits through November 19, 2014, repeat the verbiage "refuses to go to psychiatrist" and "I will decrease diazepam to 5 mg po q tid and monitor closely his symptoms." The patient chart for December 19, 2014, repeats the verbiage "refuses to go to psychiatrist," but changes the diazepam reference to, "I will continue diazepam to 5 mg po q tid and monitor closely his symptoms."

19. On January 19, 2015, respondent saw Patient B for a routine monthly visit. The patient chart, under "Care Plan," repeats the "refuses to go to psychiatrist" language, but makes no reference to diazepam; rather, it states "He is told to follow up with Ortho for possible TKA both side.pad [*sic*]." The patient charts for subsequent monthly visits repeat the following verbiage under "Care Plan":

> Pain is well-controlled. Again Given [*sic*] option for refferal [*sic*] to pain clinic patient will think over [*sic*] . . . Patient dont [*sic*] want to go to pain clinic. . . . He is told to follow up with Ortho for possible TKA both side.pad [*sic*]. Refuses to go to psychiatrist . . . ."

20. On September 7, 2018, the patient chart listed in pertinent part:

> <u>Chief Complaint/History of Present Illness</u>: . . . Patients [*sic*] pain scale is a 8/10 and level of interference with daily activities is a 8/10. . . . Has chronic pain in back knee hip shoulder. Pain scale 5/10 with medication, 9/10 without medication. . . . Patient is compliant and responsible with medication.
>
> [¶] . . . [¶]

Assessment: Pain is worse patient has severe DJA. History of avascular necrosis of both hip and both shoulders. Back pain. Pain DUE TO LUMBAR DISC DISEASE. [*sic*] is well controlled with the present pain meds 3/10 with meds 10/10 without meds. Pain is chronic and now it has increased. . . . Doing OK. Pain is controlled. . . . Patient did not take pain meds for three days no withdrawal.

[¶] . . . [¶]

Care Plan: . . . Pain is well controlled. Again Given option for refferal [*sic*] to pain clinic[.] patient will think it over. Patient dont [*sic*] want to go to pain clinic. Refill on norco will be refilled. . . . He is told to follow up with Ortho for possible TKA both side.pad [*sic*].

. . . Discontinue oxycontin and Norco. I will refer to Dr. Saggu for his shoulder pain. I will start NSAID diclofenac 75mg po bid and tramadol 50 mg po q tid for severe pain. Patient is also told to start herbal treatment like yumeric [*sic*] [and] can go to methadone clinic for detox . . .

PATIENT C

21. Patient C is a 71-year-old female suffering from low back pain resulting from a 2001 industrial injury. She has had two spinal surgeries as well as epidural

injections. Over the years, she has also been prescribed Duragesic[9] patches (100 mcg[10]), Soma, and other oral narcotics by both her former workers' compensation physician and respondent. Additionally, from September 2011 to March 2016, Patient C received meperidine 50 mg from her podiatrist, Dennis Trenner, D.P.M.

22. Respondent began treating Patient C at Del Norte Clinic in March 2007, and she followed him when he began his own practice in 2010. The Board reviewed respondent's medical records for Patient C for the period of June 7, 2010, through September 24, 2018. During this time, respondent saw Patient C on a monthly basis, for a total of 98 visits.

23. Patient C's patient charts for the review period contained multiple discrepancies and errors. On December 23, 2010, the patient chart erroneously describes the patient's pain level as "with meds 9/10 wtht [*sic*] meds 3-4/10." The error is repeated in the patient charts for January 20, 2011, and February 18, 2011.[11] On March 18, 2011, the patient chart correctly describes the patient's pain level as "without meds 10/10 with meds 3/10."

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[9] Duragesic is the brand name for fentanyl, a synthetic opioid analgesic used for long-term, chronic pain. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Micrograms.

[11] In the February 18, 2011 patient chart, the pain is noted as "with meds 9/10 wtht [*sic*] meds 4-5/10."

24. On June 18, 2012, respondent saw Patient C for a routine monthly visit. The "Current Medication" and "Care Plan" portions of the patient chart for this visit listed, in pertinent part:

> Current Medications: . . . Norco 10 mg-325 mg Tab; 1 tablet by mouth [every six hours]; Qty: 240; Refills 0. . . .
>
> Care Plan: . . . Norco 10/325 mg 2 [by mouth every six hours]. #180 PATIENT GIVEN #180 WITH 2 REFILLS. . . .

The same verbiage was repeated in the patient charts for the next eight monthly visits. The "Current Medications" section in Patient C's chart noted she was receiving 240 tablets of Norco from 2012 through May 20, 2016.

25. On March 18, 2013, respondent saw Patient C for a routine monthly visit. The "Current Medication" and "Care Plan" portions of the patient chart for this visit listed, in pertinent part:

> Current Medications: . . . Norco 10 mg-325 mg Tab; 1 tablet by mouth [every six hours]; Qty: 240; Refills 0. . . .
>
> Care Plan: . . . Norco 10/325 mg 2 [by mouth every six hours]. dECREASED [*sic*] TO #120 FOR A MONTH PATIENT GIVEN #120 WITH 2 REFILLS . . . .

The same verbiage was repeated in the patient charts for the next 16 monthly visits. The "Current Medications" section in Patient C's chart noted she was receiving 240 tablets of Norco from 2012 through May 20, 2016.

26. On October 31, 2014, respondent saw Patient C for a routine monthly visit. The "Current Medication" and "Care Plan" portions of the patient chart for this visit listed, in pertinent part:

> Current Medications: . . . Norco 10 mg-325 mg Tab; 1 tablet by mouth [every six hours]; Qty: 240; Refills 0. . . .
>
> Care Plan: . . . Norco 10/325 mg 2 [by mouth every six hours]. dECREASED [*sic*] TO #90 FOR A MONTH PATIENT GIVEN #120 WITH 2 REFILLS. . . .

The same verbiage was repeated in the patient charts for the next three monthly visits. The "Current Medications" section in Patient C's chart noted she was receiving 240 tablets of Norco from 2012 through May 20, 2016.

27. On February 4, 2015, respondent saw Patient C for a routine monthly visit. The "Current Medication" and "Care Plan" portions of the patient chart for this visit listed, in pertinent part:

> Current Medications: . . . Norco 10 mg-325 mg Tab; 1 tablet by mouth [every six hours]; Qty: 240; Refills 0. . . .
>
> Care Plan: . . . Norco 10/325 mg 1 [by mouth every six hours]. #120 Refill on these meds given. . . .

28. On December 16, 2015, respondent saw Patient C for a routine monthly visit. Under "Care Plan," respondent wrote: "I will decrease Norco 10/325 mg 1 [by mouth every six hours]. #90 Refill on these meds given." The "Current Medications" section still listed the quantity amount as 240. The same verbiage was repeated in the patient charts for the next three monthly visits.

29. On May 22, 2017, respondent decreased the dosage of the Duragesic patch to 75 mcg. On June 23, 2017, he noted he was decreasing the quantity of Norco to 90 tablets. He did not document the reason for these changes anywhere in the patient note.

30. On July 25, 2017, respondent saw Patient C for a routine monthly visit. Under "Care Plan," he noted he was decreasing the Duragesic patch dose to 50 mcg. He also documented the following:

> Chief Complaint: Patient is here today for a 1 month follow up. Patients [*sic*] pain scale is a 4/10 and level of interference with daily activities is a 2/10. . . .
>
> History of Present Illness: . . . Has chronic pain in back. Pain scale 4/10 with medication, 10/10 without medication. Needs rescue medication times a day [*sic*] for adequate pain control. . . ."
>
> [¶] . . . [¶]
>
> Assessment: Has ipain [*sic*] controlled with meds. Pain with meds 5/10 and without meds 10/10.

Respondent electronically signed the note on August 23, 2017, one month later.

31. On February 26, 2018, respondent saw Patient C for a routine monthly visit. Respondent noted the following in the patient note, in relevant part:

> Care Plan: Discontinue duragesic patc [*sic*] and start OxyContin 20 mg [by mouth] bid and Norco 10/325 mg 1 [by mouth every six hours] #90 Refill on these meds given.

Respondent repeated the language "Discontinue duragesic patc [*sic*] and start OxyContin 20 mg" in the patient notes for the next five monthly visits, notwithstanding the Duragesic patch was discontinued in February 2018.

Urine Drug Screen

32. On September 17, 2012, Patient C signed a pain management agreement. In doing so, she agreed to inform respondent of all medications she is taking, not use any illicit substances (including marijuana), and participate in random urine drug trusting. The agreement also stated: "The presence of a nonprescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship."

33. On April 15, 2016, respondent had Patient C submit to a random urine drug screen. The results were positive for fentanyl and soma, which was consistent with the prescribed opioid medications respondent knew her to be taking at that time. As was his custom and practice, respondent reviewed the test results, then signed the bottom of the page to acknowledge he had reviewed them.

34. On September 21, 2016, Patient C submitted to a random urine drug screen. The results were positive for barbiturates and marijuana, but negative for opiates. Respondent did not sign the bottom of the page to acknowledge he had reviewed the results. On the next monthly visit, October 24, 2016, respondent incorrectly charted that the results had been positive for opiates.

35. On June 23, 2017, Patient C signed another pain management agreement, similar to the 2012 agreement. On September 24, 2018, Patient C submitted to a random urine drug screen. The results were positive for opiate and marijuana. After reviewing the test results, respondent discontinued Patient C's opioid medication and documented the following in her file: "I will not give opiates as per office policy and pain contract. Patient agrees. Option for Nsaids[12] [*sic*] offered – patient declines. . . ."

Meperidine Prescription

36. From September 2011 through May 2016, Patient C was prescribed Meperidine HCL 50 mg (50 tablets) by Dennis Trenner, D.P.M. The CURES report for this time period shows the prescription was dispensed on a monthly basis.

37. On December 16, 2015, respondent reviewed Patient C's CURES report and learned for the first time of the Meperidine prescription by Dr. Trenner. He signed the bottom of the CURES report to acknowledge his review. He then documented the following under "ICD-10 Assessments" in Patient C's chart: "Pain is controlled. She was getting meperidine 50 mg po q bid from her podiatrist as she had 5 foot surgery. I discussed with her podiatrist he will wean her off meperidine." Respondent subsequently consulted with Dr. Trenner, and Patient C stopped taking Meperidine by June 2016.

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[12] Non-steroidal anti-inflammatory drugs.

PATIENT D

38. Patient D is a 58-year-old female. On January 27, 1999, she suffered a work-related injury resulting in lumbar disk disease and paresthesia, and ultimately developing into complex regional pain syndrome. Additionally, she suffered from several other ailments including daily migraines, hyperlipidemia, osteoarthritis, hyperthyroidism, insomnia, depression, and anxiety. Patient D began treating with Dr. Nguyen following her work injury. Respondent assumed her treatment and care when he bought Dr. Nguyen's practice in 2010.

39. At all relevant times, respondent served as Patient D's primary care physician as well as her workers' compensation physician for her back injury. The Board reviewed respondent's medical records for Patient D for the period of October 8, 2010, through August 31, 2018. During this time, respondent saw Patient D on a monthly basis for back-to-back visits, the first for the workers' compensation case, the second for all other matters. He also maintained two separate medical charts for her. The workers' compensation chart did not list Patient D's medications that were not related to her work injury; the primary care file did not include medications she took solely related to her workers' compensation matter.

40. A CURES report showed that, over the course of respondent's treatment, Patient D was prescribed various medications, by respondent and other providers, including: Hydrocodone/acetaminophen 10/325 mg, Soma 325 mg, and Lyrica (for workers' compensation). Additionally, she was prescribed diazepam 10 mg, gabapentin, and butorphanol nasal spray 10 mg for conditions not related to the workers' compensation matter. In 2011, respondent also referred Patient D to a pain management specialist and a neurologist, who prescribed a pain pump and other treatments.

41. On March 25, 2015, respondent documented in the workers' compensation chart that Patient D was taking carisoprodol 350 mg under "current medications." However, he did not include an explanation for prescribing this medication. On June 12, 2015, respondent removed carisoprodol from "current medications" in the workers' compensation chart, and listed it in the primary care chart instead. He did not include an explanation for the change in either chart.

Migraine Treatment

42. Patient D. testified at hearing and explained her history of migraines and migraine treatment. A narrowing of the nerve in her brain which feeds into the optic nerve was not repaired immediately after birth. This resulted in migraines from as early as the age of four. Over the decades, Patient D and her treating providers have tried numerous treatment regimens, none of which proved successful long-term. These included: Tylenol with codeine; Imitrex injections; Imitrex by mouth; Maxalt; Sominex; Topamax; and analgesics like Vicodin and other pain medications. Patient D also suffered gastric side effects from these treatments. In 2004, a 2.5-inch hole was discovered in the left side of her stomach as well as seven holes in her upper esophagus. She was required to undergo surgery to remove 18 inches of her intestine to patch her esophagus. She remained hospitalized for two weeks thereafter.

43. Ultimately, her neurologist prescribed butorphanol nasal spray which proved effective in "breaking" the migraine. She explained that by spraying the medication in her nasal cavity, it was absorbed quickly and the result was "almost instantaneous." Prior to seeing respondent, Patient D was receiving up to five 2.5 ml bottles each month. Initially, her insurance declined to pay for the medication and it was too expensive for Patient D to afford. Eventually, her insurance agreed to pay for the medication.

Documentation of Migraine Treatment

44. On November 2, 2011,[13] respondent saw Patient D for a routine follow-up visit. In the medical chart, he entered butorphanol nasal spray under "Current Medications" for the first time. He did not include an explanation as to why the medication was prescribed or who had prescribed it initially. Subsequent entries in the medical chart did not reference a migraine workup or neurology consultation, contained minimal history regarding the patient's migraines including what triggered them, their quality and description, and how they affected Patient D. Rather, respondent noted that Patient D. was there for a "migraine follow up" or that her "headaches [were] controlled with medication."

45. From January 2013 to August 2018, Patient D's medical chart listed "Patient plan has declined butorphanol for headaches as patient has been taking this meds for 19 years with good relief." The CURES report showed she was prescribed the medication on a monthly basis during this time period.

Respondent's Testimony

46. Respondent is 71 years old. He retired from medicine in March or April 2, 2020, but returned to serve as a hospitalist at Adventist Rideout in May 2020 to assist with the COVID-19 surge.

47. Prior to purchasing his practice, respondent had never used an electronic medical record (EMR) software system to chart his patient notes. Instead, it was his

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[13] Dr. Sacks' report incorrectly identifies January 19, 2012 as the first time butorphanol is listed in Patient D's medical chart.

custom and practice to either dictate or handwrite his patient charts. When he bought the practice in 2010, the EMR system, Office Ally, was already in place so respondent began to use it. Respondent never received any formal training on how to use Office Ally. He spoke a few times to Office Ally representatives by telephone to request assistance with the software.

48. Respondent struggled using Office Ally. The program contained some templates for different medical conditions. However, it did not have voice recognition for dictation, so respondent was required to enter his notes manually. When a patient returned for a repeated visit, respondent often cut and pasted portions (e.g., history of present illness, assessment, and treatment plan) of the previous visit note and updated it as needed.

49. Respondent saw an average of 20 to 25 patients per day, and saw his chronic pain patients on a monthly basis. It was office policy that patients brought in their prescription medicine bottles with them to each visit. Respondent then reviewed their current medications with them. The policy was posted on the wall in the waiting room and patients were also notified in advance.

50. Respondent conceded his medical recordkeeping while in private practice was lacking and included internal inconsistencies. Since leaving private practice and becoming a hospitalist, he has taken a medical recordkeeping course to address any deficiencies. Moreover, Adventist Rideout uses a different EMR system, CERNER, on which respondent received several hours of training. The hospital also provides technical support which respondent can access to resolve any issues he is having with CERNER or a particular EMR entry, a resource that was not available to him with Office Ally.

51. Respondent also conceded he failed to review the results of the September 21, 2016 urine drug screen for Patient C, and entered inaccurate results in her medical chart. He explained this was an oversight, and that he thought he was entering the results from the April 15, 2016 test.

Evolving Treatment of Chronic Pain with Opioids

52. The legislative policies regarding the management of chronic, non-cancer pain, has been evolving in California for many years. As recently as 2006, the focus was not on the risk of opioid death, but on patients receiving appropriate pain relief. This focus was aptly summarized in a 2006 legislative declaration to Assembly Bill No. 2918:

> (a) The investigation and prosecution of pain management cases in California have evolved over the past 15 years.
>
> (b) The Pain Patients' Bill of Rights and the Intractable Pain Treatment Act were created to ensure patients received adequate pain medication and to protect a physician and surgeon from being disciplined solely because of the amounts of controlled substances he or she prescribed or administered.
>
> (c) California recognizes that prescription medication, including controlled substances, can play a critical role in the treatment of pain, and, in and of itself, is an insufficient basis to determine if a physician and surgeon has violated the standard of care in his or her treatment of pain management patients.

(d) Under-treatment of pain, including the use of opioids, is a continuing problem in the State of California, and some terms of the Intractable Pain Treatment Act are outdated and confusing.

(e) In recognition of the Medical Board of California's consumer protection mandates, and in an attempt to provide better treatment of pain patients, as well as protect the public through the appropriate investigation and prosecution of those who violate the standard of care when treating pain patients, the Legislature recognizes that it is time to reflect upon the current state of pain management to aid both those who treat pain patients, as well as those who investigate and prosecute physicians and surgeons.

(Stats. 2006, ch. 350, § 1.)

53. Similarly evolving are the Board's policies regarding the treatment of chronic pain patients with controlled substances. In 1994, the Board formally adopted its first policy statement on Prescribing Controlled Substances for Pain. In 2007, the Board issued updated Guidelines for Prescribing Controlled Substances for Pain.

54. In its November 1, 2011 Morbidity and Mortality Weekly Report, the Centers for Disease Control and Prevention (CDC) reported its finding that between 1999 and 2008, overdose deaths involving opioid analgesics had increased to the point of exceeding deaths involving the use of heroin and cocaine, and was approaching the number of deaths from automobile accidents. The report linked the

increase in overdose deaths to wide variations in opioid prescribing, and declared prescription drug abuse to be a nationwide epidemic.

55. The November 2011 pronouncement by the CDC led the Board to issue new Guidelines for Prescribing Controlled Substances for Pain in November 2014 (2014 Guidelines). In the Preamble to these guidelines, the Board recognized that:

> Drug overdose is now the leading cause of accidental death, exceeding deaths caused by automobile accidents. A majority of the overdose deaths involved prescription drugs. The diversion of opioid medications to non-medical uses has also contributed to the increased number of deaths, although the problem is not limited to the aberrant, drug-seeking patient. Injuries occurring among the general patient population, with some groups at high risk, (e.g., those with depression). Consequently, the Board called for revision of the [2007] guidelines in which it provided additional direction to physicians who prescribe controlled substances for pain.

56. The Board's intent in adopting the 2014 Guidelines was to assist physicians in improving the outcomes of patient care and to prevent overdose death caused by opioid use in the treatment of patients with chronic pain:

> These guidelines underscore the extraordinary complexity in treating pain and how long-term opioid therapy should only be conducted in practice settings where careful evaluation, regular follow-up, and close supervision are

ensured. Since opioids are only one of many options to mitigate pain, and because prescribing opioids carries a substantial level of risk, these guidelines offer several non-opioid treatment alternatives.

57. The Board has not declared the 2014 Guidelines as mandating the standard of care, recognizing that deviation may be appropriate based on the unique needs of individual patients and based on the type of pain being treated. Nor did the Board endorse any one treatment option over another, encouraging physicians to "undertake independent research on this continually evolving subject matter." Rather, the Board cautioned physicians to document the rationale for each prescribing decision so that when records are reviewed following a quality of care complaint the "totality of the circumstances" can be considered.

58. The Department of Justice (DOJ) maintains CURES. The system was first created in 1996. In its earliest form, users had to request information by fax, mail, or telephone, and wait a few days in order to receive the information. In 2009, the DOJ created the Prescription Drug Monitoring Program (PDMP), an on-line web portal that allowed reregistered users to obtain from CURES real time patient history information regarding controlled substances. In 2013, the DOJ reported that only eight percent of licensed providers were registrants in the system.

59. In July 2015, CURES 2.0 was launched with enhancements for user interface, and faster and more reliable service. Licensed practitioners eligible to prescribe Schedule II, III and IV controlled substances may obtain the electronic history of controlled substances dispensed to an individual under his or her care. As of July 1, 2016, all California prescribers are required to register with CURES. Effective October 2, 2018, a prescriber must query the CURES database and run a patient activity report

when prescribing a scheduled drug within 24 hours of the first visit, and every four months thereafter. (Health & Saf. Code, § 11165.4.)

Expert Testimony

COMPLAINANT'S EXPERT – ANTHONY SACKS, M.D.

Background and Experience

60. Dr. Sacks has practiced family medicine in California and been board-certified in family medicine for over 39 years. He obtained his medical degree from the University of Cape Town Medical School in South Africa in 1977. He thereafter completed a one-year internship at Hadassah University Hospital in Israel, followed by a three-year family practice residency at the University of Cincinnati Medical School. Since 1982, Dr. Sacks has practiced family medicine with the Sharp Rees-Stealy Medical Group, where he has served as the Associate Medical Director (1987-1993), Department Chair (2013-2015), as well as on the executive committee and board of directors (1993-2011). From 2000 to 2014, Dr. Sacks prescribed controlled substances to less than six chronic pain patients a year.

61. From 1983 to 1995, Dr. Sacks was a clinical instructor at the University of California, San Diego (UCSD) Department of Family and Preventative Medicine; since 1995, he has served as an Associate Clinical Professor at the same. Dr. Sacks has also previously served as the Chief of Family Practice (1999-2002) and on the Family Practice Supervisory Committee (1996-2002) at Sharp Memorial Hospital.

62. Dr. Sacks was approved as a Board expert reviewer in 2016. This is the first case he has reviewed for the Board, and his first time testifying at an administrative hearing as an expert for the Board.

Expert Opinion

63. At the Board's request, Dr. Sacks reviewed respondent's care and treatment of Patient A through D, and opined on whether respondent met or departed from the standard of care. In doing so, he reviewed the following materials: medical records and prescription histories for Patients A through D; CURES reports for Patients A through D; audio interviews of Patients A through D; and the audio and written transcript of respondent's Board interview. Dr. Sacks prepared a report of his findings, dated May 1, 2019, and also testified at hearing. At hearing, he defined the standard of care generally as "the level of care, skill, and knowledge a reasonably prudent physician would provide under the same circumstances at the time in question."

A. Medical Recordkeeping

64. Dr. Sacks defined the standard of care for medical recordkeeping as requiring physicians to maintain complete and accurate documentation of the visit including patient, history, physical examination, current medication, assessment, care plan, and rationale for any medication changes. While mistakes happen and not every error in a medical record constitutes a departure from the standard of care, there is such a departure when the physician fails to correct and repeats errors in the record month after month.

65. Dr. Sacks reviewed the medical records for Patients A through C for sufficiency. He opined that respondent had committed simple departures from the standard of care as to each patient due to the inconsistencies and repeated mistakes without correction in the record. He further opined that the records were incomplete insofar as they did not provide sufficient explanation or documentation of treatment or medication changes.

B. Patient C

66. Regarding the prescribing of narcotics, Dr. Sacks noted the standard of care requires a physician to frequently review the CURES report, order regular drug testing, and consider other modalities to treat pain. Dr. Sacks opined respondent made a simple departure from the standard of care because he failed to acknowledge or respond to the CURES report showing Patient C was receiving Meperidine from another provider. However, at hearing, Dr. Sacks conceded he had concluded erroneously that respondent had not consulted Patient C's CURES report and had failed to respond to the fact she was taking Meperidine from another provider. He acknowledged that respondent consulted the CURES report in December 2015, he followed up with Dr. Trenner, and Patient C had weaned off Meperidine by June 2016, all of which met the standard of care.

67. Dr. Sacks further opined respondent made a simple departure from the standard of care when he failed to address an "initial" urine drug screen that was negative for opiates and positive for marijuana. On cross-examination, Dr. Sacks admitted his error believing the September 2016 drug screen was an initial one and that he was unaware of earlier toxicology screens that were positive for opiates consistent with Patient C's current medications. Nonetheless, he opined respondent should have (1) addressed the negative opiates result from the September 2016 drug screen to ensure there was no diversion, and (2) directed Patient C to submit to another test.

C. Patient D

68. Regarding record-keeping, Dr. Sacks defined the standard of care as requiring "complete and accurate documentation of visit to include history, exam,

current medication, assessment and plan of care, including rationale for medication changes." Based on his record review for Patient D, Dr. Sacks opined respondent's failure to document a complete list of her medications in both the workers' compensation chart and the primary care chart constituted a simple departure from the standard of care.

69. Dr. Sacks opined the standard of care for management of frequent headaches should include consideration of preventative medications, non-narcotic headache medications, additional modalities, and not solely narcotic medication. If still not controlled, the patient should be referred to a specialist. He asserted that many chronic headaches are the result of medication overuse or caffeine withdrawal. Dr. Sacks concluded that respondent had committed a simple departure from the standard of care based on his failure to adequately assess Patient D's migraines and his prolonged use of butorphanol nasal spray without "sufficient use of preventative therapies or specialist consultation for poorly controlled chronic headaches."

RESPONDENT'S EXPERT – WILLIAM BROSE, M.D.

Background and Experience

70. Dr. Brose is licensed to practice medicine in California, and is board-certified in anesthesiology, with added qualification in pain management and pain medicine. He attended medical school at Kansas University School of Medicine. He completed an internship in anesthesiology at Santa Clara Valley Medical Center, and a residency in anesthesiology at Stanford University School of Medicine (Stanford). Thereafter, he completed a one-year fellowship in obstetric anesthesia at Stanford, and the following year was named chief resident in anesthesia. From 1988 to 1989, he

served as a Physician Specialist at Stanford, and also completed a clinical research fellowship in chronic pain management in Flinders Medical Centre in South Australia.

71. Dr. Brose has held a number of academic positions at Stanford University School of Medicine since 1989 including: Director of the Standard Pain Management Service (1989-1996); Associate Professor of Anesthesia (1989-1995); Associate Professor of Anesthesia (1995-1997); Adjunct Associate Professor of Anesthesia (1997-2011); and, Adjunct Clinical Professor of Anesthesia (2011-present). He has also held numerous clinical positions over the years: President of Alpha Omega Pain Medicine Associates, Inc. (1998-2018); Chief Executive Officer (CEO) of HELP, Holdings, Inc., and HELP Pain Medical Network (2010-2018); and, CEO of American Health Medical Group (2014-2018). He has authored numerous peer-reviewed articles, and has given numerous presentations to physicians on chronic pain and opioid treatment.

72. Additionally, Dr. Brose co-founded Digital Medical Systems in 1993, a software company which created one of the early EMR systems introduced to the market in the early 1990s. This program won the HIMSS[14] award for best innovative software in 1997. When he rejoined the Stanford faculty three years ago, he was asked to serve on the hospital's information systems committee, which reviews on a monthly basis all of the issues and concerns regarding its EMR system.

73. Finally, Dr. Brose has served as an expert witness in both civil and administrative proceedings, and was approved as an expert reviewer for the Board in 2020.

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[14] Healthcare Information and Management Systems Society.

74. At respondent's request, Dr. Brose reviewed his care and treatment of Patients C and D, and opined on whether respondent met the standard of care in light of the allegations in the Accusation Dr. Brose reviewed the Accusation, the relevant medical records and CURES reports, and Dr. Sacks' expert report. Dr. Brose prepared a written report, dated January 20, 2020, regarding the history of chronic pain treatment and evolution of the CURES reporting system, as well as the applicable standards of care, respondent's treatment and care of Patients C and D, and documentation thereof. Dr. Brose testified at hearing consistent with his report.

Electronic Medical Recordkeeping

75. Dr. Brose generally noted that the Board's 2010-2018 period which is the focus of the Accusation coincides with the introduction and evolution of EMR systems in medical practice. He explained the federal government created an incentive program in 2009 to encourage practitioners to adopt and incorporate EMR into their everyday practice. During early adoption, transition from paper-charting to electronic charting was difficult, and "errors and inconsistencies in data captured within the various domains of the [EMR]" were commonplace until corrected by quality assurance (QA) or quality improvement (QI) was achieved. Regarding respondent's implementation and use of Office Ally, Dr. Brose noted:

> Not surprisingly, the small size of [respondent's] practice and the limited resources compared to a large integrated delivery system lead to predictable delays in the achievement of optimal QA/QI as is seen with many early adopters. This reality creates a circumstance where the undesirable and incorrect internal inconsistencies seen within the [EMR] are actually considered to be within the

> standard of care as the problems associated with the adoption are shared by so many.

76. Dr. Brose further opined that "these inconsistencies do not necessarily affect the operability of the [EMR] for safe patient care." Moreover, regarding inconsistencies between medications listed under "Care Plan" and "Current Medications," Dr. Brose noted that "medical record reports that would be retrieved from the system on an ad hoc basis which have been reduced to paper are unable to convey the complex system integration" included in the "Current Medications" list versus the "Care Plan" narrative. Finally, he argued, "[t]o expect perfect performance from an [EMR] implementation and operation would be a naïve mistake," as such perfection is "beyond the planning and oversight of virtually all healthcare systems."

77. Dr. Brose acknowledged the discrepancies in respondent's electronic medical charts with the narrative from the "Care Plan" section of the medical record with the "Current Medications" section on the same dates. However, he described these errors as "internal" and as "targets for correction within the [EMR] process." He opined they do not represent "errors in medical decision making and deviations from the standard of care." Moreover, regarding duplication, Dr. Brose opined:

> The duplication of notes for repeated visits is seen in virtually every practice where such a [EMR] system is employed. Indeed, many of the promised time savings from such systems are reported to be derived from such duplication. The presence of duplicate identical or nearly identical entries does not invalidate those entries. In the setting of chronic pain, the expected documentation would be similar or identical reports at each visit.

[¶] . . . [¶]

> The advent of [EMR] reporting has contributed additionally by facilitating the copying and pasting of electronic notes within sequential records. The combination of heavily templated notes and the practice of cutting and pasting has led to the nearly complete duplication of the notes from month to month for many patients. . . . Those identical notes may still be accurate and reliable. If there are internal errors or inconsistencies in those notes the practice of cutting and pasting the narrative from visit to visit may compound those error [*sic*] unintentionally. . . . [E]ven duplicate encounters with intrinsic errors . . . are within the standard of care.

78. Finally, Dr. Brose noted that respondent's custom and practice of monthly visits "is actually a sign of heightened awareness and concern." Moreover, when monthly visits are the standard practice, "the change in the chronic condition from month to month is often small or immeasurable."

Patient C

79. Dr. Brose explained that urine drug testing is a risk monitoring tool used to confirm patient compliance with medication use and, secondarily, to identify illicit drug use. When the results of a urine drug screen are inconsistent with the patient's medication regimen, the standard of care would be to repeat the test at the earliest opportunity. Dr. Brose recognized respondent's failure to review Patient C's September 21, 2016 urine drug screen results and thus continued the regular prescribing of

controlled substances. However, he opined respondent's error did not rise to the level of a deviation from the standard of care as "errors and omissions in medical care are commonplace." Here, the overlapping of prior and subsequent testing which were consistent with Patient C's medication regimen "provides reassurance for the continued prescription of controlled substances." Moreover, respondent had been treating Patient C for years. The missed review of a single urine drug screen, "while representing an undesirable breach in process does not rise to the level of a deviation from the standard of care."

80. Regarding the Meperidine prescription from Dr. Trenner, Dr. Brose opined that, prior to 2018, the standard of care did not require a physician to regularly check a patient's CURES report. Thus, respondent's failure to check Patient C's CURES report prior to December 2015 did not constitute a departure from the standard of care.

Patient D

81. Dr. Brose opined the "practice of separating the documentation of work injury treatment from non-industrial treatment is common in medicine," and that respondent's maintenance of separate charts for workers' compensation and primary care was within the standard of care. He explained this is due to workers' compensation regulations that encourage avoiding documentation of any issues not related to the industrial injury.

82. Dr. Brose also disagreed that respondent's management of Patient D's migraines deviated from the standard of care. First, he noted, "[a] standard of documentation for the evaluation of pain, headache or other overlapping pain conditions has not been established by any authority in California or throughout the

United States." Second, he noted the Accusation and Dr. Sacks incorrectly assert that respondent failed to utilize consultants in the treatment of Patient D's migraines. On the contrary, Dr. Brose pointed out that respondent referred Patient D to a pain management specialist and neurologist, and that Patient D had been evaluated by numerous specialists prior to beginning treatment with respondent.

Character Evidence

JASBIR SINGH KANG, M.D.

83. Dr. Kang testified at hearing and submitted a support letter on respondent's behalf. Dr. Kang is the Medical Director of the Hospitalist Program at Rideout, and is board-certified in internal medicine. He moved to Yuba City in 1991 to serve its large Punjabi population and has practiced medicine there ever since. He has known respondent for over 20 years and has worked with him in different capacities during that time, including as hospitalists at Rideout.

84. Dr. Kang described respondent as a competent and hardworking physician who is well-liked by patients and peers and who "goes over and above helping his patients and [is] always willing to serve underserved patients." Dr. Kang refers to respondent as a "jumbo doctor" because he "always makes himself available if he can help." Dr. Kang asserted it would be a great loss to the medical community if respondent were no longer practicing, noting there is only one area hospital and the loss of even one doctor would have a "big impact."

WENCHIANG HAN, M.D.

85. Dr. Han also testified at hearing and submitted a support letter on respondent's behalf. Dr. Han is a board-certified neurologist who has been practicing

in the Yuba City/Marysville area for the past 20 years. He has a private practice and also works as a consultant for Rideout. Dr. Han has known respondent in a professional capacity for more than two decades, and respondent has referred patients to Dr. Han on "hundreds" of occasions.

86. Dr. Han is very familiar with respondent's patient care as they used to see each other several times a week at the hospital to meet with patients before the hospital switched to a hospitalist program. Dr. Han noted that respondent "has concise and accurate diagnostic acumen" and often takes patients with multiple medical issues which are difficult to handle. Dr. Han further commented that respondent's notes are often "brief, concise, and very short." However, he explained this is respondent's stylistic choice, noting some physicians provide a lot of detail, while others are brief.

MUHAMMAD ALGHANNAM, M.D.

87. Dr. Alghannam is a pain management specialist practicing in Yuba City since 2002. He testified at hearing and wrote a letter on respondent's behalf. He met respondent at Rideout upon first arriving in Yuba City. Since that time, they have had a few mutual patients and respondent has referred a number of patients to Dr. Alghannam over the years.

88. Dr. Alghannam has always found respondent's treatment plan to be "in line with what is medically necessary, appropriate and conservative in his approach." Further, respondent's prescribing practice for controlled substances has been consistent and reasonable based on the individual patient's condition and pain. Dr. Alghannam pointed out that respondent prescribes narcotics only after all other options have been exhausted, and refers patients to a pain management specialist as

appropriate. Respondent enjoys a "very good personal relationship" with his patients, spending extra time with them and being very thorough.

GAIL SCOTT

89. Mrs. Scott and her late husband were patients of respondent during the relevant time period. She described respondent as "rocking awesome," noting he was not just a physician but a "best friend you could talk to." When her husband was hospitalized and the doctors wanted to turn off his life support, respondent intervened and prevented it. Mr. Scott recovered and survived another 13 years. Overall, she asserted respondent is a phenomenal doctor who listened and ensured his patients received the care they needed.

ADDITIONAL SUPPORT LETTERS

90. Respondent also submitted several character letters from professional colleagues and patients. Overall, these letters praise respondent for his professionalism, courtesy, time spent with his patients, and quality of care.

Analysis

STANDARD OF CARE

91. It is well settled that "the standard of care for physicians is the reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in his or her own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under

the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Proof of this standard is ordinarily provided by another physician. (*Brown v. Colm, supra*, 11 Cal.3d at p. 643.)

EXPERT TESTIMONY

92. Differences between experts' opinions go to the weight of the evidence. (*In re Marriage of Duncan* (2001) 90 Cal.App.4th 617, 632.) In considering differing opinions, consideration must be given to the qualifications and persuasiveness of each witness, the reasons for each opinion, and the factual basis of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

93. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses, thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

MEDICAL RECORDKEEPING

94. It is undisputed that respondent's medical records for Patients A through D contained inconsistencies and inaccuracies, often within the same chart note. Respondent also conceded his recordkeeping during the relevant time period was sometimes subpar and could have been better.

95. Dr. Sacks asserts the perpetuation of these inaccuracies and inconsistencies throughout the record renders it difficult for another provider to review and understand the record. Therefore, he believes it constitutes a simple departure from the standard of care. However, at hearing, Dr. Sacks also conceded to making several errors in his report and direct testimony based on his own misreading or misinterpretation of the record, which unfairly compounded the level of seriousness of respondent's errors.

96. Conversely, Dr. Brose opined that respondent's recordkeeping errors were within the standard of care. However, the fact that some of those inconsistencies and inaccuracies perpetuated in the medical record for months if not years renders these errors more than simply commonplace errors resulting from the transition to and evolution of electronic medical recordkeeping.

97. When the evidence is considered as a whole, complainant established that respondent failed to maintain accurate medical records during the relevant time periods, and that this failure constituted a simple departure from the standard of care.

PATIENT C

98. The standard of care requires a physician to order a retest when the results of a urine drug screen are inconsistent with the patient's prescription regimen.

The evidence established that respondent failed to review the results of the September 21, 2016 urine drug screen, inaccurately documented the results in the medical chart, and continued to prescribe controlled substances to Patient C. Dr. Sacks mistakenly believed this was the patient's initial drug screen, unaware of the consistent drug screen from five months earlier.

99. Both experts agree that a single error does not necessarily constitute a departure from the standard of care. This appears to be the case here. Respondent testified credibly that he never saw the September 21, 2016 test results, and believed he was entering the results from the urine drug screen taken five months earlier. Had he been aware of his error, he would have ordered a retest. The evidence established this was not a recurring failure, but rather the result of a one-time mistake, and thus does not rise to the level of a departure from the standard of care.

100. With regard to the Meperidine prescription, Dr. Sacks admitted on cross-examination that he was not aware that respondent consulted the CURES report on December 16, 2015, noted the presence of Meperidine prescribed by Dr. Trenner, and that he thereafter consulted with Dr. Trenner regarding weaning Patient C off the medication. Dr. Sacks also refused to state definitively that the standard of care prior to 2018 required physicians to regularly review a patient's CURES report. Thus, based on Dr. Brose's testimony and the Patient C's medical chart, the evidence established that respondent met the standard of care in this regard.

101. When the evidence is considered as a whole, complainant did not establish that respondent committed a simple departure from the standard of care when (1) he failed to review the results of Patient C's urine drug screen and entered the results inaccurately in her medical chart, or (2) when he did not review the CURES report and address the Meperidine prescription prior to December 16, 2015.

PATIENT D

102. The evidence did not establish that respondent deviated from the standard of care by maintaining separate charts for Patient D's workers' compensation case and her primary care. On cross-examination, Dr. Sacks conceded respondent was required to maintain a separate workers' compensation file. the workers' compensation system. He also did not refute Dr. Brose's assertion that the workers' compensation regulations discourage documenting any issues not related to the industrial injury in the workers' compensation file.

103. The evidence also did not establish that respondent deviated from the standard of care in his management and treatment of Patient D's chronic migraines. First, Dr. Sacks admitted he had little experience treating patients for chronic migraines. Second, Patient D's testimony established that, prior to beginning treatment with respondent, she consulted with numerous specialists and tried countless treatments to best manage her ailment. Moreover, Dr. Sacks ignored entries in the medical record where respondent referred her to a pain management specialist and neurologist. Finally, respondent also documented that her chronic migraines had been well-managed with butorphanol nasal spray for 19 years.

104. When the evidence is considered as a whole, complainant did not establish that respondent committed a simple departure from the standard of care in the management of Patient D's chronic migraines.

PENALTY

105. The Board has adopted a Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016) (Guidelines) to determine the appropriate level of discipline. The Guidelines recommend, at a minimum, stayed revocation and five

years' probation for general unprofessional conduct, repeated negligent acts, and failure to maintain adequate records. The maximum discipline for each of these violations is license revocation. The Guidelines further note that a public reprimand may be appropriate in cases charging repeated negligent acts regarding a single patient.

106. In exercising its disciplinary functions, protection of the public is the highest priority of the Board. (Bus. & Prof. Code, § 2229, subd. (a).) To the extent it is not inconsistent with public protection, disciplinary action taken against a physician should be calculated to aid in his or her rehabilitation. (Bus. & Prof. Code, § 2229, subd. (b).) Here, the evidence established respondent committed simple departures from the standard of care by failing to maintain accurate medical records. The more substantive allegations regarding the care and treatment of Patients C and D were not proven.

107. In mitigation, respondent has taken steps to improve his medical recordkeeping, including successfully completing a medical recordkeeping course. Respondent has not been in private practice since January 2020, and currently works part-time as a hospitalist for Adventist Rideout. He has received significant training on the hospital's EMR system, CERNER, and may avail himself to technical support when he needs further assistance. Additionally, respondent is well-respected and held in high esteem by colleagues, supervisors, and patients alike, who praised the quality of care and treatment he provides his patients. He has practiced medicine for over 40 years, and in California for more than 20 years, and has never previously been the subject of discipline by any reviewing board.

108. The imposition of a public reprimand does not fall within the Guidelines' recommended discipline. However, respondent did not intend to violate the Medical

Practice Act and no patient harm was established. Considering the mitigation evidence and respondent's current role as a hospitalist, on balance with the violations proven, probation is unnecessary to protect the public. Further, requiring completion of a medical recordkeeping course is not necessary given the passage of time since the violations, the unlikelihood of recurrence, and the fact respondent recently completed a similar course. Under the circumstances, the issuance of a public reprimand will be a sufficient measure for public protection.

LEGAL CONCLUSIONS

1. The Medical Practices Act, Business and Professions Code[15] section 2000, et seq., provides that "protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This is a heavy burden and requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt, and must be sufficiently strong that it commands the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84 [citations omitted].)

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[15] All further statutory references are to the Business and Professions Code, unless otherwise noted.

Applicable Law

3. Section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act shall:

> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Section 2234, requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes, but is not limited to: . . . repeated negligent acts." (§ 2234, subd. (c).) "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." (*Ibid.*) Unprofessional conduct also includes "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients." (§ 2266.)

Cause for Discipline

5. By reason of the matters set forth in the Factual Findings as a whole, and in particular Factual Findings 94 through 97, cause exists for disciplinary action under sections 2227, 2234, subdivision (c), and 2266. Complainant established, by clear and convincing evidence, respondent engaged in unprofessional conduct by engaging in repeated negligent acts when he failed to maintain accurate medical records for the period reviewed.

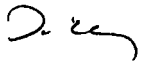
6. As set forth in Factual Findings 98 through 103, no cause exists for disciplinary action under sections 2227 and 2234, based on respondent's care and treatment of Patients C and D.

7. As set forth in Factual Findings 105 through 108, in light of the evidence as a whole, a public letter of reprimand is appropriate and adequate to protect the public.

ORDER

Physician and Surgeon's Certificate No. A 65439, issued to respondent Hari Goyal, M.D., is hereby publicly reprimanded.

DATE: May 13, 2021



TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
RYAN J. YATES
Deputy Attorney General
State Bar No. 279257
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6329
Facsimile: (916) 327-2247

Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO MAY 30 2019
BY ANDREA GERANIA ANALYST

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

In the Matter of the Accusation Against: **Hari Om Goyal, M.D.** **414 G St., Ste. 240** **Marysville, CA 95901** **Physician's and Surgeon's Certificate No. A 65439,** Respondent.	Case No. 800-2016-021321 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about June 5, 1998, the Medical Board issued Physician's and Surgeon's Certificate No. A 65439 to Hari Om Goyal, 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, 2019, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct[1]. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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[1] Unprofessional conduct under California Business and Professions Code section 2234 is 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. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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

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."

PERTINENT DRUG INFORMATION

7. Butalbital with caffeine and with acetaminophen – Generic name for Fioricet. Bultalbital is a barbiturate with an immediate duration of action. Often combined with other medications, it is commonly used for the treatment of pain and headache. Fioricet is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13. Fioricet is a Schedule III controlled substance pursuant to Health and Safety Code section 1105, and a dangerous drug pursuant to Business and Professions Code section 4022.

8. Butorphanol Tartrate – Generic name for Stadol. Butorphonal tartate is a morphinan-type synthetic agonist opioid analgesic used to manage moderate to severe pain. Butorphonal tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(g). It is a dangerous drug pursuant to Business and Professions Code section 4022.

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

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

11. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Duloxetine – Generic name for Cymbalta. Duloxetine is a serotonin–norepinephrine reuptake inhibitor medication used to treat major depressive disorder, generalized anxiety disorder, fibromyalgia, and neuropathic pain. Duloxetine is a dangerous drug, pursuant to Business and Professions Code, section 4022.

13. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long-term, chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.[2] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

14. Gabapentin – Generic name for Neurontin. Gabapentin is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one of a number of first-line medications for the treatment of neuropathic pain caused by diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. Gabapentin is a dangerous drug, pursuant to Business and Professions Code, section 4022.

15. Hydrocodone bitartrate with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e). On October 6, 2014, Hydrocodone combination

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

products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163, Code of Federal Regulations Title 21 section 1308.12. 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).

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

17. Meperidine (Pethidine) – Generic name for Demerol. Meperidine is a synthetic opioid pain medication of the phenylpiperidine class used to manage moderate to severe pain. Meperidine carries a risk of addiction and abuse. Meperidine Hydrochloride is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12, subdivision (c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Morphine Sulfate – Generic name for the drugs MS Contin and MorphaBond ER. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. MS dissolves readily in water and body fluids, creating an immediate release.

19. Oxycodone – Generic name for OxyContin, Roxicodone, and Oxecta. Oxycodone carries a high risk for addiction and dependence, and can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. OxyContin

ER is a long-acting opioid formulation consisting of an extended-release mechanism. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

20. Pregabalin – Generic name for Lyrica. Pregabalin is a medication used to treat epilepsy, neuropathic pain, fibromyalgia, restless leg syndrome, and generalized anxiety disorder. Its use in epilepsy is as an add-on therapy for partial seizures. Pregabalin is a Schedule V controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.15, and a dangerous drug pursuant to Business and Professions Code, section 4022.

21. Promethazine – Generic for the drug Phenergan. Promethazine is used to prevent and treat nausea and vomiting related to certain conditions (such as before or after surgery, or motion sickness). It is also used to treat allergy symptoms such as rash, itching, and runny nose. Promethazine is a Schedule V Controlled Substance pursuant to Code of Federal Regulations Title 21 Section 1308.15(c). Promethazine is a Dangerous Drug as defined by California Business and Professions Code section 4022. Promethazine often comes in a form of cough syrup containing codeine. This version of Promethazine is a Schedule V drug pursuant to Health and Safety Code, section 11058.

FIRST CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

22. Respondent is subject to discipline under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, Patient B, Patient C, and Patient D and as more particularly alleged hereinafter:

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Patient A:

23. Patient A is a fifty-one (51) year old female who was being treated by Respondent for low back pain, anxiety, cervical disc disease, obesity, hypertension, and peptic ulcer. Between December 29, 2010, and August 24, 2018, Patient A was prescribed Oxycodone HCL, Morphine Sulfate, Hydrocodone Bitartrate and Acetaminophen, and Lorazepam, on a regular basis.

24. During Respondent's care and treatment of Patient A, Respondent failed to create and maintain adequate and accurate medical records.

On or about September 6, 2012, Respondent increased the amount of Patient A's Norco prescription (5 milligrams of Hydrocodone Bitartrate; 325 milligrams of Acetaminophen) from sixty (60) tablets per month to ninety (90) tablets per month. Despite this increase, Patient A's chart stated "bid" (twice a day) as to the frequency of use, and the "history" portion of the records stated, "neck and back pain better." Respondent failed to include any sort of explanation as to why the increase in the Norco prescription was necessary.

25. On or about August 11, 2014, Respondent increased the amount of Patient A's Norco prescription to 10 milligrams of Hydrocodone Bitartrate per dose. He noted in Patient A's medical records that the increase was due to "breakthrough pain." However, Respondent failed to include any sort of explanation in the medical records as to why the increase in the Norco dosage was necessary.

26. There were additional discrepancies throughout Respondent's medical record keeping for Patient A. Differing medication and dosages are listed under the "Current Medications," "Assessment," and "Plan of Care," sections, which occur consistently throughout Patient A's medical records and appear as if the notes are duplicated and pasted from previous medical record entries. For example, on or about October 5, 2012, Respondent documented a visit from Patient A. Within the "Care Plan" section of Patient A's progress notes, Respondent stated, "I will added NORCO 5/325 mg po q bid [*taken orally twice daily*] for breakthrough pain #90 for a month." [*sic.*] However, Respondent listed in the "Current Medications" section of the records, "Norco...Qty [*quantity*]: 60."

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27. On or about January 28, 2013, Respondent documented a visit from Patient A. Within the "Care Plan" section of Patient A's progress notes, Respondent stated, "I will aded NORCO 5/325 mg po q bid for breakthrough pain #60 for a month with 2 refills." [*sic.*] However, Respondent listed in the "Current Medications" section of the records, "Norco...Qty: 60; Refills: 0." This verbiage remained in Patient A's medical records for subsequent visits on February 28, 2013, March 18, 2013, April 29, 2013, May 28, 2013, June 27, 2013, July 25, 2013, August 26, 2013, September 25, 2013, and October 22, 2013.

28. Respondent's care and treatment of Patient A fell below the standard of care in that:

A. He failed to produce and maintain adequate and accurate medical records.

Patient B:

29. Patient B is a sixty-six (66) year old man, who was being treated by Respondent for degenerative arthritis in the cervical and lumbar spine, hips, knees, and shoulders. Outside of Respondent's care, Patient B has had three (3) lumbar spine surgeries, bilateral hip replacements, arthroscopic knee surgery, and two (2) left shoulder replacements. Between October 16, 2015, and August 8, 2018, Respondent prescribed Oxycontin, Clonazepam, Diazepam, and Hydrocodone Bitartrate, to Patient B on a regular basis.

30. Between December 2, 2011 and September 8, 2018, Respondent made numerous inaccuracies and inconsistencies in the medical records pertaining to Patient B. Beginning on December 2, 2011, Respondent wrote in the "Care Plan" section of Patient B's medical record,

> "Refill on oxycontin 80 mg q tid#90 [*90 tablets, 80 milligrams, taken three times a day*] given and diazepam 10 mg po q tid #90 [*90 tablets, 10 milligrams taken orally three times a day*]...Refuses to go to psychiatrist.Zoloft is helping depression.I [*sic.*] will decrease diazepam to 5 mg po q tid and monitor closely his symptoms." [*sic.*]

31. Patient B saw Respondent on December 30, 2011, January 27, 2012, February 27, 2012, March 26, 2012, April 25, 2012, May 24, 2012, June 22, 2012, June 29, 2012, July 20, 2012, August 17, 2012, September 20, 2012, October 5, 2012, October 22, 2012, November 20, 2012, and December 20, 2012. Following each of these visits, Respondent included the exact aforementioned language in the "Care Plan" section of Patient B's medical records. This was

despite the fact that beginning on or about February 27, 2012, Respondent decreased Patient B's Diazepam dosage from ten (10) milligrams to five (5) milligrams.

32. This inaccurate verbiage is repeated during each of Patient B's visits, until January 18, 2013, when the Diazepam dose verbiage is correctly changed to, "HA HAS REFILL ON diazepam 5 mg po q tid #90." [*sic.*] Notwithstanding this correction, Respondent continued to use verbiage from prior medical record entries in subsequent notes, which resulted in continued inaccurate entries. Respondent continued to use the language, "...Refuses to go to psychiatrist .Zoloft is helping depression. I will decrease diazepam to 5 mg po q tid and monitor closely his symptoms..." [*sic.*] following each visit with Patient B (approximately monthly). This lasted until January 15, 2015, when Respondent removed the line, "I will decrease diazepam to 5 mg po q tid and monitor closely his symptoms," and added, "...he's told to follow up with ortho for a possible TKA [total knee anthroplasty] both side.pad..." [*sic.*]

33. On September 7, 2018, Patient B visited Respondent. Following the visit, Respondent entered the following inaccurate and inconsistent notations in Patient B's medical record:

"Chief Complaint:	...Patients pain scale is a 8/10 and level of interference with daily activities is a 7/10...Pain scale 5/10 with medication, 9/10 without medication...Patient is compliant and responsible with medication..."
. . .	
"Assessments:	.Pain is worse patient has sever DJA...Pain DUE TO LUMBAR DISC DISEASE. is well controlled with present pain meds 3/10 with meds 10/10 without meds.Pain is chronic and now it has increased...Doing OK.Pain is controlled...." *[sic.]*
. . .	
	"...Discontinue oxycontin and Norco.I will refer to Dr Saggu for his shoulder pain...Patient also told...adn can go to methadone clinic for detox. . . ." [*sic.*]

These medical records contained inconsistencies and appear to have been copied from previous medical record entries. Additionally, treatment changes were not adequately explained or documented.

34. Respondent's care and treatment of Patient B fell below the standard of care in that:

A. He failed to produce and maintain adequate and accurate medical records.

Patient C:

35. Patient C is a sixty-eight (68) year old woman being treated by Respondent for work-related lower back pain, beginning on or about March 17, 2007, on an approximately monthly basis. During Respondent's care and treatment of Patient C, Respondent made numerous errors and discrepancies when entering notes into Patient C's medical record, such as identical notes being used for multiple visits.

36. Following a visit on June 18, 2012, Respondent entered the following verbiage in Patient C's medical record:

> "Care Plan: ...Soma 350 mg pot id PATIENT GIVEN REFILL # WITH 2 REFILLS. Norco 10/325 mg 2 po q 6 hours.#180 PATIENT GIEN # 180 WITH 2 REFILLS..." [*sic.*]

This verbiage was repeated in Patient C's medical record for visits that occurred on July 17, 2012, August 16, 2012, September 17, 2012, October 17, 2012, November 19, 2012, December 20, 2012, January 21, 2013, and February 21, 2013. This was despite the fact that the "Current Medications" portion of the medical records stated that Patient C was being prescribed 240 Norco tablets following each visit from 2012 through May 20, 2016.

37. Following a visit on March 18, 2013, Respondent entered the following verbiage in Patient C's Medical Record:

> "Care Plan: ...Soma 350 mg pot id PATIENT GIVEN REFILL # WITH 2 REFILLS... Norco 10/325 mg 2 po q 6 hours.dECREASEd TO#120 FOR A MONTH PATIENT GIVEN # 120 WITH 2 REFILL..." [sic.]

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This verbiage was repeated in Patient C's medical record for visits that occurred on April 17, 2013, May 17, 2013, June 19, 2013, August 1, 2013, September 10, 2013, October 9, 2013, November 8, 2013, December 9, 2013, January 8, 2014, February 5, 2014, March 5, 2014, April 2, 2014, May 5, 2014, May 30, 2014, July 2, 2014, and August 1, 2014. This was despite the fact that the "Current Medications" portion of the medical records stated that Patient C was being prescribed 240 Norco tablets following each visit from 2012 through May 20, 2016.

38. Following a visit on October 31, 2014, Respondent entered the following verbiage in Patient C's Medical Record:

> "Care Plan: ...Soma 350 mg pot id PATIENT GIVEN REFILL # WITH 2 REFILLS... Norco 10/325 mg 1 po q 6 hours.dECREASEd TO#90 Refill on these meds given..." [sic.]

This verbiage was repeated in Patient C's medical record for visits that occurred on November 21, 2014, December 23, 2014, and January 19, 2015. This was despite the fact that the "Current Medications" portion of the medical records stated that Patient C was being prescribed 240 Norco tablets following each visit from 2012 through May 20, 2016.

39. On February 4, 2015, Respondent recorded that he increased Patient C's Norco dosage to 120 tablets. Respondent failed to provide a reason for the increase in medication. Additionally, the "Current Medications" portion of the medical records continued to state that Patient C was being prescribed 240 Norco tablets.

40. On December 16, 2015, Respondent decreased the amount of Norco being prescribed to Patient C down to 90 tablets, and entered the following verbiage in Patient C's medical record:

> "Care Plan: ...I will decrease Norco 10/325 1 po 6 hours.#90 Refill on these meds given..."[*sic.*]

This verbiage was repeated in Patient C's medical record for visits that occurred on January 15, 2016, February 12, 2016, and March 8, 2016. This was despite the fact that the "Current Medications" portion of the medical records stated that Patient C was being prescribed 240 Norco tablets following each visit from 2012 through May 20, 2016.

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41. On September 21, 2016, Respondent recorded in Patient C's medical records that Soma was discontinued and a urine drug screen report — that Respondent had failed to sign — showed that Patient C tested negative for opiates, but positive for barbiturates and marijuana. During a follow up visit on October 24, 2016, Respondent incorrectly recorded in Patient C's medical records that Patient C had tested "positive for opiates on urine drug screen." Respondent then continued to prescribe opiates and failed to address the urine drug screen results.

42. On May 22, 2017, Respondent recorded in Patient C's medical records that he decreased the dosage of the Duragesic patch prescribed to Patient C to 75 micrograms. Respondent failed to include a clear reason in Patient C's medical records as to why the dosage was decreased.

43. On June 23, 2017, Respondent recorded in Patient C's medical records that he again reduced the amount of prescribed Norco tablets to 90 per month. Respondent failed to provide an explanation as to why the amount of Norco was being reduced.

44. On July 25, 2017, Respondent recorded in Patient C's medical records that he reduced Patient C's Duragesic patch dosage to 50 micrograms. The "History of Present Illness" portion of Patient C's medical records stated, "[Patient C] has chronic pain in back Pain scale 4/10 with medication, 10/10 without medication. Needs rescue medication times a day for adequate pain control…" [*sic.*] The "Chief Complaint" section of the medical record describes Patient C's pain as, "Patients pain scale is a 4/10 and level of interference with daily activities is a 2/10." [*sic.*] However, the "Assessment" section of the medical record stated Patient C "…Has ipain controlled with meds Pain with meds 5/10 and without meds 10/10." [*sic.*] Additionally, the note was electronically signed on August 23, 2017, which was one month after the visit with Patient C occurred.

45. On February 26, 2018, Respondent recorded in Patient C's medical records that he discontinued prescribing a fentanyl patch. Respondent noted, "we will make changes to a pain management a Workmen's Comp. cut down the patch to five per month." [*sic.*] Respondent then prescribed OxyContin ER, 20 milligrams, twice daily, in addition to the ninety (90) tablets of Norco per month. Respondent stated in the March 26, 2018, April 25, 2018, May 21, 2018, July

25, 2018, and August 24, 2018, medical record entries, "discontinue Duragesic patch and start OxyContin 20 mg be ID." These notes were inaccurate, as Respondent discontinued the fentanyl patch on February 26, 2018.

46. On September 24, 2018, Respondent discontinued Patient C's narcotics, following a drug screen, which tested positive for marijuana, however, no clear follow-up plan was documented. Although CURES shows that Patient C was receiving meperidine from a podiatrist, Respondent failed to document this or address it with Patient C.

47. Respondent's care and treatment of Patient C fell below the standard of care in that:

A. He failed to produce and maintain adequate and accurate medical records; and

B. He failed to properly address an initial urine drug screen and failed to acknowledge and respond to a CURES report showing that Patient C was receiving meperidine from another provider.

Patient D:

48. Patient D was a fifty-seven (57) year old woman who was treated by Respondent for migraine headaches, depression, anxiety, irritable bowel syndrome, chest pains, insomnia, and other ailments. Respondent began treating Patient D on October 8, 2010, and continued treating her approximately monthly, until August 31, 2018.

49. Respondent was additionally treating Patient D for a worker's compensation injury to her back, which occurred on January 27, 1999. During Respondent's care and treatment of Patient D, Respondent kept two separate sets of medical records for Patient D's worker's compensation matter, and for general care and treatment of Patient D.

50. Respondent initially prescribed Patient D 120 tablets Hydrocodone with acetaminophen at 10 / 325 milligrams per month; ninety (90) Soma tablets at 325 milligrams per month; ninety (90) tablets of diazepam at 10 milligrams per month; and Gabapentin and Lyrica. Although Respondent additionally prescribed butorphanol nasal spray to Patient D, Respondent failed to include any documentation regarding the butorphanol in Patient D's medical record.

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51. Respondent additionally failed to provide a detailed history regarding Patient D's headaches, their triggers, their quality and description, and their affect on Patient D. Moreover, on almost each of the subsequent chart notes in the "Chief Complaint" and "History of Illness" sections of Patient D's medical record, Respondent inserted insufficiently brief verbiage, such as, "Patient here for 1 month follow up," "Here for medication refill," "migraine follow up," or "headaches controlled on medication." No proper documentation or assessment of Patient D's headaches was included.

52. On January 23, 2013, Respondent noted in the "Care plan" section of Patient D's medical record, "Refill on meds. Patient plan has declined butorphanol for headaches as patient has been taking this meds for 19 yrs with good relief." [*sic.*] However, Respondent's medication list for Patient D, as well as Patient D's CURES report and pharmacy review, show that Patient D was being prescribed butorphanol regularly. The above-mentioned incorrect statement was then used in every note in Patient D's medical record, through August 31, 2018.

53. Respondent prescribed diazepam to Patient D in the amount of 10 milligrams, three times per day, until June of 2017, when he changed the prescription to lorazepam in the amount ninety (90) tablets at 0.5 milligrams, per month. In December of 2017, Respondent decreased the amount of lorazepam to sixty (60) tablets per month. On August 28, 2015, Respondent began prescribing Patient D duloxetine. Patient D was additionally taking Fioricet and Phenergan, for her migraines, which were prescribed by another physician. Respondent failed to document that Patient D was taking Hydrocodone, Soma, and Lyrica, which were simultaneously being prescribed by Respondent for Patient D's worker's compensation matter. On March 25, 2015, Respondent listed carisoprodol for the first time, in the "Medication list" section of Patient D's medical records. On June 12, 2015, carisoprodol was removed without explanation from Patient D's medical records.

54. During Respondent's care and treatment of Patient D, Respondent failed to prescribe or recommend preventative therapies or advise or refer Patient D to consult with a pain management specialist.

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55. Respondent's care and treatment of Patient D fell below the standard of care in that:

A. He failed to produce and maintain adequate and accurate medical records; and

B. He allowed Patient D to use narcotics for a prolonged period without sufficient use of preventive therapies or specialist consultation.

56. Respondent's conduct as described above constitutes unprofessional conduct in violation of sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, and thereby provides cause for discipline of Respondent's physician and surgeon's license for repeated negligent acts in the care and treatment of Patient A, Patient B, Patient C, and Patient D, collectively and individually.

SECOND CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

57. Respondent is further subject to discipline under sections 2227 and 2234, as defined by section 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 hereinafter: Paragraphs 22 to 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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

58. 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 Patient A, as more fully described in paragraphs 22 through 57, above, and those paragraphs are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 65439, issued to Hari Om Goyal, M.D.;

2. Revoking, suspending or denying approval of Hari Om Goyal, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Hari Om Goyal, 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: May 30, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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