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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>Peter Dan Sliskovich, M.D.<br><br>Physician's and Surgeon's Certificate No. G 42414<br><br>Respondent. | Case No. 800-2018-048547 |

## DECISION

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

This Decision shall become effective at 5:00 p.m. on January 3, 2022.

IT IS SO ORDERED December 28, 2021.

MEDICAL BOARD OF CALIFORNIA

for William Prasifka,
Executive Director

Reji Varghese
Deputy Director

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
BRIAN D. BILL
Deputy Attorney General
State Bar No. 239146
California Department of Justice
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Facsimile: (916) 731-2117
*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>PETER DAN SLISKOVICH, M.D.<br><br>1366 W. 7th Street<br>San Pedro, CA 90732-3500<br><br>Physician's and Surgeon's Certificate G 42414,<br><br>Respondent. | Case No. 800-2018-048547<br><br>**STIPULATED SURRENDER OF LICENSE AND ORDER** |

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

## PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Brian D. Bill, Deputy Attorney General.

2. Peter Dan Sliskovich, M.D., (Respondent) is represented in this proceeding by attorney Raymond J. McMahon of Doyle, Shafer, McMahon, L.L.P., whose address is: 5440 Trabuco Road Irvine, California 92620.

3. On July 2, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42414

to Respondent. Said license has been in effect at all times relevant to this proceeding.

## JURISDICTION

4. Accusation No. 800-2018-048547 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 17, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-048547 is attached as Exhibit A and is incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-048547. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

## CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2018-048547, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

charges.

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

## RESERVATION

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

## CONTINGENCY

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

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

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

## ORDER

**IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. G 42414, issued to Respondent Peter Dan Sliskovich, M.D., is surrendered and that surrender is accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2018-048547 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

## ACCEPTANCE

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

DATED: 10/5/21

PETER DAN SLISKOVICH, M.D.
*Respondent*

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

DATED: November 2, 2021

RAYMOND J. McMAHON
*Attorney for Respondent*

**ENDORSEMENT**

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

BRIAN D. BILL
Deputy Attorney General
*Attorneys for Complainant*

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

DATED: _____

RAYMOND J. McMAHON
*Attorney for Respondent*

**ENDORSEMENT**

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

DATED: November 2, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Brian D. Bill

BRIAN D. BILL
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 800-2018-048547**

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ROBERT MCKIM BELL
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**BEFORE THE**
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| In the Matter of the Accusation Against:<br><br>PETER DAN SLISKOVICH, M.D.<br><br>1366 7th Street<br>San Pedro, California 90732-3500<br><br>Physician's and Surgeon's Certificate G 42414,<br><br>Respondent. | Case No. 800-2018-048547<br><br>**ACCUSATION** |

## PARTIES

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

2. On July 2, 1980, the Board issued Physician's and Surgeon's Certificate Number G 42414 to Peter Dan Sliskovich, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

## JURISDICTION

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

4. Section 2001.1 of the Code states:

Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

5. 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.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the Board's jurisdiction.

(i) Administering the Board's continuing medical education program.

6. 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.

7. Section 2228 of the Code states:

The authority of the Board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the Board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the Board. If an examination is ordered, the Board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

8. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the Board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the Board, the Board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the Board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the Board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

...

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the Board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the Board.

(e) Section 2314 shall not apply to this section.

## STATUTORY PROVISIONS

9. 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.

...

(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.

...

10. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

11. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

12. 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.

13. California Health and Safety Code, section 106965 states:

(a) It shall be unlawful for any person to administer or use diagnostic or therapeutic X-ray on human beings in this state after July 1, 1971, unless that person has been certified or granted a permit pursuant to subdivision (b) or (c) of Section 114870 or pursuant to Section 114885, is acting within the scope of that certification or permit, and is acting under the supervision of a licentiate of the healing arts.

...

14. California Health and Safety Code section 106970 states:

It shall be unlawful for any person to direct, order, assist, or abet a violation of Section 106965.

15. California Health and Safety Code, section 114850 states:

As used in this chapter:

...

(c) "Radiologic technology" means the application of X-rays on human beings for diagnostic or therapeutic purposes.

(d) "Radiologic technologist" means any person, other than a licentiate of the healing arts, making application of X-rays to human beings for diagnostic or therapeutic purposes pursuant to subdivision (b) of Section 114870.

...

(g) "Supervision" means responsibility for, and control of, quality, radiation safety, and technical aspects of all X-ray examinations and procedures.

(h)

(1) "Licentiate of the healing arts" means a person licensed under the provisions of the Medical Practice Act, the provisions of the initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation thereof, and repealing all acts and parts of acts inconsistent herewith," approved by electors November 7, 1922, as amended, or the Osteopathic Act.

(2) For purposes of Section 114872, a licentiate of the healing arts means a person licensed under the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code) who practices under the supervision of a qualified physician and surgeon pursuant to the act and pursuant to Division 13.8 of Title 16 of the California Code of Regulations.

(i) "Certified supervisor or operator" means a licentiate of the healing arts who has been certified under subdivision (e) of Section 114870 or 107111 to supervise the operation of X-ray machines or to operate X-ray machines, or both.

...

**REGULATORY PROVISIONS**

16. California Code of Regulations, title 17, section 30100 states:

...

(z) "User" means any person who is licensed to possess radioactive material or

who has registered as possessing a reportable source of radiation pursuant to groups 1.5 and 2 of this subchapter, or who otherwise possesses a source of radiation which is subject to such licensure or registration.

...

17. California Code of Regulations, title 17, section 30305 states:

...

(b) Use.

(1) The user shall assure that all X-ray equipment under his jurisdiction is operated only by persons adequately instructed in safe operating procedures and competent in safe use of the equipment.

...

(e) The user shall publically display at each installation where an individual performs, or supervises the performance of, radiologic technology, as defined in section 30400, either:

(1) A copy of each of the individual's applicable current and valid certificate or permit issued pursuant to subchapter 4.5 (commencing at section 30400) of this chapter; or

(2) A list of all such persons containing:

(A) For each individual, the individual's name, the applicable certificate or permit number, and the expiration date as indicated on the Department issued document. This information shall be in a font size no less than 12 points; and

(B) The statement "A copy of the individual's certificate or permit is available for viewing upon request." in a font size no less than 14 points.

(f) If a user elects to post the list specified in subsection (e)(2), the user shall maintain the certificate or permit or a copy thereof for all individuals identified on the list.

18. California Code of Regulations, title 17, section 30306 states:

(a) The definitions in section 30100 shall apply to this article.

(b) As used in this article:

...

(7) Direct supervision" means that the supervising individual is physically present and available within the facility during the performance of tasks by the supervised individual.

...

(11) Personal supervision" means that the supervising individual is physically

present to observe, and correct, as needed, the performance of the individual performing the activities.

...

(18) Supervision" means responsibility for, and control of the quality, radiation safety, and technical aspects of activities being supervised, and being available to the supervised individual.

**DEFINITIONS**

19. Controlled Substance – A controlled substance is a drug which has been declared by federal or state law to be illegal for sale or use, but may be dispensed under a physician's prescription. The basis for control and regulation is the danger of addiction, abuse, physical or mental harm, and death. Controlled substances include:

a. Opioids: Drugs generally prescribed for moderate to severe pain that have a high potential for abuse, dependence, and addiction. The dangers of using such drugs include, but are not limited to, drug abuse, psychic dependence, immunosuppression, hormonal changes, central nervous system depression, and death. Norco is an opioid.

b. Benzodiazepines: Drugs generally prescribed to treat anxiety. Benzodiazepines are habit-forming and have significant addiction potential when improperly prescribed and/or used over prolonged periods. Adverse side effects include drowsiness, dizziness, increased saliva, mood changes, hallucinations, thoughts of suicide, slurred speech, loss of coordination, difficulty walking, coma, respiratory failure, and death. Benzodiazepines include Xanax and Valium.

**FACTUAL ALLEGATIONS**

**Patient No. 1**

20. Respondent treated Patient No. 1[1] (also the "Patient") from approximately 1991 through January 2018.[2] The entire medical record for those 27 years provided by Respondent consisted of 89 pages.

21. The first available medical record is a preprinted physical examination form, dated

[1] Patients are identified by numbers to protect their privacy.

[2] These are approximate dates based on the records available for review. Patient No. 1 may have treated with Respondent before or after these dates.

April 12, 2003. The exam was documented as "normal," signified by a vertical line drawn next to the examination list. The record lacked any substantive medical information regarding Patient No. 1. The chart contained three additional preprinted physical exam forms that were completed in a similar manner.

22. The next record in the chart is, presumably, an office visit note dated May 16, 2011. The record contains only the appointment time, a blank vital signs section, and the handwritten notation, "R/S." The record lacked any substantive medical information regarding Patient No. 1.

23. Between May 16, 2011, and December 13, 2017, Respondent treated Patient No. 1 regularly. Treatment records created during this period generally lacked substantive medical information, were illegible, and often failed to document a diagnosis and/or the medications prescribed. During an interview with the Board, Respondent admitted that he could not read portions of the medical record.

24. According to a Controlled Substance Utilization Review and Evaluation System (CURES)[3] report for the period April 24, 2014, through December 13, 2017, Respondent prescribed the following controlled substances:

a. 4010 Norco 325-10 mg tablets, 450 Norco 325-7.5 mg tablets, and 120 Norco 325-5 mg tablets;[4]

b. Xanax (1,620 tablets); and

c. Valium (510 tablets, 410 of which were prescribed in a 7-month period).

25. During the treatment period, Respondent:

a. Prescribed Norco without documenting a clear medical diagnosis[5] and without

[3] CURES 2.0 (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

[4] Norco is a combination of acetaminophen and an opioid. The quantity of each medication is noted in the dose. By way of example, the dose 325-10 mg denotes 10 mg of opioid and 325 mg of acetaminophen per pill.

[5] A clear medical diagnosis is determined by obtaining objective evidence, which includes, but is not limited to: obtaining and documenting a complete medical history, which includes information regarding the beginning of the condition, location and duration of the condition, exacerbating or palliative triggers, lifestyle habits, the efficacy of prior treatments, and history of substance abuse; obtaining and reviewing prior medical records and imaging studies; performing and documenting robust physical examinations, particularly of the affected part of the patient's body; and

proper medical indication.[6]

b. Prescribed Xanax and Valium for anxiety, without documenting a clear diagnosis and without proper medical indication.

c. Failed to properly monitor[7] Patient No. 1's controlled substance use.

d. Failed to recognize the indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion.[8]

e. Failed to employ screening tools, such as pain intensity/interference scale.

f. Failed to identify potential benefits and risks of long-term opioid use.[9]

g. Failed to perform risk assessments for prescribing long-term moderate dose of narcotics.

h. Failed to fully evaluate potential risks of concomitant opioid and benzodiazepine therapy.

i. Failed to specify and/or document measurable goals and objectives to evaluate the efficacy of long-term opioid use.[10]

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identifying and documenting specific symptoms of the condition and the impact of the symptoms on a patient's functioning.

[6] A proper medical indication is based upon obtaining and documenting a clear medical diagnosis.

[7] Failure to properly monitor a patient taking controlled substances includes, but is not limited to: executing a detailed controlled substance agreement, failing to attempt safer treatment modalities prior to prescribing controlled substances; reducing the strength and/or quantity of the prescribed controlled substance(s); discussing the patient's current substance abuse issues; refer the patient for further evaluations or to specialists, including pain management, orthopedic surgery, psychiatry, or behavioral therapy; document discussions regarding the risks of using controlled substances, high doses of controlled substances, or polypharmacy; consult or obtain a CURES report; determine whether the patient exhibited misuse, dependence, addiction, or diversion of controlled substances; and conducting urine toxicology screenings.

[8] Indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion includes, but is not limited to: obtaining controlled substances from multiple providers, filling prescriptions of controlled substances at multiple pharmacies, requiring chronic high doses, using controlled substances not prescribed to the patient, resisting attempts to decrease or change medications, reporting lost or stolen medications, and negative interactions with law enforcement.

[9] Long-term opioid therapy is generally defined as the use of opioids on most days for greater than three months.

[10] Measurable goals and objectives include, but are not limited to: improvement in pain and function; improvement in pain associated symptoms such as sleep disturbance and depression/anxiety; avoidance of excessive use of medications; and creating an exit strategy in the event it becomes medically necessary.

j. Failed to document whether he discussed with Patient No. 1 the risks of concomitant opioid and benzodiazepine use; the potential side effects; the risk of impaired motor skills; the risk of misuse, dependence, addiction and overdose; and the limited evidence of efficacy of long-term opioid therapy.

**Patient No. 2**

26. Respondent treated Patient No. 2 (also "Patient") from approximately 1997 through August 2018.[11] The treatment records in the chart generally lacked substantive medical information, were illegible, and often failed to document a diagnosis and/or the medications prescribed.

27. Respondent's medical chart began on November 6, 2012. Respondent treated the patient for anxiety with controlled substances. The patient also began taking Soma for lower back muscle spasms in approximately 2014, although the specific date is illegible. The chart notes that the patient began having muscle spasms in 1996.

28. The record states that Respondent treated Patient No. 2 for both acute and chronic pain, including neck and back pain stemming from a car accident in 1996 or 1997 and several acute pain issues such as shoulder pain, foot pain, ankle pain, and back pain generally associated with trauma/accidents as described below.

29. There is a gap in the chart between 2014 (the exact date is illegible) and February 23, 2016. However, according to the CURES report, Respondent prescribed narcotics, benzodiazepines, Soma, and sedatives to Patient No. 2 in 2015.

30. The CURES reports state that Respondent prescribed Patient No. 2 the following controlled substances from at least October 19, 2016, to September 5, 2018:

a. 1,750 Norco 325-10 mg tablets; 70 Norco 320-7.5 mg tablets; and 46 Norco 325-5 mg tablets. This is an approximate average MEDs (morphine equivalent dose) of 17 MED per day. However, the dose ranged from a low of 14 in March through

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[11] These are approximate dates based on the records available for review. Patient No. 2 may have treated with Respondent before or after these dates.

June 2016, and a high of 30 from January through September 2018. These amounts would be considered a low to moderate dose.

b. Additionally, the Patient was concurrently using Xanax (300 - 0.5 mg tablets, 600 - 1.0 mg tablets, and 510 - 2.0 mg tablets), Soma (1590 tablets) and 120 tablets of Belsomra 15 mg.

31. During the treatment period, Respondent:

a. Prescribed opioids without documenting a clear medical diagnosis and without proper medical indication.

b. Failed to employ screening tools, such as pain intensity/interference scale, prior to prescribing long-term opioid treatment.

c. Failed to fully evaluate potential risks of concomitant opioid treatment with benzodiazepine, and/or sedative/hypnotics, and/or Soma treatment.

d. Failed to specify and/or document measurable goals and objectives to evaluate the efficacy of long-term opioid use.

e. Failed to identify potential benefits and risks of long-term opioid use.

f. Failed to document whether he discussed with Patient No. 2 the risks of long-term opioid use and concomitant opioid and other controlled substance use; the potential side effects; the risk of impaired motor skills; the risk of misuse, dependence, addiction, and overdose; and the limited evidence of the benefit of long-term opioid therapy.

g. Failed to properly monitor Patient No. 2's opioid use.

h. Failed to recognize the indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion.

i. Failed to perform risk assessments for prescribing a long-term moderate dose of narcotics.

32. During the treatment period, Respondent's prescribing practices likely caused harm to Patient No. 2. Patient No. 2's several accidents and injuries were likely caused by the use of multiple sedating medications, which can cause motor and cognitive impairment when used alone

or concomitantly (narcotics, benzodiazepines, muscle relaxants, and sedative hypnotics).

**Patient No. 3**

33. It is unclear when Patient No. 3 (also "Patient") began treatment with Respondent. Treatment records contained in the chart generally lacked substantive medical information, were illegible, and often failed to document a diagnosis and/or the medications prescribed. During an interview with a Board investigator, Respondent reported that he treated the patient since approximately 2008. However, Respondent also reported that he began treating the patient in the early 2000s for low back pain, which he treated with Percocet.

34. Respondent also reported that Patient No. 3 had low back surgery in 2015. Respondent stated that he referred the patient to a pain management specialist after this surgery. However, according to the CURES report, the pain management specialist's first opioid prescription was on July 6, 2017. Between July 6, 2017, and February 17, 2018, Respondent prescribed Percocet concurrently with opioids prescribed by the pain management specialist.

Respondent also concurrently prescribed other controlled substances, including Valium and Belsomra, while approximately seven other prescribers supplied controlled substances.

35. According to the CURES report, from at least October 5, 2015, to August 22, 2018, Respondent concurrently prescribed Patient No. 3 controlled substances with several other providers. During this period, Respondent prescribed:

a. 840 Norco 325/10 mg tablets, 270 Norco 325/7.5 mg;

b. 820 Percocet 325/10 mg, 1880 Percocet 325/5m g;

c. 60 tramadol 50 mg; and

d. 90 Vicodin 300/7.5 mg, which is an approximate average MEDs of 35 MED per day with a high of approximately 50 MED per day. This amount is considered a moderate dose.

36. According to the CURES report, approximately seven other providers prescribed controlled substances to Patient No. 3. Between at least October 5, 2015, to August 22, 2018, Patient No. 3 was prescribed:

a. Valium 10 mg (540 tablets) and Valium 5 mg (5 tablets);

b. Lunesta 3 mg (90 tablets); and

c. Belsomra 20 mg (1080 tablets) and Belsomra 10 mg (30 tablets).

37. During the treatment period, Respondent:

a. Prescribed opioids without documenting a clear medical diagnosis and without proper medical indication.

b. Failed to employ screening tools, such as pain intensity/interference scale, prior to prescribing long-term opioid treatment.

c. Failed to fully evaluate potential risks of concomitant opioid treatment with benzodiazepine, and/or sedative/hypnotics, and/or Soma treatment.

d. Failed to specify and/or document measurable goals and objectives to evaluate the efficacy of long-term opioid use.

e. Failed to identify potential benefits and risks of long-term opioid use.

f. Failed to document whether he discussed with Patient No. 3 the risks of long-term opioid use and concomitant opioid and other controlled substance use; the potential side effects; the risk of impaired motor skills; the risk of misuse, dependence, addiction, and overdose; and the limited evidence of the benefit of long-term opioid therapy.

g. Failed to properly monitor Patient No. 3's opioid use.

h. Failed to recognize the indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion.

i. Failed to perform risk assessments for prescribing a long-term moderate dose of narcotics.

**Patient No. 4**

38. It is unclear when Patient No. 4 (also "Patient") began treatment with Respondent. The treatment records in the chart generally lacked substantive medical information, were illegible, and often failed to document a diagnosis and/or the medications prescribed. However, during an interview with a Board investigator, Respondent reported that he began treating the patient in 1996 after the patient was diagnosed with tonsillar cancer, had chemotherapy, radiation,

and surgical excision to his neck. The patient was being treated with opioids for post-cancer therapy chronic pain.

39. On August 18, 2018, Patient No. 4 was found to be hypotensive with blood pressure at 79/51 with recheck at 107/57. On that date, Respondent documented that Patient No. 4 was taking nadolol (a beta-blocker) for essential tremor (also used to decrease blood pressure). Respondent reported that Patient No. 4 at the time of service was asymptomatic and felt that the patient's treatment for tremor outweighed the risk of hypotension. Respondent also reported that the patient was concurrently using Viagra/sildenafil (a vasodilator, which can result in mild and transient decrease in blood pressure and although not strictly contraindicated with nadolol, can potentiate vasodilator effects). Respondent further reported that he does not recall informing patient that use of these medications individually or combined can decrease blood pressure.

40. The patient exhibited concerning signs and symptoms for chronic controlled substances therapy such as medication misuse, abuse or addiction or side effects such as sedation, motor, and cognitive impairment or sedation.

41. A February 11, 2016 emergency room ("ER") record contained in Respondent's chart documents the following:

a. The admitting physician documented that Patient No. 4 was an alcoholic and has a history of binge drinking.

b. An assessment of Patient No. 4 that includes narcotic dependence, benzodiazepine dependence, and alcohol abuse.

c. Patient No. 4 appeared confused and exhibited an altered mental status due to Norco and Xanax.

d. Patient No. 4 was in a motor vehicle accident in January 2016.

e. A urology consult note documents that the patient was suffering urinary retention, which may have been related to his narcotics which the patient had been taking.

f. A drug screen was completed showing positive for opiates and benzodiazepines but negative for other drugs and negative for alcohol.

42. On May 15, 2017, a pharmacy documented in a controlled substances prescription

report that Patient No. 4 had medication stolen (Lunesta), and Respondent's authorization was needed for an early refill. This medication was last filled on April 28, 2017.

43. During the course of treatment Patient No. 4 was prescribed combinations of narcotics (Norco and tramadol) along with benzodiazepines (Xanax) for anxiety and sedative/ hypnotics (Lunesta) for insomnia. When taken alone or in combination, these medications are a high risk for such side effects as respiratory depression, motor impairment, and cognitive impairment and sedation.

44. Respondent reported that he was made aware of Patient No. 4's history of alcoholism through the patient's wife. However, Respondent reported that he did not "see that" in the patient. However, during the treatment period, Patient No. 4 was convicted of driving under the influence ("DUI"), in violation of California Vehicle Code, section 23152.

45. Respondent reported that he was made aware that Patient No. 4 was using drugs and alcohol through the patient's wife.

46. Respondent reported he was aware that Patient No. 4 suffered from memory loss and dementia due to the patient's mental and physical decline.

47. The CURES reports documents that Respondent prescribed controlled substances to Patient No. 4 from at least September 14, 2015, to August 27, 2018. During this period, Respondent prescribed:

a. 659 Norco 300-5 mg tablets;

b. 480 tramadol 50 mg tablets, and 420 tramadol/acetaminophen 325-37.5 tablets. This is an approximate average MED of 7 per day. This amount is considered a low dose.

48. Additionally, Patient No. 4 was concurrently using Xanax (180 tablets) Lunesta (1080 tablets).

49. During the treatment period, Respondent:

a. Failed to employ screening tools, such as pain intensity/interference scale, prior to prescribing long-term opioid treatment.

b. Failed to fully evaluate potential risks of concomitant opioid treatment with

benzodiazepine, and/or sedative/hypnotics, treatment.

c. Failed to complete a risk assessment after he was made aware of the patient's alcohol use.

d. Failed to specify and/or document measurable goals and objectives to evaluate the efficacy of long-term opioid use.

e. Failed to identify potential benefits and risks of long-term opioid use.

f. Failed to document whether he discussed with Patient No. 4 the risks of long-term opioid use and concomitant opioid and other controlled substance use; the potential side effects; the risk of impaired motor skills; the risk of misuse, dependence, addiction and overdose; and the limited evidence of the benefit of long-term opioid therapy.

g. Failed to properly monitor Patient No. 4's controlled substance use.

h. Failed to recognize the indicia of controlled substance misuse, dependency, addiction, abuse, and/or diversion.

i. Failed to perform risk assessments for prescribing a long-term moderate dose of narcotics.

j. Failed to properly manage the patient's hypotension.

50. During the treatment period, Respondent's prescribing practices likely caused harm to Patient No. 4. During the treatment period, Patient No. 4 was in a car accident in January 2016, was convicted of a DUI, was admitted to the hospital for altered mental status, and demonstrated a concerning mental and physical decline. Respondent prescribed inappropriate combinations of medications (narcotics, benzodiazepines and sedative/hypnotics), which can place a patient at high risk for motor and cognitive impairment when taken either alone or in combination. Additionally, Respondent prescribed this combination of medications with the knowledge that the patient was contemporaneously consuming alcohol.

**Employment and Supervision of Uncertified X-Ray Technician**

51. On June 4, 2018, the California Department of Public Health (CDPH) performed a radiation safety inspection at Respondent's office.

52. CDPH inspectors discovered Tech No. 1 was not certified to perform digital radiography. Tech No. 1 reported that, although she completed the requisite education to perform digital radiography, she had not applied for a permit and lacked the proper digital radiology certification.

53. Respondent hired and supervised Tech No. 1. During the course of employment, and under Respondent's supervision, Tech No. 1 performed approximately 5,000 digital X-rays.

54. Respondent was issued a Notice of Violation and Radiation User's Declaration (NOVRUD) for this violation.

**FIRST CAUSE FOR DISCIPLINE**

(Prescribing Without Proper Indication)

55. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2242, subdivision (a) in that Respondent prescribed multiple controlled substances to Patients 1 through 3 without obtaining objective evidence to support a proper medical indication. The facts set forth in paragraphs 20 through 37 above are incorporated by reference as if set forth in full herein.

**SECOND CAUSE FOR DISCIPLINE**

(Inadequate Record Keeping)

56. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2266, in that Respondent failed to create and maintain proper medical records of his care and treatment of Patients 1 through 4. The facts set forth in paragraphs 20 through 50, above are incorporated by reference as if set forth in full herein.

**THIRD CAUSE FOR DISCIPLINE**

(Employing, Aiding, Abetting Uncertified X-Ray Tech)

57. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2264, subdivision (a), California Health and Safety Code sections 106965, subdivision (a), 106970, in that Respondent hired X-ray Tech No. 1 to perform digital radiography, but was not certified to do so. The facts set forth in paragraphs 51 through 54, above, are incorporated by reference as if set forth in full herein.

58. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2264, subdivision (a) in that Respondent aided, and/or abetted Tech No. 1 in performing digital radiography without possessing the proper certification. The facts set forth in paragraphs 51 through 54, above, are incorporated by reference as if set forth in full herein.

**FOURTH CAUSE FOR DISCIPLINE**

(Improper Supervision of Uncertified X-Ray Technician)

59. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2234, subdivision (a); California Health and Safety Code section 106965, subdivision (a), and section 114850, subdivisions (c), (d), (g), and (h); and California Code of Regulations, title 17, section 30100, subdivision (z), section 30305, subdivisions (b)(1), (e), and (f), and section 30306, subdivisions (b)(7), (11), and (18), in that Respondent failed to properly supervise X-ray Tech No. 1, by allowing the technician to perform digital radiography without possessing the proper certification. The facts set forth in paragraphs 51 through 54, above, are incorporated by reference as if set forth in full herein.

**FIFTH CAUSE FOR DISCIPLINE**

(Repeated Negligent Acts)

60. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2234, subdivision (c) in that as to his care and treatment of Patients 1 through 4, Respondent:

a. Prescribed multiple controlled substances without engaging in a risk analysis and/or risk stratification.

b. Prescribed long-term controlled substances without creating and/or documenting a proper treatment plan and goals.

c. Prescribed long-term controlled substances without documenting whether the patient provided informed consent to the treatment.

d. Failed to properly monitor the patient's long-term use of controlled substances.

e. Failed to properly assess the efficacy of the prescribed controlled substances.

61. The facts and allegations set forth in paragraphs 20 through 50, and 55 through 57,

above, are incorporated by reference as if set forth in full herein.

62. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2234, subdivision (c) in that Respondent failed to properly manage Patient No 4's hypotension. The facts set forth in paragraph 39, above, are incorporated by reference as if set forth in full herein.

63. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2234, subdivision (c) in that Respondent:

a. Hired X-Ray Tech No. 1 to perform digital radiography without possessing the proper certification.

b. Aided and/or abetted the violation of the Radiologic Technology Act by allowing the X-Ray Tech No. 1 to perform digital radiography without possessing the proper certification.

c. Failed to properly supervise X-Ray Tech No. 1, by allowing the technician to perform digital radiography without possessing the proper certification.

64. The facts set forth in paragraphs 51 through 54, above, are incorporated by reference as if set forth in full herein.

**SIXTH CAUSE FOR DISCIPLINE**

(Inappropriate Prescribing of Controlled Substances Resulting in Harm to Patients)

65. Respondent Peter Dan Sliskovich, M.D., is subject to disciplinary action under section 2228.1, subdivision (a), subsections (1)(D) and (2), in that Respondent's prescribing of controlled substances resulted in harm to all four patients. The facts set forth in paragraphs 20 through 50, above, are incorporated by reference as if set forth in full herein.

**DISCIPLINE CONSIDERATION**

66. To determine the degree of discipline, if any, to be imposed on Respondent Peter Dan Sliskovich, M.D., Complainant alleges that on or about January 22, 2009, CDPH issued Respondent a NOVRUD for allowing X-ray technician 2, who was uncertified, to perform digital radiography without the requisite certification.

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## PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 42414, issued to Peter Dan Sliskovich, M.D.;

2. Revoking, suspending or denying approval of Peter Dan Sliskovich, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, requiring Peter Dan Sliskovich, M.D. to provide disclosures pursuant to Section 2228.1 of the Code, as further described in paragraph 8 of this Accusation.

4. If placed on probation, ordering Peter Dan Sliskovich, M.D. to pay the Board the costs of probation monitoring; and

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

DATED: DEC 17 2020

Jenna Jones, Jenna Jones Chief of Enforcement
For: WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

*Complainant*

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