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

In the Matter of the Accusation Against: John Robert Logan, M.D. Physician's and Surgeon's Certificate No. G 49918 Respondent.	Case No. 800-2017-037573

DECISION

The attached Stipulated Surrender of License and 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 31, 2021.

IT IS SO ORDERED September 14, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka,
Executive Director

ROB BONTA
Attorney General of California
JANE ZACK SIMON
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: **JOHN ROBERT LOGAN, M.D.** **3417 Forbes Avenue** **Santa Clara, CA 95051** **Physician's and Surgeon's Certificate No. G 49918** Respondent.	Case No. 800-2017-037573 OAH No. 2021060152 **STIPULATED SURRENDER OF LICENSE AND 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 Rob Bonta, Attorney General of the State of California, by Lawrence Mercer, Deputy Attorney General.

2. JOHN ROBERT LOGAN, M.D. (Respondent) is represented in this proceeding by attorneys, Dennis R. Thelen and Amanda M. Lucas, whose address is: 5001 E. Commerce Center Dr., Ste. 300, Bakersfield, CA 93309-1687.

3. On or about May 16, 1983, the Board issued Physician's and Surgeon's Certificate No. G 49918 to JOHN ROBERT LOGAN, 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. 800-2017-037573 and will expire on March 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-037573 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 May 26, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-037573 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-037573. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. 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.

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-037573, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

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

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 49918, issued to Respondent JOHN ROBERT LOGAN, M.D., is surrendered and accepted by the Board.

1. As of October 31, 2021, Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

2. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

3. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-037573 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorneys, Dennis R. Thelen and Amanda M. Lucas. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate and that, as of the effective date of October 31, 2021, I will lose all rights and privileges as a physician and surgeon in California. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/29/2021

JOHN ROBERT LOGAN, M.D.
Respondent

I have read and fully discussed with Respondent JOHN ROBERT LOGAN, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

LEBEAU THELEN, LLP

DATED: 9/3/2021

AMANDA M. LUCAS
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 9/3/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-037573

XAVIER BECERRA
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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: **John Robert Logan, M.D.** **3417 Forbes Avenue** **Santa Clara, CA 95051** **Physician's and Surgeon's Certificate No. G 49918,** Respondent.	Case No. 800-2017-037573 **ACCUSATION**

PARTIES

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

2. On May 16, 1983, the Medical Board issued Physician's and Surgeon's Certificate Number G 49918 to John Robert Logan, 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 March 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 unless otherwise indicated.

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

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

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

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

"(b) Gross negligence.

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

" . . . ."

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."

FACTS

7. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

PATIENT P-1[1]

8. Respondent treated Patient P-1 from as early as May 2011 and has chart notes for her from September 16, 2011 through November 3, 2015. He saw her approximately monthly over that time. He treated her for, among other conditions, abdominal pain of no known etiology, cirrhosis of the liver, anxiety, depression, bipolar disorder, post-traumatic stress disorder, knee pain, and insomnia.

9. Respondent initially prescribed oxycodone with acetaminophen 5/325[2] for P-1 for pain, and then switched to morphine sulfate[3] and, by 2012, to hydromorphone[4] which he continued prescribing, occasionally with various other opioid medications, through November 11, 2015. P-1's average morphine milligram equivalency (MME)[5] for the entire period she was under Respondent's care was approximately 148 MME per day. By the final eleven and a half months that he treated her, her dose had increased to approximately 167 MME daily. Opioid dosages over 50 MME should be carefully used and dosages exceeding 90 MME should be very limited and clearly justified. Respondent prescribed the opioid medications for abdominal pain of

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[1] The patients are designated in this document as Patients P-1 through P-4 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Oxycodone with acetaminophen (trade name Percocet) is indicated for moderate to moderately severe pain. The 5/325 reflects that each pill contains 5 mg of oxycodone HCl and 325 mg of acetaminophen. Oxycodone HCl is semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

[3] Morphine sulfate is an opioid medication indicated for moderate to severe pain. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

[4] Hydromorphone, also known by the trade name Demerol, is an opioid analgesic. It is a a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code. Hydromorphone is four times as potent as morphine and can produce drug dependence. It has a central nervous system depressant effect.

[5] MME stands for morphine milligram equivalency. This is used to convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 100 mg of oxycodone is equivalent to 150 MME. The concept is alternatively referred to as morphine equivalent dose (MED).

unknown etiology without documenting a thorough investigation or medical necessity for the medications.

10. At the same time Respondent was prescribing these high levels of opioid medications for P-1, he was simultaneously prescribing various benzodiazepines including temazepam,[6] clonazepam,[7] diazepam,[8] and flurazepam[9] for her for anxiety and insomnia and, from June 4, 2015, carisoprodol[10] as well. Respondent did not document a clinical indication for long-term, i.e. over four years, benzodiazepine therapy.

11. Over this period, Respondent did not document a comprehensive treatment plan or specify measurable goals and objectives to evaluate progress toward treatment goals except to note that opioid medications permitted her to perform activities of daily living (ADLs) more easily. He did not document evaluating P-1's progress toward treatment objectives, discussion of improvement in level of function, discussion of medication abuse or diversion He did not document an exit strategy for discontinuing controlled substances therapy in the event it became medically necessary to taper or discontinue the therapy.

12. Respondent continued prescribing a combination of opioids and benzodiazepines for Patient P-1 despite evidence of numerous risk factors including diagnoses of anxiety, depression, bipolar disorder, and post-traumatic stress disorder and a past history of alcohol and drug abuse. P-1 had multiple emergency room visits for apparent opioid overdoses, pain and withdrawal

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[6] Temazepam (trade name Restoril) is a benzodiazepine. It is a sedative used to treat anxiety and insomnia. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance. Since temazepam has a central nervous system (CNS) depressant effect, special care should be taken when prescribing temazepam with other CNS depressant drugs.

[7] Clonazepam (trade name Klonopin) is an anticonvulsant of the benzodiazepine class of drugs. It is a long-acting benzodiazepine. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs.

[8] Diazepam (trade name Valium) is a benzodiazepine. It is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[9] Flurazepam (trade name Dalmane) is a benzodiazepine. It is a psychotropic drug used to treat insomnia. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance

[10] Carisoprodol (trade name Soma) is a muscle relaxant and sedative. Carisoprodol is a Schedule II controlled substance and a dangerous drug as defined by Business and Professions Code section 4022. Using carisoprodol together with an opioid may increase side effects such as dizziness, drowsiness, confusion, and difficulty concentrating.

symptoms having run out of pain medication early, and altered mental status. On November 8, 2012, she was administered and responded to Narcan[11] and the ER physician recommended tapering hydromorphone and gave diagnoses of altered mental status and overdose of drugs. In addition, she reported several falls, often exhibited confusion, presented with slurred speech, and ran out of pain medications early on a number of occasions.

13. Respondent failed to document having considered P-1's symptoms, diagnosis, alternatives to treatment, and goals of treatment as well as her substance abuse history and other risk factors when prescribing and increasing dosages of opioid medications. He did not document using tools to assess risk of medication abuse such as the SOAP-R, Opioid Risk Tool, or GAD-7 and did not document classifying P-1's risk of addiction.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

14. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to address or respond to numerous red flags for abuse or diversion of controlled substances by Patient P-1 and to classify and/or to document having classified Patient P-1's risk of abuse or diversion prior to initiating or continuing long-term use of high dosage controlled substances.

B. Respondent prescribed high doses of opioid medications for Patient P-1—an average of 167 MME over the final 11 months he treated her—over an extended period without documenting a clinical indication or medical necessity for the medications.

[11] Narcan, a trade name for naloxone, is an opioid antagonist and is indicated for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids. Narcan is also indicated for diagnosis of suspected or known acute opioid overdosage.

C. Respondent failed to specify measurable goals and objectives to evaluate Patient P-1's treatment progress, to document evidence of Patient P-1's progress toward treatment objectives, and to document an exit strategy for discontinuing drug therapy if medically necessary.

D. At the same time Respondent was prescribing high doses of opioid medications for Patient P-1, he was also prescribing various benzodiazepines without documenting a clinical indication for the potentially dangerous combination of opioids and benzodiazepines or for long-term benzodiazepine therapy.

PATIENT P-2

15. Respondent has chart notes for Patient P-2 for at least the period from March 9, 2012 through October 14, 2015. He saw her approximately monthly over that time. He treated her for, among other conditions, chronic pain associated with rheumatoid arthritis.

16. On March 9, 2012, P-2's initial visit, Respondent diagnosed her with advanced rheumatoid arthritis and noted that she was no longer able to get out of bed. She was transported to her visits with Respondent by gurney. On her first visit, Respondent prescribed MS Contin[12] 15 mg twice a day and naprosyn 500, a non-steroidal anti-inflammatory. Two months later, P-2 reported to another health care provider in Respondent's practice that she had been taking the 15 mg tablets of MS Contin three to four times a day instead of two times daily as it was prescribed. Respondent did not document discussing this overuse with P-2. A few months after that, on August 17, 2012, Respondent increased P-2's dose of MS Contin to 30 mg two times a day without explanation, then to 30 mg three times a day, and on February 5, 2013, to 100 mg three times a day. He did not document a risk/benefit analysis and rationale for these increases. On October 12, 2013, P-2 reported to Respondent that she had run out of morphine and gotten

[12] MS Contin, a trade name for morphine sulfate extended-release tablets, is a strong opioid pain medicine that is used to manage pain severe enough to require daily around-the-clock, long-term treatment with an opioid. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined in section 11055 of the Health and Safety Code.

hydrocodone/acetaminophen from the ER to tide her over to her appointment with him. He did not document discussing with P-2 her using more medication than prescribed and, without documenting a risk/benefit analysis or rationale, added hydrocodone/acetaminophen 10/325[13] four times a day to the MS Contin. On April 15, 2015, P-2 reported that she had run out of pain medication four to five days earlier and had had nausea and been vomiting for two days. Again, Respondent failed to document a discussion of the medication overuse and refilled P-2's prescriptions. A month after that, without explanation, Respondent increased the potency of P-2's break-through pain medication by twelve and a half percent by replacing hydrocodone/acetaminophen 10/325 four times a day with the stronger opioid medication oxycodone/acetaminophen 10/325 three times a day.

17. P-2's average morphine milligram equivalency when she started seeing Respondent was 30 MME a day. Her average MME during the time Respondent was prescribing for her was around 180 MME daily. By the final five months, her dose had increased to an average of approximately 317 MME daily. Opioid dosages over 50 MME should be carefully used and dosages exceeding 90 MME should be very limited and clearly justified. Respondent prescribed high-dose long-term opioid therapy for P-2's rheumatoid arthritis without documenting a medical necessity for the medications despite there being no scientific evidence to support either high-dose or long-term use of opioid medications.

18. At the same time Respondent was prescribing these high levels of opioid medications for P-2, he was simultaneously prescribing the benzodiazepines temazepam and clonazepam for her to treat insomnia and anxiety, respectively.

19. Respondent did not document using tools to assess risk of medication abuse such as the SOAP-R, Opioid Risk Tool, or GAD-7 and did not document classifying P-2's risk of addiction.

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[13] Hydrocodone bitartrate with acetaminophen (trade name Norco) is an analgesic used to treat moderate to severe pain. The 10/325 reflects that each pill contains 10 mg of hydrocodone bitartrate and 325 mg of acetaminophen. Hydrocodone bitartrate is a dangerous drug as defined in section 4022 and, since October 6, 2014, a Schedule II controlled substance. Before that date, it was categorized as a Schedule III controlled substance.

20. Over this period, Respondent did not document a comprehensive treatment plan or specify measurable goals and objectives—other than to reduce pain—to evaluate progress toward treatment goals. He did not document evaluating P-2's progress toward treatment objectives, discussion of improvement in level of function, discussion of medication abuse or diversion He did not document an exit strategy for discontinuing controlled substances therapy in the event it became medically necessary to taper or discontinue the therapy.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

21. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to address or respond to red flags for increased risk of abuse, addiction, or diversion of controlled substances as Patient P-2's running out of medications early and her being under treatment for anxiety and insomnia. He failed to clearly document a risk/benefit analysis; and failed to classify and/or to document having classified Patient P-2's risk of abuse or diversion prior to initiating or continuing long-term use of high dosage controlled substances. He did not document using tools to assess risk of medication abuse such as the SOAP-R, Opioid Risk Tool, or GAD-7 and he did not document monitoring P-2's compliance with the terms of her pain contract by using such tools as drug testing and review of CURES Reports.

B. Although there is no evidence to support long-term use of high doses of opioid medications to treat rheumatoid arthritis, Respondent treated Patient P-2 with high doses of opioid medication over several years—around 180 MME for most of the time he was treating her—without documenting a clinical indication or medical necessity for the medication.

C. Respondent failed to specify measurable goals and objectives to evaluate Patient P-2's treatment progress, to document evidence of Patient P-2's progress toward treatment objectives, and to document an exit strategy for discontinuing drug therapy if medically necessary.

PATIENT P-3

22. Respondent has chart notes for Patient P-3 from at least June 2012 through November 2015 and saw her approximately monthly over that time. She had abdominal pain, back pain, rectal and uterine prolapse, hypertension, and anxiety, among other conditions.

23. Respondent began prescribing hydrocodone with acetaminophen 10/325 for P-3 in February 2012 and continued prescribing opioid medications for her along with the benzodiazepine temazepam through November 14, 2015. While the medical records are not always clear, it appears that he was prescribing the opioid medications for abdominal and back pain. Over this period, Respondent did not document a physical examination of P-3's back except, occasionally, to note that she had mid and lower back tightness and tenderness. Nor did he document a treatment plan or specify measurable goals and objectives to evaluate progress toward treatment goals except to note that opioid medications permitted her to perform activities of daily living (ADLs) with less discomfort. He did not document an exit strategy for implementation in the event it became medically necessary to discontinue her controlled substances.

24. Over the period he was treating P-3, Respondent prescribed the opioids hydrocodone and oxycodone for her. P-3's average morphine milligram equivalent (MME) for the entire period she was under Respondent's care was approximately 176 MME per day. By the final eleven and a half months he treated her, her dose had increased to approximately 230 MME daily.

25. Respondent continued prescribing a combination of controlled substances for P-3 despite evidence of numerous risk factors including a diagnosis of and treatment for anxiety, several falls and feelings of light-headedness, and running out of pain medications early on a number of occasions. She also had multiple emergency room visits for complaints such as pain with the hope of getting pain medication, light-headedness, and altered mental status. On one

occasion—October 16, 2014—she was administered and responded to Narcan and the ER physician recommended stopping oxycodone and temazepam and gave a differential diagnosis of narcotic abuse. Also, although a urine toxicology screen done in the ER on June 5, 2014 was positive for barbiturates and Respondent was not prescribing barbiturates for P-3, there is no documentation of his having discussed this with her. Respondent did not document using such tools to assess risk of medication abuse as the SOAP-R, Opioid Risk Tool, PHQ-2 or otherwise document undertaking an assessment of risk.

26. Respondent did not document having discussed with P-3 the potential risks of combining opioid medications with benzodiazepines and did not document having placed P-3 on a controlled substances contract until May 6, 2015, several years after he began prescribing controlled substances for her.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

27. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate medical records, including but not limited to the following:

A. Respondent failed to address or respond to numerous red flags for abuse or diversion of controlled substances by Patient P-3 and to classify and/or to document having classified Patient P-3's risk of abuse or diversion prior to initiating or continuing long-term use of high dosage controlled substances.

B. Respondent failed to have a comprehensive treatment plan specifying measurable goals and objectives to evaluate Patient P-3's treatment progress, to document evidence of Patient P-3's progress toward treatment objectives, and to document an exit strategy for discontinuing drug therapy if medically necessary.

C. Respondent failed to document that he discussed the potential risks of long-term use of controlled substances with Patient P-3 or that he discussed the risks specific to combining opioid medications with benzodiazepines with her.

D. Respondent failed to place, or to document having placed, Patient P-3 on a controlled substances contract until over three years into her treatment.

PATIENT P-4

28. Respondent first saw Patient P-4 on April 2, 2012. He had a history of cerebral palsy, COPD/asthma, and hypertension among other conditions. P-4's insurer no longer covered his pain management physician and Respondent agreed to refill his pain medication prescriptions until he found a new pain management specialist. Initially, Respondent prescribed for P-4, as the pain management physician had, one 60 mg tablet of OxyContin twice a day and three 30 mg tablets of oxycodone four times a day for a daily total of 720 MME. Respondent's chart notes do not include a muscle-skeletal examination or neurological examination and do not indicate what exactly the pain medication was intended to treat.

29. Respondent continued treating P-4 for what was eventually identified as chronic back pain secondary to cerebral palsy until October 2015 when he referred him to pain management for ongoing care and treatment. After about a year and a half of treating P-4, Respondent reduced his oxycodone to two 30 mg tablets four times a day where it remained until he referred him to pain management. From August 2013 through October 2015, Respondent's prescriptions for P-4 for OxyContin and oxycodone totaled approximately 540 MME a day.

30. Despite prescribing high doses of opioid medications for P-4 for an extended period of time, Respondent did not document using such tools as the SOAP-R, Opioid Risk Tool, PHQ-2, PHQ-9 to assess P-4's risk of medication abuse or otherwise document undertaking an assessment of risk. Nor did he document a treatment plan or specify measurable goals and objectives to evaluate progress toward treatment goals except to note that opioid medications permitted P-4 to perform activities of daily living with less discomfort. He did not document an exit strategy for implementation in the event it became medically necessary to discontinue his controlled substances.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts and/or Failure to Maintain Adequate Records)

31. Respondent, John Robert Logan, M.D., is guilty of unprofessional conduct and subject to disciplinary action under section 2234, subdivisions (b) and/or (c), and/or section 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate medical records, including but not limited to the following: :

A. Respondent failed to classify and/or to document having classified Patient P-4's risk of abuse or diversion prior to initiating or continuing long-term use of high dosage opioid medications.

B. Respondent failed to have a comprehensive treatment plan specifying measurable goals and objectives to evaluate Patient P-4's treatment progress, to document evidence of Patient P-4's progress toward treatment objectives, and to document an exit strategy for discontinuing drug therapy if medically necessary.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 49918, issued to John Robert Logan, M.D.;

2. Revoking, suspending or denying approval of John Robert Logan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Robert Logan, 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 26 2020

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

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