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

In the Matter of the Accusation Against: **Vernal Martin Hansen, M.D.** **Physician's and Surgeon's Certificate No. G 34639** **Respondent.**	**Case No.: 800-2019-051643**

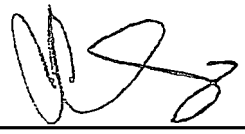
DECISION

The attached Stipulated Settlement 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 March 24, 2022.

IT IS SO ORDERED: February 22, 2022.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the Accusation Against: **VERNAL MARTIN HANSEN, M.D.** **2557 Chino Hills Parkway, Ste. A** **Chino Hills, CA 91709** **Physician's and Surgeon's Certificate No. G 34639,** Respondent.	Case No. 800-2019-051643 OAH No. 2021030257 **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 Karolyn M. Westfall, Deputy Attorney General.

2. Respondent Vernal Martin Hansen, M.D. (Respondent) is represented in this proceeding by attorney Jack M. Schuler, Esq., whose address is: 5850 Canoga Ave., Suite 400, Woodland Hills, CA 91367.

3. On or about July 1, 1977, the Board issued Physician's and Surgeon's Certificate No. G 34639 to 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. 800-2019-051643, and will expire on October 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-051643 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 January 19, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-051643 is attached hereto as Exhibit A and is 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. 800-2019-051643. 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. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2019-051643.

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10. 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

11. 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.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-051643 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.

13. 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.

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

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 34639 issued to Respondent Vernal Martin Hansen, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years from the effective date of the Board's Decision and Order, which shall be February 1, 2022, on the following terms and conditions:

1. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for sixty (60) days beginning the sixteenth (16th) day after the effective date of this Decision.

2. 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.

3. 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.

4. 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.

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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.

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical

condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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 not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

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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.

7. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting 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 not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, 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 not resume practice until an appropriate practice setting is established.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, 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 AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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.

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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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Jack M. Schuler, 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: 11-3-2021

VERNAL MARTIN HANSEN, M.D.
Respondent

I have read and fully discussed with Respondent Vernal Martin Hansen, 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: 11/4/21

JACK M. SCHULER, ESQ.
Attorney for Respondent

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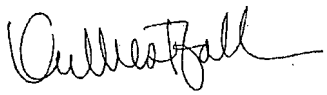
ENDORSEMENT

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

DATED: 11/4/21

Respectfully submitted,

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



KAROLYN M. WESTFALL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-051643

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **VERNAL MARTIN HANSEN, M.D.** **2557 Chino Hills Parkway, Ste. A** **Chino Hills, CA 91709** **Physician's and Surgeon's Certificate No. G 34639,** Respondent.	Case No. 800-2019-051643 **A C C U S A T I O N**

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 July 1, 1977, the Medical Board issued Physician's and Surgeon's Certificate No. G 34639 to Vernal Martin Hansen, 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 October 31, 2022, unless renewed.

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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 2227 of the Code states, in pertinent part:

> (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.
>
> ...

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

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> ...
>
> (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.
>
> ...
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview with the Board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. G 34639 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patients A,[1] B, C, and D, as more particularly alleged hereinafter:

PATIENT A

8. Sometime prior to on or about February 23, 2016, Patient A, a then fifty-four year old female, began receiving treatment from Respondent as her primary care physician. Patient A was a smoker with a medical history of neck and low back pain, anxiety, and migraines. Patient A's prior treatment regimen from other physicians included monthly prescriptions of opioids and benzodiazepines.

9. On or about February 23, 2016, Patient A was seen by Respondent for medication refills. At this visit, the patient's blood pressure was measured as 162/90. Respondent diagnosed Patient A with, among other things, hypertension, disc disease, and chronic pain syndrome based upon her history, but did not review objective corroboration. At the conclusion of the visit, Respondent prescribed Patient A verapamil and digoxin for high blood pressure, referred her to pain management, and prescribed her 120 tabs of Soma[2] 350 mg, 240 tabs of Norco[3] 10/325 mg,

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[1] To protect the privacy of the patients involved, the patients' names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[2] Soma (brand name for carisprodol) is a muscle relaxant medication, a Schedule IV controlled substance, and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Norco (brand name for hydrocodone/acetaminophen combination) is an opioid medication used to treat pain, 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.

and 90 tabs of lorazepam[4] 2 mg. Respondent did not consider safer alternatives to these medications, did not discuss the risks and benefits of these medications, and did not refer the patient to counseling at that time or any time thereafter. The patient's chart does not contain any prior treatment records from other prescribers, does not indicate any history or symptoms of anxiety, and does not contain any medical reasoning for these prescriptions.

10. Between on or about February 23, 2016, and on or about December 24, 2019, Patient A was seen by Respondent for approximately 50 clinical visits. Throughout that time, Respondent's handwritten notes are difficult to read and regularly fail to include a history of present illness (HPI). At approximately thirty (30) of these visits, a blood pressure reading was not obtained from Patient A.

11. Between on or about February 23, 2016, and on or about December 24, 2019, Respondent maintained Patient A on monthly refills of medications, that included but was not limited to, Soma, Norco, MS Contin,[5] Percocet,[6] and lorazepam. Throughout that time, Respondent did not prescribe the patient naloxone,[7] and the patient's chart does not indicate pain levels or how the patient was functioning at each visit. The chart also does not indicate the patient's history, symptoms, or severity of anxiety, or contain a referral for mental health treatment. Her chart also does not contain a signed pain contract, urine drug screens, imaging to confirm his diagnoses, a documented discussion with the patient regarding safer alternatives or complementary therapies, or a referral for mental health treatment.

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[4] Lorazepam (brand name Ativan) is a benzodiazepine medication used to treat anxiety, 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.

[5] MS Contin (Brand name for morphine) is an opioid pain medication, 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.

[6] Percocet (brand name for oxycodone and acetaminophen combination) is an opioid pain medication, 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.

[7] Naloxone (brand name Narcan) is a medication used to rapidly reverse opioid overdose.

12. Between on or about February 23, 2016, and on or about December 24, 2019, Respondent did not offer the patient any vaccinations or counseling regarding smoking cessation, did not obtain a colon cancer screen or annual physical, and did not refer her to gynecology.

13. On or about May 17, 2016, Patient A was seen by Respondent for a medication refill. During this visit, although the patient reported that she had recently fallen in the shower and was rendered unconscious, Respondent did not perform a neurologic examination. During this visit, Respondent performed cryotherapy[8] on the patient, but the records do not contain a skin exam or documented informed consent for this procedure.

14. On or about July 14, 2016, Patient A was seen by Respondent for a medication refill with complaints of sore throat. Respondent did not perform a rapid strep test or order a throat culture, but diagnosed the patient with pharyngitis, and prescribed antibiotics.

15. On or about September 8, 2016, Patient A was seen by Respondent for a medication refill. During this visit, Respondent performed cryotherapy on the patient, but the records do not contain a skin exam or documented informed consent for this procedure.

16. On or about October 20, 2016, Respondent refilled Patient A's digoxin prescription.

17. On or about December 1, 2016, Patient A was seen by Respondent for a medication refill with complaints of headaches and backaches. During this visit, the patient refused to provide a blood pressure reading, but Respondent refilled her digoxin prescription with three refills.

18. On or about January 26, 2017, Patient A was seen by Respondent for a medication refill with complaints of sore throat and postnasal drip. Respondent did not perform a rapid strep test or order a throat culture, but diagnosed the patient with pharyngitis, and prescribed antibiotics.

19. On or about February 16, 2017, Patient A was seen by Respondent for a medication refill and monthly check-up. During this visit, Respondent performed cryotherapy on the patient, but the records do not contain a skin exam or documented informed consent for this procedure.

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[8] Cryotherapy involves the local or general use of low temperatures to treat a variety of tissue lesions.

20. On or about April 13, 2017, Patient A was seen by Respondent for a follow-up. Although the patient's lungs were clear, Respondent ordered a throat culture and prescribed antibiotics.

21. On or about July 3, 2017, Patient A was seen by Respondent for a medication refill with complaints of tonsil pain. Respondent ordered a throat culture, recommended the patient stop smoking, provided her with an ENT referral, and prescribed antibiotics.

22. On or about July 20, 2017, Patient A was seen by Respondent for an urgent care visit with complaints of throat pain. Respondent did not obtain a rapid strep test, but diagnosed the patient with pharyngitis and sinusitis, and prescribed antibiotics.

23. On or about August 10, 2017, Patient A was diagnosed with tongue cancer.

24. In or around September 2017, Patient A was seen by pain management physician, J.K., M.D., (Dr. J.K.). Dr. J.K. prescribed Patient A fentanyl[9] patches for pain.

25. On or about September 28, 2017, Patient A was seen by Respondent for a medication refill. Although Respondent was aware that the patient was seeing a pain management physician at that time, Respondent did not speak with that provider or obtain those treatment records at any time. At the conclusion of this visit, Respondent counseled Patient A not to take her Norco and Percocet at the same time, but maintained her on the same medication regimen.

26. On or about October 2, 2017, Patient A was seen by Respondent for an urgent care visit with complaints of cough. Respondent did not obtain a rapid strep test but ordered a throat culture, the results of which revealed routine respiratory flora. At the conclusion of this visit, Respondent prescribed the patient antibiotics.

27. On or about December 19, 2017, Patient A was seen by Respondent for a check-up and medication refill. At the conclusion of this visit, Respondent added 90 tabs of MS Contin to the patient's monthly medication regimen. The patient's chart does not indicate any medical reasoning for this prescription.

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[9] Fentanyl is an opioid pain medication, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

28. On or about May 10, 2018, Patient A was seen by Respondent for a follow-up visit with complaints of nausea. At the conclusion of this visit, Respondent diagnosed the patient with sinusitis and a dental infection, and prescribed antibiotics and nystatin.[10] The patient's chart does not indicate Respondent's rationale for this treatment.

29. On or about January 2, 2019, Patient A was seen by Respondent for a medication refill. The patient's CURES report was printed for the first time on this date.

30. On or about May 1, 2019, Patient A was seen by Respondent for a medication refill with complaints of a bad cough. Although the patient's lungs were clear, Respondent diagnosed the patient with bronchitis, and prescribed antibiotics.

31. On or about December 4, 2018, May 30, 2019, November 20, 2019, and December 18, 2019, Respondent provided Patient A with B-12 injections. The patient's chart does not contain Patient A's B-12 level or any rationale for this treatment.

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

A. Failing to document why Patient A needed chronic opioids for approximately four (4) years;

B. Failing to safely prescribe opioids to Patient A;

C. Failing to safely prescribe benzodiazepines to Patient A;

D. Failing to maintain complete, legible records regarding his care and treatment of Patient A;

E. Prescribing several sedating medications to Patient A without weaning, without adequately warning of risks associated with combined medications, and without use of safer alternatives;

F. Failing to document an appropriate HPI at each visit with Patient A;

G. Failing to provide routine preventative care to Patient A, including but not limited to, vaccinations, colon cancer screenings, annual physical examinations, gynecology referral, and counseling regarding cessation of smoking;

[10] Nystatin is an antifungal medication that fights infections caused by fungus.

H. Repeatedly prescribing antibiotics to Patient A without rationale;

I. Failing to document his rationale for care and treatment of Patient A, including but not limited to, providing B-12 injections, failing to perform a neurological examination when the patient complained of head trauma, and performing cryotherapy without documenting a skin exam; and

J. Failing to adequately assess and treat Patient A's hypertension.

PATIENT B

33. On or about July 13, 2015, Patient B, a then fifty-four year old female, began receiving treatment from Respondent as her primary care physician. Patient B had a history of chronic intermittent neck and back pain, obesity, type II diabetes, bilateral plantar fasciitis, and chronic cough. Patient B's prior treatment regimen from other physicians included monthly prescriptions of opioids and benzodiazepines.

34. Between on or about July 13, 2015, and October 12, 2017, Respondent provided Patient B regular prescriptions of lorazepam, Soma, and Norco, but her certified complete records contain no treatment records for that timeframe.

35. On or about October 13, 2017, Patient B was seen by Respondent for medication refills, complaints of cough, and a request for him to complete a DMV form on her behalf. The patient reported she was seeing a pulmonologist, but Respondent did not speak with that provider or obtain those treatment records at any time. At this visit, Respondent diagnosed the patient with, among other things, pain, anxiety, and depression. At the conclusion of this visit, Respondent prescribed Patient B 120 tabs of Soma 350 mg, 120 tabs of Norco 10/325 mg, and promethazine with codeine.[11] Respondent did not consider safer alternatives to these medications, did not discuss the risks and benefits of these medications, and did not refer the patient to counseling at that time or any time thereafter. The patient's chart does not contain a

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[11] Promethazine with codeine is an opioid cough suppressant used to treat symptoms caused by the common cold, flu, allergies, or other breathing illnesses, 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.

completed DMV form,[12] any prior treatment records from other prescribers, indicate any history or symptoms of anxiety, or any medical reasoning for these prescriptions.

36. Between on or about October 13, 2017, and on or about December 15, 2019, Patient B was seen by Respondent for approximately 26 clinical visits. Throughout that time, Respondent's handwritten records are difficult to read and regularly fail to include an HPI.

37. Between on or about October 12, 2017, and on or about June 12, 2018, Respondent maintained Patient B on monthly prescriptions of lorazepam. Throughout that time, the patient's chart does not indicate her history, symptoms, or severity of anxiety, or contain a referral for mental health treatment.

38. Between on or about October 13, 2017, and on or about December 15, 2019, Respondent maintained Patient B on monthly refills of Norco, Soma, and promethazine with codeine. Throughout that time, Respondent did not prescribe the patient naloxone, and the patient's chart does not indicate pain levels or how the patient was functioning at each visit. Her chart also does not contain any CURES reports, urine drug screens, or imaging to confirm his diagnoses, and does not include a documented discussion with the patient regarding safer alternatives or complementary therapies.

39. Between on or about October 13, 2017, and on or about December 15, 2019, Respondent did not offer the patient any vaccinations or counseling regarding weight loss, and did not obtain a colon cancer screen, an annual physical, or refer her to gynecology.

40. On or about September 7, 2018, Patient B was seen by Respondent for a medication refill with complaints of sore throat and cough. At this visit, Respondent did not obtain a rapid strep test or order a chest x-ray, but ordered a throat culture that later revealed negative results. At the conclusion of this visit, Respondent diagnosed Patient B with bronchitis and pharyngitis, and prescribed antibiotics.

41. On or about December 3, 2018, Patient B was seen by Respondent for a medication refill with complaints of yellow phlegm and cough medicine not working. At this visit, the

[12] The patient requested additional DMV forms from Respondent on April 11, 2018 and May 11, 2018, though the chart contains no copies of these forms.

patient's lungs were clear and Respondent did not order a chest x-ray. At the conclusion of this visit, Respondent diagnosed Patient B with bronchitis and prescribed antibiotics.

42. On or about March 13, 2019, Patient B was seen by Respondent for a medication refill with complaints of cough. At this visit, the patient's lungs were clear and Respondent did not order a chest x-ray. At the conclusion of this visit, Respondent diagnosed Patient B with bronchitis and prescribed antibiotics.

43. On or about September 4, 2019, Patient B was seen by Respondent for a medication refill with complaints of cough, sore throat, and aches. At this visit, the patient's lungs were clear, and Respondent did not obtain a rapid strep test or order a chest x-ray. At the conclusion of this visit, Respondent diagnosed Patient B with bronchitis and prescribed antibiotics.

44. On or about October 8, 2019, Patient B was seen by Respondent for a medication refill. At that time, her oxygen saturation was measured to be 82%, her lungs were clear, and Respondent did not order a chest x-ray. At the conclusion of this visit, Respondent diagnosed the patient with bronchitis and prescribed antibiotics.

45. On or about October 29, 2019, Patient B was seen by Respondent for an urgent care visit with complaints of sore throat, cough, runny nose, and fever. At this visit the patient's lungs were clear, and Respondent did not obtain a rapid strep test or order a chest x-ray. At the conclusion of this visit, Respondent diagnosed the patient with bronchitis and prescribed antibiotics.

46. On or about November 15, 2019, Patient B underwent a chest x-ray that had been ordered by Respondent sometime prior. The results revealed clear lungs with no acute cardiopulmonary disease.

47. On or about January 2, 2020, Patient B signed an agreement for using pain medication for chronic pain for the first time during her care and treatment with Respondent.

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

A. Failing to document why Patient B needed chronic opioids for over four (4) years;

B. Failing to safely prescribe opioids to Patient B;

C. Failing to safely prescribe benzodiazepines to Patient B;

D. Failing to maintain complete, legible records regarding his care and treatment of Patient B;

E. Prescribing several sedating medications to Patient B without weaning, without warning of risks associated with combined medications, and without use of safer alternatives;

F. Failing to document an appropriate HPI at each visit with Patient B;

G. Failing to provide routine preventative care to Patient B, including but not limited to, vaccinations, colon cancer screenings, annual physical examinations, and gynecology referral;

H. Repeatedly prescribing antibiotics to Patient B without rationale; and

I. Failing to document his rationale for care and treatment of Patient B, including but not limited to, failing to address documented oxygen saturation of 84%, and repeated prescriptions for codeine despite normal lung examinations and normal chest x-ray.

PATIENT C

49. In or around 2014, Patient C, a then forty-four year old male, began receiving treatment from Respondent as his primary care physician. Patient C had a history of low back pain, a prior fusion at lumbar four/five, intermittent bilateral sciatica, an implantable nerve stimulator, left shoulder pain with chronic rotator cuff tear, and migraine. Patient C's prior treatment regimen from other physicians included monthly prescriptions of opioids and benzodiazepines.

50. In or around 2017, Respondent provided Patient C regular prescriptions of fentanyl, Norco, and Xanax,[13] but his certified complete records contain no treatment records for 2017.

[13] Xanax (brand name for alprazolam) is a benzodiazepine medication used to treat anxiety, 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.

51. On or about January 5, 2018, Patient C was seen by Respondent for a follow-up visit. At this visit, no HPI, review of systems, subjective complaints, lipid levels, or lab results were noted, but Respondent prescribed the patient atorvastatin.[14] Three days later, Respondent prescribed the patient 60 tabs of Norco 10/325 mg, 15 fentanyl 100 mcg patches, 15 fentanyl 75 mcg patches, and 60 tabs of Xanax 1 mg.

52. Between on or about January 5, 2018, and on or about December 16, 2019, Patient C was seen by Respondent for approximately twenty-four (24) clinical visits. Throughout that time, Respondent's handwritten records are difficult to read and regularly fail to include an HPI.

53. Between on or about January 5, 2018, and on or about August 15, 2019, Respondent maintained Patient C on monthly prescriptions of Norco and fentanyl. Throughout that time, Respondent did not discuss the risks and benefits of these medications with Patient C, and the patient's chart does not contain any prior treatment records from other prescribers, urine drug screens, pain levels, how the patient was functioning at each visit, or a documented discussion with the patient regarding safer alternatives or complementary therapies.

54. Between on or about January 5, 2018, and on or about December 16, 2019, Respondent maintained Patient C on monthly prescriptions of Xanax. Throughout that time, the patient's chart does not indicate his history, symptoms or severity of anxiety, or contain a referral for mental health treatment.

55. Between on or about January 5, 2018, and on or about December 16, 2019, Respondent did not offer Patient C any vaccinations, and did not obtain a colon cancer screen or annual physical.

56. On or about April 16, 2018, Patient C was seen by Respondent for a medication refill. At this visit, no HPI, review of systems, subjective complaints, lipid levels, or lab results were noted, but Respondent diagnosed the patient with hyperlipidemia and refilled the patient's atorvastatin prescription.

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[14] Atorvastatin (brand name Lipitor) is a medication used to treat high cholesterol, and a dangerous drug pursuant to Business and Professions Code section 4022.

57. On or about October 18, 2018, Patient C was seen by Respondent for a medication refill. At the conclusion of this visit, Respondent ordered labs, including a complete blood count (CBC) and comprehensive metabolic panel (CMP).

58. On or about December 20, 2018, Patient C was seen by Respondent for a medication refill. The patient's CURES report was printed for the first time on this date. At this visit, Patient C informed Respondent that he was using a transcutaneous electrical nerve stimulation unit for approximately twelve (12) hours most days and requested an increase in his anxiety medication. Respondent declined to increase the medication at that time, but the medical record does not contain any documented discussion with the patient regarding his symptoms or Respondent's medical reasoning for that decision.

59. On or about February 4, 2019, Patient C was seen by Respondent for a medication refill. At this visit, Respondent referred the patient to pain management, prescribed Narcan, and advised the patient not to take Norco and Xanax together.

60. On or about June 20, 2019, Patient C was seen by Respondent for a medication refill. Although the patient informed Respondent that he had seen a pain management specialist on April 19, 2019, Respondent did not speak with that provider or obtain those treatment records at any time. At the conclusion of this visit, Respondent maintained the patient on the same medication regimen.

61. On or about June 25, 2019, Patient C completed the CBC and CMP labs that had been ordered by Respondent on or about October 18, 2018. The results revealed a low-density lipoprotein (LDL) level of 149.

62. On or about July 11, 2019, Patient C was seen by Respondent for a medication refill and to obtain his lab results. The chart notes for this visit make no reference to the LDL results or any change to his statin medication.

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

A. Failing to document why Patient C needed chronic opioids over five (5) years;

B. Failing to safely prescribe opioids to Patient C;

C. Failing to safely prescribe benzodiazepines to Patient C;

D. Failing to maintain complete, legible records regarding his care and treatment of Patient C;

E. Prescribing several sedating medications to Patient C without weaning, without adequately warning of risks associated with combined medications, and without use of safer alternatives;

F. Failing to document an appropriate HPI at each visit with Patient C; and

G. Failing to provide routine preventative care to Patient C, including but not limited to, vaccinations, colon cancer screenings, and annual physical examinations.

PATIENT D

64. In or around March 2014, Patient D, a then nineteen year old male with a history of substance abuse, underwent a posterior spinal fusion and subsequent revision surgery for painful Scheuermann's kyphosis.[15]

65. Between in or around March 2014 and in or around March 2015, Patient D was prescribed various opiates and benzodiazepines from different prescribers.

66. Between in or around October 2014 and in or about March 2015, Patient D overdosed on his prescribed medications two times.

67. On or about February 11, 2015, Patient D presented to Chino Hills Family and Urgent Care Center. Patient D was not seen by a physician at that visit, but completed an initial patient questionnaire form identifying his medical history of spinal fusion and hardware in 2014, and current medications of oxycodone[16] 30 mg every 4 to 6 hours, alprazolam 1 mg four times daily, and gabapentin[17] 800 mg four times daily.

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[15] Scheuermann's kyphosis is a structural deformity of the vertebral bodies and spine.

[16] Oxycodone is a narcotic pain medication, 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.

[17] Gabapentin is an anticonvulsant and nerve pain medication. It is a dangerous drug pursuant to Business and Professions Code section 4022.

68. On or about March 30, 2015, Patient D presented to Chino Hills Family and Urgent Care Center and was seen by Respondent for an initial visit, medication refill, and pain management referral. At this visit, vital signs were obtained from the patient, but an HPI and complete physical examination was not obtained and/or documented. The patient's chart does not reference review of CURES, a discussion with the patient regarding his substance abuse history, or an attempt to obtain prior medical records. Respondent diagnosed the patient with back pain with a history of surgeries, and anxiety with panic attacks. At the conclusion of this visit, Respondent referred Patient D to pain management and psychotherapy, and prescribed him a thirty-day supply of medications, including 120 tabs of oxycodone 30 mg, 60 tabs of alprazolam 2 mg, and 120 tabs of gabapentin 800 mg. Respondent did not discuss the risks and benefits of these medications with Patient D or safer alternatives or complementary therapies.

69. On or about April 1, 2015, Patient D was found unconscious and cyanotic in his bed. Patient D was taken to the emergency room by ambulance and treated for overdose of his prescription medications. Four days later, Patient D died as a result of complications of multiple drug toxicity.

70. On or about September 29, 2020, an investigator for the Board (Investigator J.M.) spoke with Respondent by phone and informed him that she wanted to schedule an interview to discuss his care and treatment of Patient D. Respondent informed the investigator that he needed to contact his attorney before scheduling an interview.

71. On or about October 2, 2020, Investigator J.M. called Respondent to follow-up on the scheduling of the interview. Respondent informed the investigator that he was still looking for legal representation. Investigator J.M. told Respondent to get back to her by October 9, 2020.

72. On or about October 12, 2020, having not received any correspondence from Respondent, Investigator J.M. sent a certified letter to Respondent informing him that he had until October 21, 2020, to provide his availability for an interview or she would issue a subpoena for his appearance.

73. On or about October 16, 2020, Respondent contacted Investigator J.M. by phone and requested she contact his attorney, J.S., to schedule the interview.

74. On or about October 20, 2020, Investigator J.M. spoke with attorney J.S. by phone regarding scheduling the interview. On that same date, Investigator J.M. emailed attorney J.S. and requested he provide five potential dates for the interview in the next thirty days.

75. On or about November 6, 2020, attorney J.S. emailed Investigator J.M. and confirmed that the interview could take place on November 17, 2020.

76. On or about November 9, 2020, Investigator J.M. emailed an interview confirmation letter to attorney J.S., indicating that the interview would occur on November 17, 2020, at 10:00 a.m., via a conference call.

77. On or about November 17, 2020, at 10:00 a.m. Respondent did not call in for the interview as scheduled. Attorney J.S. informed Investigator J.M. that he had previously confirmed the interview date and time with Respondent.

78. Respondent committed gross negligence in his care and treatment of Patient D, which included, but was not limited to, prescribing high doses of opiate and benzodiazepine medications to a new patient with previous controlled substance use, history of substance abuse and overdose, and who had recently been prescribed benzodiazepines by other providers.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

79. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 34639 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 hereinafter:

A. Paragraphs 7 through 78, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to adjust Patient C's statin dosage according to lipid panel results;

C. Failing to run CURES or obtain substance abuse history before prescribing controlled substances to Patient D; and

D. Failing to discuss and/or document a discussion of the risks and benefits of use of controlled substances before prescribing controlled substances to Patient D.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

80. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 34639 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 7 through 78, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Attend and Participate in Interview)

81. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 34639 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (g), of the Code, in that without good cause, Respondent failed to attend and participate in an interview by the Board, as more particularly alleged in paragraphs 64 through 78 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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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 No. G 34639, issued to Respondent, Vernal Martin Hansen, M.D.;

2. Revoking, suspending or denying approval of Respondent, Vernal Martin Hansen, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Vernal Martin Hansen, 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: JAN 19 2021

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

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