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

In the Matter of the Accusation Against: Gurmail Singh Brar, M.D. Physician's & Surgeon's Certificate No. A 63668 Respondent.	Case No. 800-2017-036806

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 8, 2021.

IT IS SO ORDERED September 8, 2021

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
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Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **GURMAIL SINGH BRAR, M.D.** **460 Plumas Blvd.** **Yuba City, CA 95991** **Physician's and Surgeon's Certificate No. A 63668** Respondent.	Case No. 800-2017-036806 OAH No. 2019100847 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

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2. Respondent Gurmail Singh Brar, M.D. (Respondent) is represented in this proceeding by attorney Dominique A. Pollara, whose address is: 100 Howe Avenue, Suite 165N, Sacramento, CA 95825.

3. On or about October 17, 1997, the Board issued Physician's and Surgeon's Certificate No. A 63668 to Gurmail Singh Brar, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-036806, and will expire on May 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-036806 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 21, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-036806 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-036806. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-036806, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-036806, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 63668 to disciplinary action.

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

RESERVATION

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

CONTINGENCY

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

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 63668, issued to Respondent Gurmail Singh Brar, M.D., shall be and is hereby publicly reprimanded pursuant to California Business and Professions Code, section 2227, subdivision (a) (4.) This public reprimand, which is issued in connection Respondent's care and treatment of Patient A, B, C, D, E, and F, as set forth in Accusation No. 800-2017-036806, is as follows:

"You failed to strictly follow the 2014 Board Guidelines for Prescribing Controlled Substances for Pain resulting in simple departures from the standard of the care."

A. CLINICAL COMPETENCE ASSESSMENT PROGRAM

Within one year (1) of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The

program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. Any violation of this condition or failure to complete the program and program recommendations shall be considered unprofessional conduct and grounds for further disciplinary action.

B. <u>MEDICAL RECORD KEEPING COURSE</u>

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete

the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure and the coursework requirements as set forth in Condition B of this stipulated settlement.

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

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

C. <u>PRESCRIBING PRACTICES COURSE</u>

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

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

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

ACCEPTANCE

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

DATED: 3/01/2021

GURMAIL SINGH BRAR, M.D.
Respondent

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

DATED: 3/1/21

DOMINIQUE A. POLLARA
Attorney for Respondent

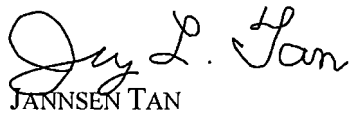
ENDORSEMENT

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

DATED: 5/20/2021

Respectfully submitted,

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



JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-036806

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO AUGUST 21 2019
BY [illegible] ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2017-036806
GURMAIL SINGH BRAR, M.D. **460 Plumas Blvd.** **Yuba City, CA 95991** **Physician's and Surgeon's Certificate No. A 63688,** Respondent.	**A C C U S A T I O N**

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 October 17, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. A 63688 to Gurmail Singh Brar, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2021, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

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

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

(d) Incompetence.

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

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

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

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

6. Section 2242 of the Code states:

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

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

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

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

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

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

(3) The licensee was a designated practitioner serving in the absence of the

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

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

7. 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.

8. Health and Safety Code § 11165.4[1] states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, first time means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

[1] Effective October 2, 2018

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

9. Section 725 of the Code states:

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

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred

dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

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

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

10. Section 4021 of the Code states:

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

DEFINITIONS

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

12. 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.

13. 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.

14. 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).

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 products were reclassified as Schedule II controlled substances. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

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

17. 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.

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

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

19. Morphine Sulfate – Generic name for the drugs Kadian, 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. MS dissolves readily in water and body fluids, creating an immediate release. Morphine is a Schedule 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.

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

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

22. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV

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

23. Diazepam – Generic name for Valium, is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Ménière's disease. 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.

24. Gabapentin – Generic name for Neurontin, is a medication used as an anticonvulsant and analgesic used to treat epilepsy. It is a dangerous drug pursuant to Business and Professions Code section 4022.

25. Pregalbin – Generic name for Lyrica, is a medication used for neuropathic pain and generalized anxiety disorder. It is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

FIRST CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

26. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patients A, B, C, D, E, and F[3]. The circumstances are as follows:

27. Respondent is a physician and surgeon, board certified in family medicine who at all times relevant to the charges brought herein practiced medicine under Sutter North Medical Group in Yuba City, California.

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[3] Patient names are redacted to protect privacy.

Patient A

28. Patient A is a 62-year-old female with diagnoses of obesity, COPD[4], tobacco smoking, congestive heart failure, hypertension, peripheral edema, peripheral vascular disease, degenerative disk disease, osteoarthritis, diverticulosis, leg cellulltis, opiate induced hyperalgesia, and chronic pain.

29. On or about November 25, 2013, Respondent first saw Patient A for an office visit. During the visit, Respondent documented his assessment and plan as "pneumonia on the left base." Respondent started Patient A on antibiotics and advised follow up. He also documented COPD and advised Patient A to quit smoking.

30. On or about October 15, 2015, Respondent saw Patient A for an office visit. Respondent documented his assessment and plan as acute sinusitis with pharyngitis. Respondent prescribed an oral antibiotic. Respondent also documented COPD, and advised Patient A to continue with nebulizer.

31. On or about March 25, 2016, Respondent saw Patient A for an office visit. Respondent assumed Patient A's care as his patient at this time. Respondent documented that at the time, Patient A was a 59-year-old female establishing care, who had been sick for one week with nasal congestion, sore throat, headache, and phlegm. Patient A was also wheezing. Respondent documented COPD exacerbation. Respondent also documented osteoarthritis, anxiety, and urinary frequency. Respondent began refilling prior prescriptions on an ongoing monthly basis for long acting opioid Oxycontin 40 mg twice daily, and 2 short acting opioids, Oxycodone 20 mg 6 times daily and Norco 6 times daily.

32. During the period of March 25, 2016, to March 1, 2017, Respondent prescribed Lorazepam 1 mg, 90 tablets; Oxycodone HCL 40 mg, 60 tablets, and 20 mg, 180 tablets; Hydrocodone Acetaminophen 325 mg/10mg, 150 tablets, monthly.

33. In or about March, 2017, Patient A moved to Ohio. Respondent continued to renew Patient A's prescriptions while Patient A was living outside of California.

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[4] Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, and refractory (non-reversible) asthma. This disease is characterized by increasing breathlessness.

34. On or about September 19, 2017, a Walgreens pharmacist in Ohio filed a complaint with the Board stating that Patient A has been living in Ohio since March, 2017, and Respondent has continued to prescribe narcotics to her by sending electronic prescriptions.

35. During the period of March, 2017, to September, 2017, Respondent continued to prescribe opioids to Patient A without seeing her in person.

36. On or about December 15, 2017, a Health Quality Investigations Unit (HQIU) Investigator interviewed Sutter Pharmacy's lead pharmacist, Mr. P. Mr. P stated that he spoke with Respondent regarding his concern involving the dosage and amount prescribed to Patient A. Mr. P told the investigator that Respondent did not take his concerns seriously. Mr. P also printed out Patient A's CURES report in February 2017, and forwarded his concerns to Respondent.

37. On December 28, 2017, the HQIU Investigator interviewed the Walgreen's pharmacy employees, Ms. M and Ms. B. Both stated that they told Patient A that she needed a local doctor to prescribe opioids. Both Walgreens pharmacy employees also stated that they expressed their concerns to Respondent's office.

38. Respondent's care and treatment of Patient A departed from the standard of care in that:

A. Respondent prescribed excessive amounts of controlled medications to Patient A, including two short acting and one long acting opioid despite the pharmacist notifying him of their concerns;

B. Respondent failed to taper Patient A off opioids despite ongoing discussions with her;

C. Respondent did not have a signed pain management contract with Patient A in place;

D. Respondent did not perform periodic drug screening of Patient A;

E. Respondent did not refer Patient A to a specialist;

F. Respondent did not check CURES and kept refilling opioid prescriptions even when Patient A left California.

<u>Patient B</u>

39. Patient B is a 56-year-old patient with diagnoses of chronic cervical root pain, cellulitis, mannose binding lectin deficiency, depression, anxiety, and Opioid Induced

Hyperalgesia (OIH.) In the mid 1990s, Patient B was a patient at the Mayo Clinic in Minnesota. She was diagnosed with an immune deficiency condition called mannose binding lectin deficiency (MBL). The Mayo Clinic made recommendations on how much and what medications she should be taking, and Respondent saw Patient B from April 2014, to September 2018, following the Mayo Clinic's recommendations.

40. During the period of April, 2014, to September, 2018, Respondent prescribed Oxycontin 360 mg daily, and liquid Morphine from 400-700cc daily for her pain as well as prescribing Klonopin for anxiety.

41. On or about March 23, 2018, Patient B saw Dr. K. Dr. K reviewed Respondent's records for Patient B and documented that Patient B did not have a pain contract. Dr. K documented that he was going to have Patient B sign a pain contract and do a urine screen test before the next refill. Dr. K documented that Patient B will wait for Respondent and at the time does not want to sign a pain contract or perform a pain test.

42. In or about May 2018, chart notes indicate that CVS pharmacy called expressing concern why Patient B was taking benzodiazepines and opioids at the same time.

43. Respondent's care and treatment of Patient B departed from the standard of care in that:

A. Respondent prescribed excessive amounts of controlled medications to Patient B despite having been notified of pharmacist concerns;

B. Respondent failed to taper Patient B off medications despite ongoing discussions with her;

C. Respondent failed to have a pain management agreement in place with Patient B;

D. Respondent failed to perform periodic screening of Patient B until 2018;

E. Respondent failed to refer Patient B to a pain specialist;

F. Respondent failed to check the CURES database for Patient B.

Patient C

44. Patient C is a 51-year-old patient who saw Respondent in 2011 for a work related injury and elevated blood sugar. She became his regular patient from 2014-2018 with diagnoses

of diabetes mellitus, depression, anxiety, complex regional pain syndrome, peripheral vascular disease requiring angioplasty, ultimately with a non-healing foot ulcer requiring trans-metatarsal amputation of the foot, followed finally by below knee amputation with a complicating non-healing stump ulcer, phantom limb pain, and Opiate Induced Hyperalgesia (OIH.)

45. On or about September 15, 2014, Respondent saw Patient C for an office visit. Patient C was 46 years old at the time of the visit. Respondent documented Patient C's past medical history as diabetes type II, unspecified essential hypertension; Complex Regional Pain Syndrome (CRPS) type II, CRPS lower limb (HCC) right foot, and depressive disorder. Under assessment and plan, Respondent documented: "diabetes mellitus; have a long discussion with patient. Patient will continue present medication. I have discussed the patient would diet and exercise;" "peripheral vascular disease; discussed with the patient. Patient will continue present medication...;" "CRPS in depression; discussed with patient. Patient will continue present medication." Respondent noted that Patient C has black discoloration of toes on the right foot.

46. On or about January 30, 2015, Respondent saw Patient C for a follow up visit. Under past medical history, Respondent documented diabetes type II, right foot amputation, peripheral vascular disease, and complex regional pain syndrome.

47. During the period of August 2014, to August 2018, Respondent prescribed and renewed medications including Hydrocodone, Dilaudid, Fentanyl, MS Contin, Gabapentin, Lyrica, Lorazepam, and Diazepam.

48. Respondent's care and treatment of Patient C departed from the standard of care in that:

A. Respondent prescribed excessive amounts of controlled medications to Patient C;

B. Respondent failed to taper off Patient C's medications despite ongoing discussions with her;

C. Respondent failed to have a pain management agreement in place with Patient C;

D. Respondent failed to perform periodic screening of Patient C until 2018;

E. Respondent failed to refer Patient C to a pain specialist;

F. Respondent failed to check the CURES database for Patient C.

Patient D

49. Patient D is a 56-year-old patient who saw Respondent from October, 2015, to August, 2018, with diagnoses including obesity, chronic back pain from degenerative disc disease, lower extremity peripheral neuropathy, opioid addiction, and opioid induced hyperalgesia. Prior to seeing Respondent, Patient D was seen in a pain clinic where his addiction to opioids for chronic pain was treated with Methadone and cortisone injections.

50. On or about October 12, 2015, Respondent saw Patient D for an office visit, and to establish care. Patient D was 53 years old at the time of the visit. Respondent documented a past medical history of: unspecified otitis media, chronic pain, basal cell carcinoma eyelid, including canthus, hyperlipidemia, Vitamin D deficiency, and degenerative lumbar disc. Under assessment and plan, Respondent documented "thoracic and lumbar spine pain with chronic pain syndrome; have a long discussion (sic) the patient. Discussed for chronic pain management. Patient will continue present medication. Discussed for diet and exercise."

51. During the period of October 2015, to August 2018, Respondent prescribed and renewed Methadone, three tabs every 4-6 hours as needed at 120 mg – 180 mg per day or 360-450 tablets per month.

52. On or about February 17, 2017, Respondent saw Patient D for a follow up visit. Under assessment and plan, Respondent documented "lumbar disc disease and chronic pain; have long discussion (sic) the patient. Patient will tried (sic) to cut down on his methadone 1 pill a week. All questions answered."

53. On or about June 13, 2017, Respondent saw Patient D for a follow up visit. Under assessment and plan, Respondent documented that "Patient will cut down on methadone dose. Half tablet every week. Patient will slowly bring down the does (sic) of medication."

54. Respondent's care and treatment of Patient D departed from the standard of care in that:

A. Respondent prescribed excessive amounts of controlled medications to Patient D;

B. Respondent failed to taper Patient D off medications despite ongoing discussions with him;

C. Respondent failed to have a pain management agreement in place with Patient D;

D. Respondent failed to perform periodic screening of Patient D;

E. Respondent failed to refer Patient D to a pain or addiction specialist;

F. Respondent failed to check the CURES database for Patient D.

Patient E

55. Patient E is a 60-year-old patient who saw Respondent from October 2011, to March 2017, with diagnoses of obesity, osteoarthritis of the back and knees, depression, anxiety, hypertension, diabetes mellitus, and colovesical fistula.

56. In or around 2015-2016, Respondent had ongoing discussions with the patient to try to reduce Norco and increase Methadone respectively. Respondent did not discuss having a signed pain contract in place until 2015.

57. During the period of September 2013, to May 2016, Respondent prescribed and renewed Methadone 10 mg 600 tablets, Clonazepam 1 mg 300 tablets, and Hydrocodone 325/10 mg at 180 tablets.

58. Respondent's care and treatment of Patient E departed from the standard of care in that:

A. Respondent prescribed excessive amounts of controlled medications to Patient E;

B. Respondent failed to taper Patient E off medications despite ongoing discussions with her;

C. Respondent failed to have a pain management agreement in place for Patient E;

D. Respondent failed to perform periodic screening of Patient E;

E. Respondent failed to refer Patient E to a pain or addiction specialist;

F. Respondent failed to check the CURES database for Patient E.

Patient F

59. Patient F is a 52-year-old patient who saw Respondent from June 2007, to June 2018, with diagnoses of gastric bypass surgery, depression, anxiety, low back pain and muscle spasms, chronic abdominal pain, degenerative osteoarthritis, and insomnia.

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60. On or about March 18, 2013, and April 8, 2014, Patient F reported her medication was stolen. Respondent had ongoing discussions with Patient F regarding tapering off Norco as a breakthrough medication, as the patient was using Methadone in large amounts as needed, as well as Soma.

61. During the period of September 2013, to August 2018, Respondent prescribed and renewed Methadone 10 mg at 180 tablets to be taken as needed, Norco 325/10 mg 120 tablets, Oxycontin, Soma 350 mg at 90 tablets, Ambien 10 mg at 30 tablets, and Xanax 2 mg at 120 tablets.

62. Respondent's care and treatment of Patient F departed from the standard of care in that:

A. Respondent prescribed excessive amounts of controlled medications to Patient F;

B. Respondent failed to taper Patient F off medications despite ongoing discussions with her;

C. Respondent failed to have a pain management agreement in place with Patient F;

D. Respondent failed to perform periodic screening of Patient F;

E. Respondent failed to refer Patient F to a pain or addiction specialist;

F. Respondent failed to check the CURES database for Patient F.

63. 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 Patients A, B, C, D, E, and F, collectively and individually.

SECOND CAUSE FOR DISCIPLINE
(Excessive Prescribing)

64. Respondent is further subject to disciplinary action under sections 2227, 2234 and 725, in that he has excessively prescribed controlled substances and dangerous drugs to Patients A, B, C, D, E, and F. The circumstances are set forth in paragraphs 26 through 63, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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

65. Respondent is further subject to disciplinary action under sections 2227, 2234 and 2242, in that he has prescribed controlled substances and dangerous drugs to Patients A, B, C, D, E, and F without an appropriate examination or medical indication. The circumstances are set forth in paragraphs 26 through 63, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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

66. Respondent's license is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, D, E, and F. The circumstances are set forth in paragraphs 26 through 63, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

67. Respondent is further subject to disciplinary action 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 of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 26 through 63, above, which are hereby realleged and 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 63688, issued to Gurmail Singh Brar, M.D.;

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2. Revoking, suspending or denying approval of Gurmail Singh Brar, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Gurmail Singh Brar, 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: August 21, 2019

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

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