

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

In the Matter of the Accusation Against:

Benjamin Shwachman, M.D.

Physician's & Surgeon's
Certificate No. G 11026

Case No. 800-2018-043920

Respondent.

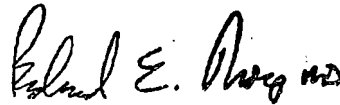
DECISION and ORDER

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. January 7, 2022.

IT IS SO ORDERED December 9, 2021.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D., Chair
Panel B

1 ROB BONTA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 EDWARD KIM
Deputy Attorney General
4 State Bar No. 195729
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 269-6000
Facsimile: (916) 731-2117
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 800-2018-043920

12 **BENJAMIN SHWACHMAN, M.D.**
13 **P.O. Box 4157**
Covina, CA 91723

OAH No. 2021080467

14 **Physician's and Surgeon's**
15 **Certificate No. G 11026,**

STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER

16 Respondent.

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

19 **PARTIES**

20 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
21 California (Board). He brought this action solely in his official capacity and is represented in this
22 matter by Rob Bonta, Attorney General of the State of California, by Edward Kim, Deputy
23 Attorney General.

24 2. Respondent Benjamin Shwachman, M.D. (Respondent) is represented in this
25 proceeding by attorney Joel Bruce Douglas, Esq., whose address is: 355 South Grand Ave., Ste.
26 1750, Los Angeles, CA 90071-1562.

27 3. On or about August 9, 1965, the Board issued Physician's and Surgeon's Certificate
28 No. G 11026 to Benjamin Shwachman, M.D. (Respondent). The Physician's and Surgeon's

1 Certificate was in full force and effect at all times relevant to the charges brought in Accusation
2 No. 800-2018-043920, and will expire on July 31, 2023, unless renewed.

3 **JURISDICTION**

4 4. Accusation No. 800-2018-043920 was filed before the Board, and is currently
5 pending against Respondent. The Accusation and all other statutorily required documents were
6 properly served on Respondent on April 29, 2021. Respondent timely filed his Notice of Defense
7 contesting the Accusation. A copy of Accusation No. 800-2018-043920 is attached as Exhibit A
8 and incorporated herein by reference.

9 **ADVISEMENT AND WAIVERS**

10 5. Respondent has carefully read, fully discussed with counsel, and understands the
11 charges and allegations in Accusation No. 800-2018-043920. Respondent has also carefully read,
12 fully discussed with his counsel, and understands the effects of this Stipulated Settlement and
13 Disciplinary Order.

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

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

22 **CULPABILITY**

23 8. Respondent understands and agrees that the charges and allegations in Accusation
24 No. 800-2018-043920, if proven at a hearing, constitute cause for imposing discipline upon his
25 Physician's and Surgeon's Certificate. Respondent does not contest that at an administrative
26 hearing, Complainant could establish a prima facie case with respect to the charges and
27 allegations contained in Accusation 800-2018-043920, and that he has thereby subjected his
28 license to disciplinary action.

1 1. PUBLIC REPRIMAND.

2 The Public Reprimand issued in connection with Accusation No. 800-2018-043920, against
3 Respondent is as follows:

4 As alleged in Accusation No. 800-2018-043920, you failed to maintain adequate and
5 adequate records as required by section 2266 of the Business and Professions Code on four
6 occasions between November 2015 and April 2018 in connection with your care of Patient 1, on
7 three occasions between March and November 2016 in connection with your care of Patient 2,
8 and on five occasions between April 2016 and December 2017 in connection with your care of
9 Patient 3.

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

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

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

27 If Respondent fails to enroll, participate in, or successfully complete the prescribing
28 practices course within the designated time period, Respondent shall receive a notification from

1 the Board or its designee to cease the practice of medicine within three (3) calendar days after
2 being so notified. Respondent shall not resume the practice of medicine until enrollment or
3 participation in the prescribing practices course has been completed. Failure to successfully
4 complete the prescribing practices course outlined above shall constitute unprofessional conduct
5 and is grounds for further disciplinary action.

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

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


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

23 If Respondent fails to enroll, participate in, or successfully complete the medical record
24 keeping course within the designated time period, Respondent shall receive a notification from
25 the Board or its designee to cease the practice of medicine within three (3) calendar days after
26 being so notified. Respondent shall not resume the practice of medicine until enrollment or
27 participation in the medical record keeping course has been completed. Failure to successfully
28 complete the medical record keeping course outlined above shall constitute unprofessional


1 conduct and is grounds for further disciplinary action.

2 ACCEPTANCE

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

8
9 DATED: 09/02/21 
10 BENJAMIN SHWACHMAN, M.D.
Respondent

11 I have read and fully discussed with Respondent Benjamin Shwachman, M.D. the terms and
12 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
13 I approve its form and content.


14 DATED: 9/8/21 
15 JOEL BRUCE DOUGLAS, ESQ.
Attorney for Respondent

16 ENDORSEMENT

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

19
20 DATED: 9-9-21

Respectfully submitted,
ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General


HOWARD KIM
Deputy Attorney General
Attorneys for Complainant

26 LA2021601395
27 64499255

28

Exhibit A

Accusation No. 800-2018-043920

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 CHRIS LEONG
Deputy Attorney General
4 State Bar No. 141079
California Department of Justice
5 300 South Spring Street, Suite 1702
Los Angeles, California 90013
6 Telephone: (213) 269-6460
Facsimile: (916) 731-2117
7 E-mail: chris.leong@doj.ca.gov
Attorneys for Complainant

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2018-043920

13 **BENJAMIN SHWACHMAN, M.D.**
14 **Post Office Box 4157**
Covina, California 91723

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **G No. 11026,**

17 Respondent.

18
19
20 **PARTIES**

21 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
22 as the Executive Director of the Medical Board of California (Board).

23 2. On August 9, 1965, the Board issued Physician's and Surgeon's Certificate Number G
24 11026 to Benjamin Shwachman, M.D. (Respondent). That license was in full force and effect at
25 all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

26 //

27 //

28 //

1 avoiding driving or other high-risk activities if sedated while taking these medications. There is
2 no documentation of the dangers of mixing opioids with benzodiazepines.

3 11. Respondent failed to document his patient monitoring adequately. Despite the
4 notation in the medical record that the patient would require closer monitoring, no additional
5 monitoring was initiated. A prudent physician would have significantly increased monitoring
6 once it was determined that the patient had lost control of the use of the medication and had
7 developed an opioid use disorder. In his subject interview, Respondent admitted that the
8 prescriptions were often given without a face-to-face meeting with his patients.

9 12. On September 7, 2017, Respondent again saw Patient 1, who was complaining of low
10 back pain. The medical record showed that Patient 1 was taking "10 hydrocodone per day in last
11 two weeks and last time he was here in December." This note was made after an interval of nine
12 months. The standard of care requires that the patient should be seen on a regular basis. If the
13 patient on chronic opioid therapy should demonstrate an increased risk while taking this therapy,
14 a reasonably prudent physician should change the monitoring interval to at least 30 days.

15 13. The documentation of physical examinations performed by Respondent is cut-and-
16 pasted in most follow-up reports. The physical examination was limited to vital signs. There is no
17 documentation that the CURES² report was ever evaluated. These omissions were in the medical
18 records dated November 30, 2015; December 5, 2016; September 7, 2017; and April 16, 2018,
19 when Patient 1 was seen by Respondent. For example, the medical records on those dates have
20 the same notes:

21 *"Had C Spine ESI by me about 8 years ago and did well Was Getting random blind*
22 *injections by VA and quit and came here."*

23 in which the typographical errors are the same and the same "8 years ago" interval is repeated.

24 15. Respondent failed to refer the patient to drug rehabilitation services. Given the high
25 dose of medication that Patient 1 was using, Respondent was obligated to refer him to a drug

26 ² CURES stands for Controlled Substance Utilization Review and Evaluation System
27 (CURES). It is a record from the pharmacy containing controlled substances prescribed to a
28 patient. Physicians are mandated to consult CURES prior to prescribing, ordering, administering,
or furnishing a Schedule II-IV controlled substance in order to determine whether the patient is
receiving substance dosages or dangerous combinations that put patient at high risk for overdose.

1 treatment center. The medical records, including those dated November 30, 2015; December 5,
2 2016; September 7, 2017; and April 16, 2018, do not show that the patient was referred for
3 rehabilitation services.

4 16. Respondent's medical records, including those dated November 30, 2015; December
5 5, 2016; September 7, 2017; and April 16, 2018, failed to provide documentation of an adequate
6 interim history, an appropriate physical examination, his treatment plan, adequate records of
7 Schedule II and III prescriptions, and informed consent.

8 Patient 2

9 17. Respondent first saw Patient 2 on September 27, 2011. At that time, she was 61
10 years old. Patient 2 was seen by Respondent in three-month intervals between September 27,
11 2011, and January 2017 and was prescribed opioid analgesics for chronic pain. On February 10,
12 2017, Patient 2 died as a result of acetaminophen toxicity. Her death was not related to the
13 deficiencies in Respondent's treatment, prescribing, or documentation.

14 18. Respondent failed to monitor Patient 2 adequately. Patient 2's follow-up history was
15 cut and pasted into subsequent reports, and physical exams were limited to vital signs. In
16 addition, the medical records, including those for patient visits on March 17, 2016; July 19, 2016;
17 and November 17, 2016, contain no documentation that a CURES report was ordered or
18 evaluated, and the analgesic effect of the medications already prescribed to the patient was not
19 documented.

20 19. Patient 2 received 150 tablets of Norco on October 10, 2016; November 8, 2016;
21 December 7, 2016; and January 11, 2017. However, the medical records show that Respondent
22 did not see the patient on or just before those dates. Therefore, these medications were prescribed
23 without face-to-face evaluation of the patient. CURES reports showed that Respondent
24 prescribed controlled substances to Patient 2 on multiple occasions, including February 27, 2016;
25 October 10, 2016; November 8, 2016; December 7, 2016; and January 11, 2017. There were no
26 medical records for Patient 2 during this period.

27 20. Respondent's documentation of physical examinations was inadequate. The medical
28 records, including those dated March 17, 2016; July 19, 2016; and November 17, 2016, have

1 inadequate documentation of regular face-to-face physical examinations, and exam details in
2 follow-up reports again were cut-and-pasted.

3 21. As with Patient 1, the medical records for Patient 2 had repeated copied and pasted
4 entries, including those dated March 17, 2016; July 19, 2016; and November 17, 2016. For
5 example, each had the same entry repeated: "*Pain flared in low back for about 2 months and then*
6 *subsided considerably.*" The entry on each record contained the same typographical error:
7 "cnsiderably."

8 22. Medical records showed that Respondent failed to adequately document patient
9 encounters, including for records dated March 17, 2016; July 19, 2016; and November 17, 2016.
10 Respondent failed to provide documentation of an adequate interim history, an appropriate
11 physical examination, his treatment plan, adequate records of Schedule II and III prescriptions
12 and informed consent.

13 23. In addition, Respondent was required to maintain an analgesic agreement with Patient
14 2, for her opioid therapy for chronic pain, but Respondent failed to document an analgesic
15 agreement with Patient 2 in the medical records, including records dated March 17, 2016; July 19,
16 2016; and November 17, 2016.

17 Patient 3

18 24. When Respondent first saw Patient 3 on March 15, 2012, she was a 65-year-old
19 female suffering from chronic pain from cervical and lumbar spine areas, apparently due to an
20 automobile accident in 2009 that resulted in cord compression.

21 25. The medical records for Patient 3 are missing required documentation. This includes
22 the records dated December 19, 2017; June 20, 2017; March 21, 2017; August 2, 2016; and April
23 28, 2016. The patient's medical records required additional information because there were
24 controlled substances prescribed to Patient 3 as follows: Patient 3 received 90 tablets of
25 acetaminophen-codeine on January 19, 2017; December 4, 2017; June 13, 2017; March 17, 2017;
26 and September 20, 2016. The medical records for the visits, including those listed above were
27 inadequate as follows:

1 1) Failure to document informed consent regarding the use of opioid treatment
2 therapy for the treatment of chronic pain;

3 2) Failure to document adequate monitoring of a patient prescribed opioid
4 medication for the treatment of chronic pain conditions;

5 3) Failure to document appropriate physical examinations prior to the
6 prescription of opioid analgesics;

7 4) Failure to refer to drug rehabilitative services; and

8 5) Failure to maintain adequate and accurate medical records.

9 B. Patient 2:

10 1) Failure to document informed consent regarding the use of opioid treatment
11 therapy for the treatment of chronic pain;

12 2) Failure to document adequate monitoring of a patient prescribed opioid
13 medication for the treatment of chronic pain conditions;

14 3) Failure to document appropriate physical examinations before the
15 prescription of opioid analgesics;

16 4) Failure to maintain adequate and accurate medical records.

17 5) Failure to maintain an analgesic agreement with a patient on opioid therapy
18 for chronic pain.

19 C. Patient 3:

20 1) Failure to document informed consent regarding the use of opioid treatment
21 therapy for the treatment of chronic pain;

22 2) Failure to maintain an analgesic agreement with a patient on opioid therapy
23 for chronic pain.

24 3) Failure to maintain adequate and accurate medical records.

25 4) Failure to document appropriate physical examinations prior to the
26 prescription of opioid analgesics;

27 5) Failure to document adequate monitoring of a patient prescribed opioid
28 medication for the treatment of chronic pain conditions;

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records of Patient Care)

27. Respondent is subject to disciplinary action under Code section 2266 by failing to maintain adequate and accurate records of his care and treatment of Patients 1, 2, and 3. The circumstances and allegations set forth in Paragraph 7 through 26 above are incorporated by reference and re-alleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)


28. Respondent is subject to disciplinary action under Code section 2234 for unprofessional conduct in his care and treatment of Patients 1, 2 and 3. The circumstances and allegations set forth in Paragraph 7 through 27 above are incorporated by reference and re-alleged 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 Number G 11026, issued to Benjamin Shwachman, M.D.;
- 2. Revoking, suspending, or denying approval of Benjamin Shwachman, M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 3. If placed on probation, ordering Benjamin Shwachman, M.D. to pay the Board the costs of probation monitoring; and
- 4. Taking such other and further action as deemed necessary and proper.

DATED: APR 29 2021


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

Complainant