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

In the Matter of the Second Amended Accusation Against: John Ray Schafer, M.D. Physician's and Surgeon's Certificate No. G 6244 Respondent.	Case No.: 800-2017-035916

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 January 10, 2022.

IT IS SO ORDERED: December 10, 2021.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
REBECCA D. WAGNER
Deputy Attorney General
State Bar No. 165468
HAMSA M. MURTHY
Deputy Attorney General
State Bar No. 274745
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3760
Facsimile: (415) 703-5480
E-mail: Rebecca.Wagner@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **JOHN RAY SCHAFER, M.D.** **353 Patten Street** **Sonoma, CA 95476** **Physician's and Surgeon's Certificate No. G 6244** Respondent.	Case No. 800-2017-035916 OAH No. 2021010353 **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 Rob Bonta, Attorney General of the State of California, by Rebecca D. Wagner, Deputy Attorney General.

2. Respondent John Ray Schafer, M.D. (Respondent) is represented in this proceeding by attorney Virgil Pryor, whose address is: 220 Montgomery Street, Suite 910, San Francisco, CA 94104.

3. On or about August 19, 1960, the Board issued Physician's and Surgeon's Certificate No. G 6244 to John Ray Schafer, 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 Second Amended Accusation No. 800-2017-035916, and will expire on April 30, 2023, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 800-2017-035916 was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on August 4, 2020. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation.

5. A copy of Second Amended Accusation No. 800-2017-035916 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 Second Amended Accusation No. 800-2017-035916. 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 Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

9. Respondent understands that the charges and allegations in Second Amended Accusation No. 800-2017-035916, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. 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. ACKNOWLEDGMENT. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

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

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Second Amended Accusation No. 800-

2017-035916 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 6244 issued to Respondent JOHN RAY SCHAFER, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. PRACTICE RESTRICTIONS. During the period of probation, Respondent may not prescribe any medications and may only practice medicine as follows: Respondent may continue to conduct Aviation Medical Examiner physicals as long as there is a chaperone present if the examinee[1] is a female and/or a minor; and Respondent may administer COVID-19 and Influenza vaccines through the Sonoma County Medical Reserve Corps as long as there is a chaperone present if the person receiving a vaccine is a female and/or a minor. Respondent agrees to cease all other practice of medicine on or by the effective date of this agreement. Respondent may not practice medicine in any other way expect as expressly described above. Respondent also may not provide health care services in any other manner during the period of probation unless and until this condition is modified by the Board or its designee.

2. CONTROLLED SUBSTANCES - TOTAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

[1] For purposes of this stipulation the phrase "patient" does not include physical examinees and/or vaccine recipients.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

3. CONTROLLED SUBSTANCES - SURRENDER OF DEA PERMIT. Respondent is prohibited from practicing medicine until Respondent provides documentary proof to the Board or its designee that Respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, Respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

4. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

5. PRESCRIBING PRACTICES COURSE. Respondent will not be allowed to prescribe medications and/or controlled substances unless and until Respondent enrolls in and successfully completes 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.

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

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

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

7. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program,

that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

8. PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate Respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees

in writing to a later time for completion. Based on Respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, Respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The program has the authority to determine whether or not Respondent successfully completed the program.

A professional boundaries 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.

If Respondent fails to complete the program within the designated time period, Respondent shall cease all practice of medicine including Aviation Medical Examiner physicals and administration of immunizations (as described in Paragraph 1 above) within three (3) calendar days after being notified by the Board or its designee that Respondent failed to complete the program.

9. CLINICAL COMPETENCE ASSESSMENT PROGRAM. In no event will Respondent be allowed to return to the practice of medicine, beyond the limited practice described in Paragraph 1, and/or prescribe medications unless and until Respondent enrolls in, and successfully completes, a clinical competence assessment program approved in advance by the Board or its designee. Respondent, however, may continue to conduct Aviation Medical Examiner physicals as long as there is a chaperone present without enrolling in, or completing, a clinical competence assessment program; and Respondent may administer COVID-19 and Influenza vaccines through the Sonoma County Medical Reserve Corps as long as there is a

chaperone present without enrolling in, or completing, a clinical competence assessment program.

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, Accusation, 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.

Respondent shall not practice medicine other than physicals and immunizations as outlined above until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

10. PSYCHIATRIC EVALUATION. Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological

testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions, conditions, and/or recommendations, including but not limited to psychotherapy, if recommended by the evaluating psychiatrist, within 15 calendar days after being notified by the Board or its designee.

Respondent shall pay for the cost of all psychotherapy and psychiatric evaluations.

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

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall

make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

12. THIRD PARTY CHAPERONE. During probation, Respondent shall have a third party chaperone present while consulting, examining or treating female and/or minor patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If Respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its

designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision and the Accusation, and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, Respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If Respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

Respondent shall provide written notification to Respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with a female and/or minor patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the

13. PROHIBITED PRACTICE. During probation, Respondent is prohibited from any practice of medicine including prescribing except as follows: Respondent may continue to conduct Aviation Medical Examiner physicals as long as there is a chaperone present if the examinee is a female and/or a minor; and Respondent may administer COVID-19 and Influenza vaccines through the Sonoma County Medical Reserve Corps as long as there is a chaperone present if administering a vaccine to a female and/or a minor. Respondent may not return to any other practice of medicine without enrolling in and successfully completing the clinical competence assessment program and the prescribing practice course. Respondent also may not return to any other practice of medicine without a further order of the Board.

14. REQUIRED NOTIFICATIONS. Respondent shall be required to notify his patient, or the patient's guardian or health care surrogate, before the patient's first visit following the probationary order of the following: his probation status, the length of probation, the probation end date, all practice restrictions placed on the Respondent, the Board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on Respondent's profile page on the Board's online license information website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

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

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

15. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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

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

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

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

18. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any

areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

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

19. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

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

22. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the

application shall be treated as a petition for reinstatement of a revoked certificate.

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

24. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-035916 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

25. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Virgil Pryor. 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: 6/11/2021

JOHN RAY SCHAFER, M.D.
Respondent

I have read and fully discussed with Respondent John Ray Schafer, 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: June 11, 2021

VIRGIL PRYOR
Attorney for Respondent

ENDORSEMENT

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

DATED: June 18, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

Rebecca D. Wagner

REBECCA D. WAGNER
Deputy Attorney General
Attorneys for Complainant

SF2019200859
John Ray Schafer, M.D. Stipulated Settlement and Disciplinary Order

Exhibit A

Second Amended Accusation No. 800-2017-035916

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
REBECCA D. WAGNER
Deputy Attorney General
State Bar No. 165468
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3760
Facsimile: (415) 703-5480
E-mail: Rebecca.Wagner@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **John Ray Schafer, M.D.** **353 Patten Street** **Sonoma, CA 95476-6741** **Physician's and Surgeon's Certificate No. G 6244,** Respondent.	Case No. 800-2017-035916 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 19, 1960, the Medical Board issued Physician's and Surgeon's Certificate Number G 6244 to John Ray Schafer, 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 April 30, 2021, unless renewed.

JURISDICTION

3. This Second Amended 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 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . ."

5. 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."

6. 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.

". . ."

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

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022[1] without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

". . ."

8. 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."

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.

". . ."

10. Section 2241(b) of the Code states that "[n]othing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose."

11. Section 2238 of the Code states that "[a] violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

12. California Health and Safety Code section 11156, states:

[1] Dangerous drug means any drug unsafe for self-use in humans or animals including drugs that require a prescription to be lawfully dispensed.

"(a) Except as provided in Section 2241 of the Business and Professions Code, no person shall prescribe for, or administer, or dispense a controlled substance to, an addict, or to any person representing himself or herself as such. . ."

13. Section 726(a) of the Code states that the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this or under any initiative act referred to in this division.

14. Section 729(a) of the Code states that any physician and surgeon. . .who engages in an act of . . . sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts. . .is guilty of sexual exploitation by a physician and surgeon . . .Section 729(c) of the Code defines "sexual contact" to include the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse. Section 729(c)(4) of the Code adopts the definitions of "touching" and "intimate part" as defined in Penal Code section 243.4. An "intimate part" is defined in Penal Code section 243.4 to include a female's breast or anyone's anus, groin, sexual organ or buttocks and "touching" is defined to include directly or through clothing.

15. Section 2228.1 of the Code requires a licensee to provide a separate disclosure to his patients of his probation status, length of probation, probation end date, all practice restrictions, the Board's telephone number, and an explanation of how to find further information related to the probation in any case where the final adjudication by the Board established any act of sexual abuse or misconduct pursuant to sections 726 and 729 of the Code or inappropriate prescribing resulting in patient harm with a probationary period of five years or more.

FACTUAL ALLEGATIONS

16. At all times relevant to this matter, Respondent was licensed and practicing medicine as a family practitioner at Sonoma Family Practice in Sonoma, California.

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PATIENT A

17. Respondent treated Patient A[2] for a variety of ailments including hypertension, arthritis, dietary issues, chest pain, and chronic-obstructive pulmonary disease beginning, based on medical records provided, according to chart notes, on August 3, 2012 and ending on January 9, 2013, for a total of six (6) visits. A CURES[3] report states that Respondent began prescribing controlled substances to Patient A as early as August 30, 2011.[4]

18. On August 3, 2012, Patient A presented to Respondent and requested medication refills of alprazolam[5] for anxiety and depression (which Patient A requested as a replacement for diazepam[6]). Patient A also requested methadone[7] to try to get off and/or take less of Norco[8]. Respondent prescribed alprazolam (2 milligrams four times daily/CURES report shows 60 tablets) and methadone (10 milligrams twice daily/CURES report shows 124) for the diagnosis of arthritis. Respondent did not include any record of review of systems, physical exam or a complete and adequate history of the patient's present illness. Respondent explained in his subject interview that he prescribed Norco (10 mg, up to 10 tablets a day, up to 240 tablets every 30 days) to Patient A based on a previous doctor's note indicating Patient A needed that amount

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[2] The first patient in this document is designated as Patient A to protect his privacy. The second patient is designated as Patient B to protect her privacy. Respondent knows the names of the patients and can confirm Patient A and Patient B's identity through discovery.

[3] CURES is the Controlled Substance Utilization Review and Evaluation System, a prescription drug monitoring database.

[4] Patient A's records indicate a Health History form was completed on August 30, 2011 but there are no chart notes related to that date indicating that a physical exam occurred, however, the medical records request was only for February 16, 2012 to February 16, 2013 so additional medical records may exist that were not provided.

[5] Alprazolam (trade name Xanax) is a benzodiazepine. It is a psychotropic drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[6] 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.

[7] Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance. Methadone exhibits a non-linear relationship due to the long half-life and accumulates with chronic dosing.

[8] Norco is a trade name for hydrocodone bitartrate with APAP (hydrocodone with acetaminophen) tablet. Norco 10/325 reflects that each pill contains 10 mg of hydrocodone bitartrate and 325 mg of acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled substance.

of Norco to remain working because of a motor vehicle accident from eleven years prior. Respondent also stated that he had prescribed diazepam for chronic anxiety. Respondent did not document his rationale in his medical record, and was unable to locate a copy of the letter from the previous doctor.

19. On August 17, 2012, Patient A filled a prescription written by Respondent for Norco 10/325 for 240 tablets. Then, less than two weeks later, on August 30, 2012, Patient A filled another prescription written by Respondent for Norco for 240 tablets.

20. Patient A was next seen by Respondent on September 7, 2012 for prescription refills and for a reported hospitalization for a lung infection. Respondent documented no review of systems or physical exam. Respondent prescribed methadone for arthritis and ordered a CURES report for the dates of September 8, 2011 to August 31, 2012, which showed additional prescriptions from other providers. Respondent stated in his subject interview that he reviewed the CURES report and counseled Patient A to cease getting controlled substances from other providers, and that Patient A agreed.

21. On September 17, 2012, Patient A filled a prescription for Norco 10/325 for 240 tablets which was prescribed by Respondent. On September 29, 2012, Patient A filled another prescription for Norco 10/325, 240 tablets also prescribed by Respondent.

22. Respondent treated Patient A next on October 5, 2012 for test results and noted a swollen and painful left hand but no physical examination was conducted or documented. Respondent diagnosed Patient A with arthritis and prescribed Norco 10/325 with 2 tablets every 4 hours. Patient A refilled the Norco prescription written by Respondent on October 6, 2012 and on October 17, 2012, Patient A again refilled the Norco prescription.

23. On October 24, 2012, Patient A was treated by Respondent and reported he was in a motorcycle accident on October 22, 2012 with a complaint of pain to his left hip, right hand, and face. Patient A reported he was carrying groceries on his handlebars and crashed into a tree. Respondent conducted no review of systems, no physical exam, and documented no treatment plan.

24. On October 26, 2012 and November 8, 2012, Patient A refilled the same Norco prescriptions written by Respondent. On November 16, 2012, Patient A reported to Respondent that he had pain on his right pinky for two months and wanted to go back on methadone. Again, Respondent failed to conduct or document a review of systems or physical exam. Respondent diagnosed arthritis and hypertension and prescribed methadone (10 milligrams/120 tablets/1 – 2 daily). On that same date, November 16, 2012, Patient A filled his diazepam (120 quantity), Norco (240 quantity) and methadone (120 quantity) prescriptions written by Respondent.

25. On November 20, 2012, Patient A again obtained more diazepam (60 tablets), and an additional 60 tablets of diazepam three days later on November 23, 2012 from prescriptions written by Respondent.

26. On January 9, 2013, Patient A was last seen by Respondent for medication refills. Again, there was no review of systems conducted or documented, however, Respondent did conduct a physical exam and noted that Patient A had some wheeze and rales and diagnosed him with chronic-obstructive pulmonary disease and bronchitis and prescribed Norco.

27. Between November 25, 2012 and January 9, 2013, Patient A refilled Respondent's Norco 10/325 prescription as follows: 11/25/2012 (240 tablets); 11/29/2012 (240 tablets); 12/13/2012 (240 tablets); 12/23/2012 (240 tablets); 12/29/2012 (240 tablets); 1/10/2012 (240 tablets); 1/21/2013 (240 tablets); 2/4/2013 (240 tablets); and 2/25/2013 (240 tablets). On January 23, 2013, Patient A filled his methadone prescription (120 tablets of 10 milligrams each).

28. On February 16, 2013, Patient A was found unresponsive in a motel room and was pronounced dead. The cause of death was determined to be hydrocodone intoxication. The Coroner's report stated that Patient A had a hydrocodone level of .32 milligrams/liter in his blood (with a potentially toxic range of 0.1 milligrams/liter). Benzodiazepines were also detected.

29. In summary, between August 3, 2012 and January 9, 2013, Respondent prescribed 3,310 morphine tablets (200 milligrams each); 5,132 hydrocodone tablets (10 milligrams each); 90 tablets of OxyContin[9] (80 milligrams each); 1,110 tablets of alprazolam (1 milligram each);

[9] OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II controlled substance. It is a more potent pain reliever than morphine or hydrocodone.

2,520 tablets of alprazolam (.5 milligrams each); 90 tablets of alprazolam (.25 milligrams each); 90 tablets of diazepam (5 milligrams each); and 120 tablets of lorazepam[10] (.5 milligrams each). Respondent's doses varied from 420 to 620 morphine equivalent doses (MEDs).[11]

30. Between July 9, 2012 and August 30, 2012, Patient A received from Respondent 960 tablets of Norco and 124 tablets of methadone with an average of 252 MEDs per day. Then, between August 31, 2012 to November 23, 2012, Respondent prescribed 1800 tablets of Norco for an average of 560 MEDs, including, at times, 9100 milligrams daily of Tylenol (with a maximum daily recommended dose not to exceed 4000 milligrams); and 470 tablets of diazepam (10 milligrams). Between November 25, 2012 and February 25, 2013, Respondent prescribed 2,160 tablets of Norco and 120 tablets of methadone for an average of 293 MEDs per day. In one four-week period, Patient A received four prescriptions of 240 tablets each for a total of 960 tablets in 30 days (an average of 320 MEDs); 10,400 milligrams of Tylenol per day; and 530 tablets of diazepam. During this same time period, guidelines for opiate therapy in patients without cancer stated that over 200 milligrams per day would be considered a high dose.[12]

31. Patient A's CURES report details that Patient A utilized up to six different pharmacies, had up to four other providers of care in addition to Respondent, and was concurrently prescribed Norco, diazepam and methadone from July 9, 2012 to August 30, 2012.

32. Respondent reported during his subject interview that Patient A suffered from withdrawal symptoms when he lowered his dose of Norco. Respondent only ran Patient A's CURES report one time during his treatment. Respondent admitted that he was aware other doctors were prescribing controlled substances to Patient A concurrently, at times. Respondent admitted also that he did not complete any drug screens of Patient A.

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[10] Lorazepam (trade name Ativan) is a benzodiazepine. It is a sedative used to treat anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[11] Morphine equivalent doses (MEDs) 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 milligrams of oxycodone is equivalent to 150 MEDs.

[12] Huntzinger, Amber: *American Academy of Family Physicians* (Dec 1 2009); 80 (11) 1315-1318.

PATIENT B

33. Respondent treated Patient B for over fifteen years for muscle pain, osteoarthritis, fibromyalgia[13], post-polio syndrome[14], chronic pain, depression, and anxiety. During the course of her treatment, Respondent prescribed several controlled substances to attempt to control Patient B's pain and anxiety including, but not limited to: hydrocodone bitartrate acetaminophen (also known by the trade name Norco)[15]; diazepam[16]; methadone[17]; and alprazolam[18] Ultimately, Patient B became addicted to her medications and exhibited many concerning signs, symptoms and risk factors for abuse, misuse and diversion including: use of illicit drugs; obvious impairment; abusive or assaultive behaviors; change in mental status; demonstrating loss of appropriate motor functions including falls, car accidents, and dizziness; requests for early refills; reporting medications lost or stolen; and using inappropriate amounts of medications.

34. On September 15, 2014, Patient B reported negative side effects from methadone to Respondent including stomach pain and feeling sluggish. Despite these negative side effects, Respondent continued to prescribe methadone to Patient B approximately nineteen (19) additional times during the course of his treatment of her.

35. Patient B, on multiple occasions, reported that she had taken more than her prescribed dosage of pain pills including, but not limited to the following dates: 8/8/2012; 8/10/2012; and 8/30/2016 (admits she takes "too many" diazepam). Despite this fact, of note, Respondent wrote a letter on August 19, 2016 to the court per Patient B's request that stated she used her medication "occasionally" which is inaccurate based on Respondent's medical records which show Patient B is prescribed daily narcotics and benzodiazepines.

36. Patient B repeatedly requested early refills, or higher doses, of her medications: 3/12/2013 (medication lost in luggage: Norco and diazepam); 11/9/2013 (Norco); 3/20/2017

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[13] Fibromyalgia is a medical condition characterized by chronic widespread pain, a heightened pain response to pressure, and tiredness.

[14] Post-polio syndrome is a viral infection of the nervous system which typically occurs some years after the initial polio attack and symptoms can include decreasing muscular function and acute weakness with pain and fatigue.

[15] See Footnote 8 for additional details.

[16] See Footnote 6 for additional details.

[17] See Footnote 7 for additional details.

[18] See Footnote 5 for additional details.

(higher dose of diazepam); 6/23/2016; 7/8/2016; 9/28/2016 (claims her brother stole her diazepam); 10/25/2016 (diazepam stolen again); 1/17/2017 (early refill of hydrocodone); tells emergency room (ER) out of Norco (6/19/2017); stolen medication after car accident (7/28/2017); and ran out of medications and needs refills (1/9/2018).

37. Patient B reported, or other medical professionals reported, many concerning symptoms to Respondent possibly related to her prescriptions for controlled substances including: vertigo (8/5/2013); confusion (3/25/2016); headache and changed vision (3/20/2016); tripped over cat (8/1/2016); history of recurring falls, lethargy and slow and halting speech (8/2/2016); fractured her toe when she stubbed it (10/6/2016); trip and fall injury to right flank (1/7/2017); ER visit for a fall (3/13/2017); car accident reported to ER (6/30/2017); reports multiple car accidents over a month to ER and cannot be prescribed narcotics because she is over-sedated already and drowsy (7/4/2017); again to ER claiming car accident two weeks prior but patient very sedated and over-medicated (8/2/2017); Patient B went to ER hysterically reporting her brother assaulted her and reported using five or more Percocet per day and possibly heroin (8/16/2017); and having slurred speech (12/13/2017).

38. Respondent was advised by the emergency room on multiple occasions of Patient B refusing treatment for her injuries unless she is given more pain medications: 6/15/2016 (demands schedule IV opioids for chest pain) and on 8/1/2016 (demands Demerol[19]).

39. On January 25, 2017, Respondent writes a letter to the Department of Motor Vehicles (DMV) advising that Patient B occasionally takes more diazepam than recommended, and as early as February 7, 2018, the medical records show that Patient B also drinks alcohol occasionally. Despite this, Respondent failed to document that he counseled Patient B on the effects of alcohol in combination with narcotics and barbituates.

40. Patient B's medical records document that she was arrested in early August, 2017 by the Petaluma Police Department for repeatedly calling 911 (approximately 40 times). On

[19] Demerol is the brand name for Meperidine and is a narcotic used to treat moderate to severe pain with a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol.

August 16, 2017 at an ER visit, Patient B states her boyfriend shot her up with heroin which was corroborated by her father's housekeeper.

41. Respondent prescribed high dosages of opioids to Patient B. From December 26, 2013 to February 24, 2014, Patient B was prescribed on average 310 MEDs[20] per day. Starting in 2014, greater than 90 MEDs a day is considered high dosing. Respondent prescribed the following average MEDs doses to Patient B:

a. February 25, 2014 to July 29, 2014: 116 MEDs per day.

b. August 13, 2014 to December 2, 2014: 187 MEDs per day.

c. December 4, 2014 to April 21, 2015: 144 MEDs per day.

d. April 21, 2015 to August 11, 2015: 127 MEDs per day.

e. September 4, 2015 to February 5, 2016: 240 MEDs per day.

f. February 5, 2016 to July 13, 2016: 155 MEDs per day.

g. August 11, 2016 to February 17, 2017: 122 MEDs per day.

h. March 14, 2017 to October 14, 2017: 91 MEDs per day.

i. October 31, 2017 to June 13, 2018: 98 MEDs per day.

42. Respondent also prescribed high-risk combinations of medications. Throughout his treatment of Patient B, Respondent prescribed long and short acting narcotics along with benzodiazepines which, when taken together, are a high risk for respiratory depression. As an example, Respondent prescribed 900 tablets of diazepam 10 milligram dose between October 31, 2017 and June 13, 2018 when the patient was also being prescribed high dosages of narcotics. As another example, Patient B was prescribed 210 tablets of benzodiazepines during a 10-day period from March 20, 2017 to March 30, 2017. In addition, Patient B appeared to be using illicit drugs and alcohol during these same periods of time which placed her at an even greater risk of overdose and death.

43. Respondent alleges that on June 11, 2018, Patient B was discharged from his practice.

44. On July 19, 2018, Patient B filed a complaint with the Board stating that between January 2018 and June 2018, Respondent "fondled" Patient B's breasts "a few times" while he

[20] See Footnote 11 for additional details.

was examining her. Patient B described his behavior as "subtle but obvious" that he was crossing boundaries but because she was addicted to the medications he was prescribing her, she did not report the behavior or protest because she was "too afraid to speak up because of her dependency." Patient B said she "fired" Respondent eventually and never returned. Respondent, during his subject interview with the Board, said he would rather "fondle a porcupine" than fondle Patient B.

PATIENT C

45. On November 30, 2017, Patient C was seen by Respondent, who was covering for her regular physician, for an allergy shot. Patient C was seated on a chair with her back to the wall. Respondent sat in another chair and pulled it "very close" to Patient C on her right side. Respondent took Patient C's blood pressure in such a way that if she relaxed her hand it would have fallen into Respondent's lap. Patient C tensed up and Respondent told her to relax and guided her hand with his hand "toward his crotch." Respondent proceeded to take Patient C's blood pressure, and positioned her hand in a manner such that it hovered over his lap. Respondent and Patient C discussed that she did not get flu shots and Respondent told her to be careful not to have "wet kisses" with anyone.

46. Respondent then used his stethoscope on her back to listen to Patient C's lungs. At Respondent's instruction, Patient C started to pull up her shirt. When the shirt did not immediately come untucked, Respondent put his hand beside her hand and lifted the shirt for her, which made Patient C uncomfortable. Respondent put the stethoscope under Patient C's shirt and listened to her breathing.

47. Respondent then moved to the front of Patient C's upper body, with his hand under her shirt, and placed the stethoscope on the left side of her chest, with his fingers touching her breast. Patient C was wearing a sports bra. During his purported examination, Respondent moved the stethoscope around her chest with his fingers going in and out of her bra.

48. Respondent next prepared to administer an allergy shot. Patient C asked Respondent for her shot in her left arm. Respondent instead again sat down near her and assisted in pulling down the patient's pants, then administered an allergy shot in her gluteus maximus.

49. As Patient C attempted to leave the room, Respondent blocked the door with his body and said that it was now "time for your hug." Patient C felt awkward and uncomfortable, and in order to get Respondent to move so she could leave, accepted his hug and left the office.

50. Patient C filed a complaint with the Board on December 3, 2017, and on December 6, 2017 filed a police report with the Sonoma County Sheriff's Office.

51. Respondent acknowledged in his subject interview that he does give hugs to old patients although he was surprised to hear he hugged Patient C as he did not know her. Respondent further stated that he thought Patient C was too shy to make a complaint.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Incompetence/Improper Prescribing/Excessive Prescribing/Prescribing to an Addict/Prescribing for Non-Medical Purpose – Patient A)

52. Respondent John Ray Schafer, M.D. is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence) and/or 2242 (improper prescribing) and/or 725 (excessive prescribing) and/or 2241, subdivision (b) (prescribing for a non-medical purpose) and/or 2238 of the Code and/or 11156 of the Health and Safety Code (prescribing to an addict) in that Respondent has committed gross negligence and/or exhibited incompetence and/or excessively prescribed controlled substances and/or prescribed to an addict and/or prescribed for non-medical purposes as described above in Paragraphs 17 through 32, including, but not limited to, the following:

A. Respondent failed to establish a diagnosis or medical necessity for chronic opioid use for Patient A for non-cancer treatment of pain given the potential risks of long-term use of opioids.

B. Respondent failed to conduct and document sufficient clinical evaluation of Patient A or order appropriate testing. Respondent failed to review past medical records, failed to conduct detailed questioning of Patient A, failed to obtain imaging diagnostic tests including, but not limited to, magnetic imaging resonance testing (MRI), failed to obtain specific tests including laboratory tests, failed to document clinical or imaging testing, failed to consider appropriate

therapies for Patient A's report of musculoskeletal pain including, but not limited to, screening tools such as pain intensity and interference or the Sheehan Disability Scale.

C. Respondent failed to undertake or document risk assessment for continued prescribing of long-term use of controlled substances, including use of screening and monitoring tools. Respondent failed to classify Patient A's risks using risk stratification analysis of benefits versus risks to evaluate the potential for opioid abuse and the risk of adverse effects. Respondent failed to evaluate the potential risks of mixed narcotics including Norco and methadone, and the risks of combining opiates (Norco) with other respiratory depressants such as benzodiazepines (alprazolam and diazepam).

D. Respondent failed to develop a treatment plan and objectives for Patient A including, for example, improvement in pain and function, improvement in pain associated symptoms such as sleep disturbance and depression/anxiety, and avoidance of excessive use of medication. Patient A did not demonstrate any improvement while under Respondent's care, in fact, he continued to have anxiety and Respondent escalated the narcotic doses without any explanation for the change to the treatment plan. Respondent failed to specify measurable goals and objectives, failed to identify an exit strategy for discontinuing narcotic therapy including tapering or termination. Respondent repeatedly prescribed in escalated doses without any stated treatment objective or patient need, including dose recommendations above the daily recommended dosage with no clinical evidence of a change in condition requiring such excessively high doses.

E. Respondent failed to discuss and/or document that he discussed, the risks and benefits of long-term opioid use, combined narcotic use, and combined narcotic and benzodiazepine use with Patient A. Respondent failed to discuss and/or document that he discussed the risk of potential side effects including impaired motor skills with a concern for activities such as driving, and the risks of misuse, dependence, addiction and overdose. Respondent did not discuss and/or failed to document that he discussed, the limited evidence of benefits of long-term opioid therapy.

F. Respondent failed to ensure appropriate compliance monitoring with tools such as drug testing and/or conducting pill counting. Respondent failed to take appropriate action when a

CURES report revealed that Patient A obtained drugs from multiple providers and multiple pharmacies.

G. Respondent failed to meaningfully reassess Patient A periodically including whether there was progress toward functional goals, whether there were side effects, progress in pain status, and a lack of evidence of patient misuse, abuse or diversion. Respondent failed to base care on outcomes such as making progress toward functional goals or the presence and nature of side effects or pain status. Instead, despite warning signs for long-term narcotic and benzodiazepine use, Respondent continued prescribing high-dose narcotics, mixed narcotics, and mixed narcotic and benzodiazepine treatment. Respondent failed to reassess treatment of Patient A despite evidence of increased risk of abuse, misuse and diversion including usage of multiple providers and multiple pharmacies.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Records – Patient A)

53. Respondent John Ray Schafer, M.D. is subject to disciplinary action under section 2266 of the Code (inadequate and/or inaccurate medical records) in that Respondent failed to maintain adequate and accurate medical records, as described above in Paragraphs 17 through 32, including but not limited to:

A. Respondent failed to document a clear and detailed history of present illness for the various complaints made by Patient A.

B. Respondent failed to document a review of systems and largely failed to note any physical exam findings.

C. Respondent failed to document a treatment plan, including rationale for diagnosis, or discussion of with Patient A related to the medications chosen or discontinued including risks, benefits and side effects.

D. Respondent failed to maintain clear, detailed, and accurate written records for the planning and maintaining quality of patient care.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Sexual Misconduct/Sexual Exploitation – Patient B)

54. Respondent is subject to disciplinary action under Sections 2234(a) and (b) for unprofessional conduct and/or gross negligence and/or Section 726(a) and/or 729(a) and (c) of the Code in that he engaged in sexual misconduct and exploitation of Patient B as outlined in Paragraph 44, above. By repeatedly fondling Patient B's breasts, while also prescribing her high doses of narcotics and benzodiazepines to which Patient B was addicted, as outlined in Paragraphs 33 through 44 above, Respondent exploited Patient B physically, violated professional boundaries, and betrayed her trust. Respondent's conduct as described above, constitutes unprofessional conduct and/or gross negligence, and is cause for discipline pursuant to Sections 2234(a) and/or (b) and/or 726(a) and/or 729(a) of the Code.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Incompetence/Improper Prescribing/Excessive Prescribing/Prescribing to an Addict/ Prescribing for a Non-Medical Purpose/Failure to Maintain Adequate Records – Patient B)

55. Respondent is subject to disciplinary action under Section 2234, subdivisions (b) (gross negligence) and (d) (incompetence) and/or 2242 (improper prescribing) and/or 725 (excessive prescribing) and/or 2241, subdivision (b) (prescribing for non-medical purpose) and/or 2238 of the Code and 11156 of the Health and Safety Code (prescribing to an addict) and/or 2266 (inadequate medical records), as outlined in Paragraphs 33 through 44, above, in that:

A. Respondent prescribed long-term narcotic therapy for post-polio syndrome, fibromyalgia and chronic pain yet he never independently established these diagnoses, nor did he review Patient B's prior records to verify these diagnoses. Respondent also failed to establish the

medical necessity of prescribing long-term use of opioids for chronic, non-cancer pain, and failed to use screening tools or other non-opioid treatment options.

B. Respondent failed to undertake a risk assessment for prescribing long-term controlled substances for chronic, non-cancer pain utilizing risk stratification tools, and he failed to fully evaluate potential risks of combined opiate therapy (Norco and methadone) or combinations with other respiratory depressants such as benzodiazepines (diazepam and alprazolam).

C. Respondent failed to develop a comprehensive treatment plan for Patient B including treatment goals and an exit strategy, should the risks of long-term use of opioids for chronic, non-cancer pain outweigh the benefits. Respondent failed to specify measurable goals and objectives to evaluate treatment progress or developing an exit strategy to include tapering or termination of opioid therapy if it became necessary.

D. Respondent failed to document and/or discuss the potential risks of long-term opioid use, combined opioid use and combined narcotic and benzodiazepine use with Patient B. In addition, Respondent failed to document and/or discuss the potential side effects of Patient B's prescriptions including the risk of impaired motor skills necessary for driving, the risk of misuse, dependence, addiction and overdose. Respondent failed to document and/or discuss safe ways to store medications to avoid theft. Respondent failed to document and/or discuss the benefits of long-term opioid therapy versus the risks of use and misuse of prescription and illicit drugs.

E. Respondent failed to ensure and/or document appropriate compliance monitoring such as drug testing, review of CURES reports and/or conducting pill counting. Respondent failed to address Patient B's illicit drug use or her drug-seeking behaviors such as obtaining early refills.

F. Respondent failed to document and/or review evidence of Patient B's progress toward treatment objectives such as pain improvement documentation, improvement in function, side

effect discussions, or medication abuse. Respondent failed to consider numerous signs and symptoms for abuse of controlled substances by Patient B.

G. Respondent failed to place and/or document placing Patient B on a long-term (greater than 90 days) use of controlled substances contract.

H. Respondent repeatedly violated the standard of care for a primary care provider by: failing to conduct and/or document additional testing and studies including electromyography, nerve conduction studies, and muscle biopsy; failing to review and/or document proper magnetic resonance imaging (MRI) or computed tomography (CT) scans; failure to document and/or refer Patient B to a neurologist or other proper specialist; and failure to have a treatment plan for post-polio management plans such as: energy conservation, use of assisted devices, physical therapy, speech therapy, and common pain relievers; improperly prescribing methadone for low back pain and improperly prescribing hydrocodone for fibromyalgia.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Sexual Misconduct/Sexual Exploitation – Patient C)

56. Respondent is subject to disciplinary action under Sections 2234, 2234(a), (b) and (c) for unprofessional conduct and/or gross negligence and/or repeated negligent acts and/or Section 726(a) (sexual misconduct) and/or 729(a) and (c) (sexual exploitation) of the Code related to his treatment of Patient C as outlined in Paragraphs 45 - 51, above, including but not limited to:

A. Respondent had contact with the intimate parts of the female body without medical indication or necessity by going up the front Patient C's shirt and moving his hand and stethoscope up her body to her left breast area and under her sports bra making unnecessary contact with Patient C's breasts.

B. Respondent blocked the door and hugged Patient C in a clinical exam setting in a manner which caused Patient C social discomfort. Respondent had no prior relationship with Patient C and made her uncomfortable and caused her to hug him in order to be able to leave the room.

C. Respondent conducted a lung exam with the patient in clothing instead of a gown and failed to describe a procedural touch when he untucked Patient C's shirt and put the stethoscope on her back, and then on the front of her body. Respondent further created an uncomfortable and unprofessional atmosphere by assisting the patient in raising her shirt, lowering her pants, and hugging her.

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 6244, issued to John Ray Schafer, M.D.;

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

3. Ordering John Ray Schafer, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering John Ray Schafer, M.D. if placed on probation for sexual misconduct or exploitation, or overprescribing with a finding of patient harm and five years of probation, to notify his patients pursuant to 2228.1 of the Code; and

5. Taking such other and further action as deemed necessary and proper.

DATED: AUG 0 4 2020

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

SF2019200859
Schafer.john.second.amended.accusation