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

In the Matter of the Accusation Against: Seth Camhi, M.D. Physician's and Surgeon's Certificate No. A 121153 Respondent.	Case No.: 800-2017-038533

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 February 25, 2022.

IT IS SO ORDERED: January 26, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9515
Facsimile: (619) 645-2012

Attorneys for Complainant

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

In the Matter of the Accusation Against: **SETH CAMHI, M.D.** 8929 University Center Lane, Suite 201 San Diego, CA 92122-1006 **Physician's and Surgeon's Certificate No. A 121153** Respondent.	Case No. 800-2017-038533 OAH No. 2020120315 **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 Keith C. Shaw, Deputy Attorney General.

2. Respondent Seth Camhi, M.D. (Respondent) is represented in this proceeding by attorney Steven H. Zeigen, Esq., whose address is: 10815 Rancho Bernardo Rd., Suite 310, San Diego, CA 92127-2189.

3. On or about May 2, 2012, the Board issued Physician's and Surgeon's Certificate No. A 121153 to Seth Camhi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-038533, and will expire on May 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-038533 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 November 3, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-038533 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-038533. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-038533, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent gives up his right to contest that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in the Accusation.

11. 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 Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2017-038533 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.

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

CONTINGENCY

13. 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.

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. A 121153 issued to Respondent Seth Camhi, 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. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any Schedule II controlled substance as defined by the California Uniform Controlled Substances Act, except for the following drugs listed in Schedule II of the Act: Stimulants, as defined under Health and Safety Code section 11055, subdivision (d).

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and

address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. 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, focused in the areas of primary care, wellness and/or preventive medicine, 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.

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

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

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

5. 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.

6. 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.

7. MONITORING - PRACTICE/BILLING. 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(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), 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, billing appropriately or both. 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 five (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.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's

expense during the term of probation.

8. NOTIFICATION. 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.

9. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. 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's 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.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

15. 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.

16. 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.

17. 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 or her 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.

18. 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.

19. 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. 800-2017-038533 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.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Steven H. Zeigen, Esq. 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: 1/2/22

SETH CAMHI, M.D.
Respondent

I have read and fully discussed with Respondent Seth Camhi, 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: *1/03/2022*

Steven H. Zeigen

STEVEN H. ZEIGEN, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: January 3, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

Keith Shaw

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-038533

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9515
Facsimile: (619) 645-2012

Attorneys for Complainant

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

In the Matter of the Accusation Against: **SETH CAMHI, M.D.** 9339 Genesee Avenue, Suite 150 San Diego, CA 92121-2144 **Physician's and Surgeon's Certificate No. A 121153,** Respondent.	Case No. 800-2017-038533 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this 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 May 2, 2012, the Medical Board issued Physician's and Surgeon's Certificate No. A 121153 to Seth Camhi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

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

". . .

"(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.

". . ."

6. Section 725 of the Code states:

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

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

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

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

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

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

9. **Adderall**, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system (CNS) stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder (ADHD) and narcolepsy. According to the DEA, amphetamines, such as Adderall, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2017), at p. 50.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

10. **Diazepam**, known by the trade name Valium, is a medicine of the benzodiazepine class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces CNS

depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

11. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCP's) to Schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, HCP's are used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA).

12. **Hydromorphone hydrochloride** (Dilaudid) is primarily used as a pain reliever. It is a dangerous drug as defined in Business and Professions Code section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving other narcotic analgesics,

anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

13. **Opana ER**, also known as oxymorphone hydrochloride extended release, is an opioid pain medication used to treat moderate to severe pain. The extended-release form of this medication is for around-the-clock treatment of pain. It is a dangerous drug as defined in section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b)(1).

14. **Oxycodone with acetaminophen** (Percocet), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

15. **Oxycodone HCL** (OxyContin) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, OxyContin is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The DEA has identified OxyContin as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

16. **OxyContin** is a trade name for oxycodone hydrochloride controlled-release tablets. It is used for pain relief. It can also include relief from anxiety with feelings of euphoria and

relaxation. OxyContin is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. OxyContin should be used with caution in patients who are concurrently receiving other CNS depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

17. **Soma**, a trade name for carisoprodol tablets, is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined by Health and Safety Code section 11057. It can be habit forming and its side effects may impair thinking or reactions; it can increase dizziness and drowsiness.

18. **Suboxone**, a trade name for buprenorphine and naloxone, is used to treat opiate addiction. Buprenorphine is an opioid medication, which the naloxone blocks the effects of the opioid medication that can often lead to abuse. It is a Schedule III controlled substance and narcotic as defined by section 11056 of the Health and Safety Code, and is a dangerous drug as defined in section 4022.

19. **Xanax** (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Xanax, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

20. **Zolpidem**, known by the trade name Ambien, is a Schedule IV controlled substance, and a sedative primarily used to treat insomnia. It is an addictive substance and users should avoid alcohol as serious interactions may occur.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, and D, as more particularly alleged hereinafter:

PATIENT A

22. Respondent began treatment with Patient A,[1] a then 49-year-old male, on or about July 6, 2017. The patient presented with numerous medical conditions, including chronic bone pain and chronic pain syndrome, anxiety disorder, depression, ADHD, migraines, and had a history of marijuana use. Patient A was seen for 29 months and had his last visit on or about December 4, 2019.

23. Respondent indicated that Patient A had metastatic disease to the bone, however, there were no documented imaging studies, progress notes from other physicians, attempts to collaborate with an oncologist, laboratory reports, or pathology reports to corroborate such a disease. Similarly, Respondent made no independent attempt to verify whether the patient had migraine headaches.

24. On or about August 7, 2017, Respondent began prescribing oxycodone, 30 mg (#120), to Patient A on a monthly basis. However, a Controlled Substance Agreement (CSA) was not signed by Patient A until nearly seven months later on or about March 1, 2018. It was unclear from the notes the indication for which Respondent prescribed opiates, including any corroborating physical examination findings. Respondent did not offer non-opiate medications prior to prescribing opiates. Respondent continued a morphine equivalent dosage (MED) of approximately 220 for the patient through approximately July 2, 2018.

25. On or about August 1, 2018, Respondent referred Patient A to a pain management specialist, but he returned to Respondent's care in May 2019 and was continued on opiates. Patient A was routinely prescribed two separate short acting opiates concurrently, including

[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

oxycodone, Percocet, and/or Norco. Respondent apparently failed to recognize that Percocet already contained oxycodone, as it was prescribed concurrent to regular oxycodone. The patient was also regularly prescribed Xanax and Adderall throughout his treatment with Respondent.

26. At no time did Respondent conduct a urine drug test or random pill count for Patient A as authorized under the CSA, despite him being at a moderate risk for future opiate abuse due to his history. Patient A filled prescriptions for controlled substances at multiple pharmacies, even though the CSA required the use of a single pharmacy to fill prescriptions. Respondent routinely failed to document and assess pain as it related to the use of controlled substances, including the analgesic effects of the opiates, the patient's daily functional state, and inquiring into any to potential aberrant behavior.

27. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to properly conduct urine toxicology screenings;

(b) Respondent failed to safely prescribe controlled substances; and

(c) Respondent failed to appropriately document an indication for the use of controlled substances.

PATIENT B

28. Respondent started treating Patient B, a then 25-year-old female, on or about December 8, 2015. The patient presented with a history of chronic pain syndrome, including lower back, abdominal, pelvic and hip pain. Respondent began prescribing Norco, 325/10 mg (#120), and Soma, 350 mg (#30), to Patient B on a monthly basis, followed closely by monthly prescriptions for oxycodone, 30 mg (#60). At this appointment, Patient B indicated that she would shortly obtain an MRI of her lower back and pelvic area to determine the underlying cause of her problems.[2] Patient B was seen for 26 months and had her last visit on or about January 30, 2018.

[2] Despite numerous requests by Respondent throughout the patient's care to undergo an MRI to determine the source of her pain, she neglected to obtain one. Still, Respondent continued regular prescriptions for opiates and missed multiple opportunities to withhold or reduce prescribing until the patient followed through with obtaining an MRI and/or lab testing.

29. Respondent commonly complied with Patient B's requests for additional controlled substances and/or increased dosages, demonstrating a lack of full prescriptive decision-making. On or about February 22, 2016, Patient B requested an early refill with an increased dosage for Norco, which Respondent prescribed. On or about September 15, 2016, Patient B requested and was granted an increased quantity of oxycodone. On or about, December 27, 2016, Patient B requested and was prescribed Opana, after conveying to Respondent that she had tried Opana from a friend and had liked it.

30. On or about February 27, 2017, Patient B indicated that she was stuck in Nashville after being in a car crash and requested prescriptions for both Opana and oxycodone. Respondent complied with this request, which significantly increased Patient B's MED from 75 to 270, which continued for the remainder of her care. On or about June 13, 2017, Patient B requested the addition of Valium, which Respondent complied and continued to regularly prescribe for the remaining duration that the patient was under his care. Only once did Respondent decline to add a new requested medication when Patient B relayed that she had "tried one of her friend's Xanax" in June 2016.

31. A Controlled Substance Agreement was not present or documented during the entirety Patient B was prescribed controlled substances by Respondent. Respondent did not conduct a single urine drug test for Patient B, despite evidence of aberrant drug behavior, including multiple early refill requests, taking controlled substances given to her by friends (Opana and Xanax), potential withdrawal symptoms, and traveling out-of-state frequently where she obtained controlled substances. Additionally, Patient B reported being in two car accidents, but no inquiry was made whether she was the driver and potentially intoxicated. Respondent was unaware whether the patient was exposed to other prescribed or non-prescribed medications or illicit drugs that may have interacted with her prescribed opiates.

32. Respondent commonly failed to document an appropriate pain assessment of Patient B. Respondent frequently noted in the review of symptoms that the patient did not have back or abdominal pain despite contrary examination findings. Throughout the course of treatment with Patient B, there was marked escalation of opioids rather than structured tapering.

Patient B filled prescriptions for controlled substances at multiple pharmacies. Respondent did not collaborate with the patient's prior prescribers or physicians that prescribed controlled substances in Tennessee, and who may have had more extensive medical records and imaging.

33. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Respondent failed to properly use and/or adhere to a Controlled Substance Agreement;

(b) Respondent failed to properly conduct urine toxicology screenings; and

(c) Respondent failed to safely prescribe controlled substances.

PATIENT C

34. Respondent began treating Patient C, a then 31-year-old male, on or about April 24, 2015. The patient presented with a medical history of drug overdose, rhabdomyolysis,[3] peroneal neuropathy,[4] ADHD, OCD,[5] insomnia, and GERD.[6] He had a history of cocaine, amphetamine, barbiturate, marijuana, and alcohol use. Patient C was seen for approximately 29 months with his last visit occurring on or about September 18, 2017.

35. At the initial visit, Patient C relayed that he had recently stopped taking oxycodone and was experiencing some withdrawal symptoms, but was taking Suboxone. On or about April 30, 2015, Patient C requested a refill of oxycodone for his lower back and foot drop[7] as he was tapering Suboxone. The patient indicated that he had a pain contract with another physician that

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[3] Rhabdomyolysis is a rare condition where a muscle injury causes the muscle tissue to break down.

[4] Peroneal neuropathy is weakness, numbness, and pain from nerve damage, usually in the hands and feet.

[5] Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by unreasonable thoughts and fears (obsessions) that lead to compulsive behaviors.

[6] Gastroesophageal reflux disease (GERD), also known as acid reflux, occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach.

[7] Foot drop is a general term for difficulty lifting the front part of the foot.

he wanted to break in order to have Respondent prescribe his medications, but Respondent did not document the reason why the patient wanted to transfer his care. According to CURES,[8] Patient C was obtaining controlled substance prescriptions from seven different prescribers between January 2015 and April 2015 prior to seeing Respondent. Respondent prescribed oxycodone, 15 mg (#10), and Valium. Patient C had just filled prescriptions for oxycodone, 30 mg (#99), and OxyContin, 20 mg (#16), earlier that month, but there was no mention that Respondent reviewed CURES.

36. On or about May 5, 2015, the patient requested a refill of oxycodone and was prescribed oxycodone, 30 mg (#28). On or about May 14, 2015, Patient C conveyed that he stopped taking oxycodone, even though he filled prescriptions for oxycodone, 30 mg, from another physician on or about May 10, 2015, and May 15, 2015. On or about May 21, 2015, Respondent noted, "pain addiction, we'll refill short course of oxycodone, but advised patient he needs to cut down and eventually quit for good. Coming off and then going back on medication does him no good." An additional 20 pills of oxycodone were prescribed that day. Less than a week later, another prescriber issued a prescription for 30 pills of oxycodone.

37. On or about June 4, 2015, Patient C told Respondent that he was off oxycodone, however, he filled a prescription for oxycodone from another prescriber the following day. One week later, Patient C stated that he had received another prescription for oxycodone in a "moment of weakness," but had flushed them down the toilet. Respondent prescribed an additional 10 pills of oxycodone that day, and 12 more pills five days later.

38. On or about June 19, 2015, Patient C indicated that oxycodone was ineffective and he wanted another medication. Respondent prescribed Opana, 10 mg, and noted, "if he gets medications from other provider or urgent care prior to then that I will no longer refill his controlled substances." However, Patient C received prescriptions for controlled substances from other prescribers on 11 separate occasions between October 2015 and November 2016, and Respondent continued prescriptions for controlled substances. In July 2015, Patient C indicated

[8] The Controlled Substance Utilization Review and Evaluation System (CURES) is a platform that tracks all Schedule II – IV controlled substances dispensed to patients in California.

he had given up marijuana and was noted to have severe anxiety, depression, and stress, and was subsequently prescribed Valium and Xanax. In August 2015, Patient C alerted Respondent that he was also seeing another physician for pain and/or addiction management.

39. On or about September 28, 2015, Respondent noted that Patient C had obtained "a lot of oxycodone this past month, but shows me a picture of him dumping it in the toilet." The following day, Patient C asked for Norco and was prescribed 20 pills of Norco, 10 mg, by Respondent. Three days later, the patient told Respondent that "he feels the Xanax, Valium, OxyContin and Norco that he had gotten recently" are not really helping, so Respondent switched him back to oxycodone. On or about October 8, 2015, Respondent noted that Patient C was admitted to two urgent care facilities. Soon after, Respondent prescribed Percocet since Patient C no longer wanted oxycodone. On or about November 5, 2015, Patient C requested to try another medication, so Respondent prescribed Dilaudid. However, this medication was discontinued several days later and oxycodone was resumed.

40. In December 2015, Patient C was seen by Respondent approximately every 2-3 days, excluding holidays, and was prescribed a daily average MED of 414. On or about January 5, 2016, a pharmacist inquired with Respondent into the prescribing habits for Patient C. At this time, Respondent informed the patient that he would be checking CURES. For the first time, a Controlled Substance Agreement was also completed, occurring eight months after Respondent began prescribing controlled substances to Patient C. The following day, Respondent reviewed the results of a urine drug test with Patient C, which came back negative for controlled substances even though he was regularly being prescribed opiates.

41. On or about January 22, 2016, Patient C requested an early refill of oxycodone since he was going out of town. Respondent noted that it was a "recurrent theme" for Patient C to ask for medications he did not like, and for the first time, began decreasing the dosage of opiates prescribed to the patient. On or about February 1, 2016, a urine drug test was "negative for oxycodone because [the patient] has been out." Later that month, Patient C again "flushed the rest (oxycodone) down the toilet" and requested Norco, which Respondent did not agree. It was

noted that Patient C would reduce his usage of marijuana. Patient C obtained Norco and Percocet prescriptions from anther provider the following month.

42. On or about April 29, 2016, Respondent prescribed oxycodone to Patient C for the last time. In the following months, Patient C obtained and filled prescriptions for oxycodone at five different pharmacies from multiple different prescribers. Patient C also obtained multiple benzodiazepines and Adderall prescriptions from several prescribers and sold at various pharmacies. On or about December 27, 2016, Patient C resumed his care with Respondent, but after reviewing CURES, Respondent informed Patient C that he would no longer prescribe controlled substances and that he would need to obtain them from his psychiatrist.

43. During the course of treatment, Patient C did not adhere to the CSA he entered into in January 2016, as prescriptions for controlled substances were filled at multiple pharmacies, and he continued to use illicit drugs. While urine drug tests were conducted at least twice for Patient C, they did not occur until after Respondent was alerted by a pharmacist of potential aberrant drug behavior, and long after Respondent knew that Patient C was not only at high risk for addiction, but "addicted" to pain medication. In fact, Respondent knew Patient C was addicted to pain medication and continued to prescribe opiates, as well as a combination of opiates and benzodiazepines concurrently. Despite multiple notes by Respondent that Patient C needed to taper his MED, Respondent continued to escalate the MED until January 2016 when he was alerted by the pharmacist of potential aberrant drug behavior.

44. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Respondent failed to properly use and/or adhere to a Controlled Substance Agreement; and

(b) Respondent failed to safely prescribe controlled substances.

PATIENT D

45. Respondent began treating Patient D, a then 46-year-old male, on or about October 21, 2016, who was at the time working and living in Mexico. The patient presented with a history

of chronic back pain, and was later diagnosed with hypothyroidism, dyslipidemia, and ADHD.[9] Patient D was seen for 39 months continuously and had his last visit on or about February 6, 2020.

46. At the initial visit, Respondent recommended an MRI and physical therapy for Patient D for chronic lower back pain with radiculopathy, but the patient never followed up on obtaining an MRI. Patient D was prescribed oxycodone prior to seeing Respondent, who continued oxycodone, 30 mg (#90). One month later, Respondent increased the quantity of oxycodone to 120 pills, which would recur on a monthly basis until August 2018, when it was increased to 150 pills each month. On or about December 15, 2016, Respondent noted that Patient D was going to a "prominent back specialist" in London and was prescribed Xanax for "travel and panic issues." Xanax prescriptions would continue on a monthly basis and would be incrementally increased in dosage throughout the course of treatment with Respondent.

47. On or about August 17, 2017, Patient D indicated that he had tried a friend's Adderall, which had improved his focus and attention. Respondent agreed to start prescribing Adderall, 10 mg, and diagnosed him with ADD/AHD.[10] Respondent would increase the dosage for the recurring monthly prescription of Adderall to 30 mg (#30) by April 2018, and then doubled the amount of pills to 60 by June 2019.

48. Between May 2017 and August 2017, Patient D received prescriptions for Xanax and oxycodone from other prescribers, though Respondent did not document this detail when he noted that he reviewed CURES in July 2017 and September 2017. It was not until on or about September 16, 2019, that a Controlled Substance Agreement was completed, approximately 35 months after the first prescription for controlled substances.

49. On or about November 14, 2019, Patient D's blood pressure was 174/111, which Respondent noted was high. There was no mention under Assessment or Plan that Patient D had

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[9] Patient D presumably had undiagnosed hypertension as he was prescribed Lisinopril by Respondent to treat consistent high blood pressure.

[10] Even though Patient D presented with risk factors for coronary disease and untreated and undiagnosed hypertension, he was prescribed Adderall for ADHD based on incomplete diagnostic information.

high blood pressure and no intervention was documented. On or about January 9, 2020, Patient D returned, but a blood pressure reading was not documented and hypertension was not diagnosed. However, Patient D was prescribed Lisinopril, a medication used to treat high blood pressure. Patient D's blood pressure was elevated 11 times at separate office visits, and was high 33 out of 38 times it was checked. Respondent noted Patient D's blood pressure was high on a number of occasions, yet he was never diagnosed with hypertension.[11]

50. On or about February 17, 2020, Patient D was referred to a pain management specialist. During the course of treatment with Patient D, there was no structured tapering of opiates, but rather an escalation. There was no evidence that Patient D was offered pharmaceutical alternatives to opiates. Additionally, opiates were regularly prescribed concurrently with benzodiazepines.

51. Respondent committed gross negligence in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Respondent failed to safely prescribe controlled substances; and

(b) Respondent failed to diagnose, treat and manage hypertension in a timely manner.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

52. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, and D, as more particularly alleged herein.

PATIENT A

53. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Paragraphs 21 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein;

[11] Diagnosis of hypertension is basic medicine and if left undiagnosed and untreated, it may lead to significant, irreversible harm. Hypertension, Stage 1, is defined as blood pressure readings of 130/90 or higher, and Stage 2 is defined as 140/90 or higher.

(b) Respondent failed to properly use and/or adhere to a Controlled Substance Agreement.

PATIENT B

54. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Paragraphs 21 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT C

55. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Paragraphs 21 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to properly conduct urine toxicology screenings.

PATIENT D

56. Respondent committed repeated negligent acts in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Paragraphs 21 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to properly use and/or adhere to a Controlled Substance Agreement.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

57. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to patients A, B, C, and D, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 21 through 56, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

58. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of patients A, B, C, and D, as more particularly alleged in paragraphs 21 through 56, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 121153, issued to Seth Camhi, M.D.;

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

3. Ordering Seth Camhi, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: NOV 0 3 2020

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

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