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

In the Matter of the Accusation Against: Robert Michael Hutchman, M.D. Physician's and Surgeon's Certificate No. A 85762 Respondent.	Case No.: 800-2018-043227

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

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
CHRISTINE R. FRIAR
Deputy Attorney General
State Bar No. 228421
300 South Spring Street, Suite 1702
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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: **ROBERT MICHAEL HUTCHMAN, M.D.** **517 East Wilson Avenue, Suite 103A** **Glendale, CA 91206** **Physician's and Surgeon's Certificate No. A 85762,** Respondent.	Case No. 800-2018-043227 OAH No. 2021040146 **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 Christine R. Friar, Deputy Attorney General.

2. Respondent Robert Michael Hutchman, M.D. (Respondent) is represented in this proceeding by attorney Edward Shkolnikov, Law Offices of Edward Shkolnikov, 14930 Ventura Blvd., Suite 340, Sherman Oaks, California 91403.

3. On or about January 23, 2004, the Board issued Physician's and Surgeon's Certificate No. A 85762 to Robert Michael Hutchman, 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. 800-2018-043227, and will expire on March 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-043227 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 7, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-043227 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. 800-2018-043227. 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.

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2018-043227.

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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. 800-2018-043227 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 the 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. A 85762 issued to Respondent Robert Michael Hutchman, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years 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. 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 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. PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall

undergo and complete the program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The program shall evaluate Respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on Respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, Respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

Respondent shall not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

8. PSYCHIATRIC EVALUATION. Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its

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

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that Respondent is mentally fit to practice medicine safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

9. MONITORING - PRACTICE AND 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 and billing 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 and billing 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 billing, 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 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.

10. 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.

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

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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. 800-2018-043227 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, Edward Shkolnikov. 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: 02/DEC/2021

ROBERT MICHAEL HUTCHMAN, M.D.
Respondent

I have read and fully discussed with Respondent Robert Michael Hutchman, 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: 12/02/21

EDWARD SHKOLNIKOV
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

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

CHRISTINE R. FRIAR
Deputy Attorney General
Attorneys for Complainant

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Edward Shkolnikov. 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: _____ _____

ROBERT MICHAEL HUTCHMAN, M.D.
Respondent

I have read and fully discussed with Respondent Robert Michael Hutchman, 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: _____ _____

EDWARD SHKOLNIKOV
Attorney for Respondent

ENDORSEMENT

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

DATED: December 2, 2021

Respectfully submitted,

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

Christine Friar Digitally signed by Christine Friar Date: 2021.12.02 15:47:47 -08'00'

CHRISTINE R. FRIAR
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2018-043227

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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: **ROBERT MICHAEL HUTCHMAN, M.D.** **517 East Wilson Avenue, Suite 103A** **Glendale, CA 91206-4376** Physician's and Surgeon's Certificate No. A 85762, Respondent.	Case No. 800-2018-043227 **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 January 23, 2004, the Medical Board issued Physician's and Surgeon's Certificate Number A 85762 to Robert Michael Hutchman, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2021, 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.

STATUTORY PROVISIONS

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2228.1 of the Code provides, in pertinent part:

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:
>
> (1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:
>
> ...
>
> (D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.
>
> (2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.
>
> (b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.
>
> (c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:
>
> (1) The patient is unconscious or otherwise unable to comprehend the

disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

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

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

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

"...."

6. Section 2234 of the Code, states:

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

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

...

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

....

7. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled

substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

8. Section 2242, subdivision (a), of the Code states:

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

9. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or

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

(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.

10. 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)

11. Respondent Robert Michael Hutchman, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence when he borrowed money from a patient. The circumstances are as follows:

12. Respondent specializes in neurology. Since approximately October 2017, he has co-owned and been engaged in the practice of medicine at a private outpatient medical practice located in Glendale, California. Prior to that, and since 2004, he had been in private practice in Reseda, California.

Patient 1[1]

13. Patient 1 was a patient of Respondent's for approximately eight (8) years.

14. Respondent's January 26, 2015, progress note for Patient 1 states that he is 68 years old with a history of Parkinson's disease, benign prostatic hypertrophy, anxiety, depression,

[1] The patients whose care and treatment are at-issue in this charging document are designated by number (e.g., "Patient 1") to address privacy concerns. The patients' identities are known to Respondent and will be further disclosed during discovery.

gastritis, age-related dementia, lower back pain, restless leg syndrome, and orthostatic hypotension. Patient 1's current medications included baby aspirin, Azilect (for Parkinson's disease), melatonin, Nasonex, pantoprazole (a proton pump inhibitor for acid reflux), ropinirole (a dopamine promotor used to treat Parkinson's disease and restless leg syndrome), venlafaxine (a selective serotonin and norepinephrine reuptake inhibitor (SSNRI)), and Zyrtec.

15. At the January 26, 2015, visit, Respondent diagnosed Patient 1 with dementia, among other ailments. Patient 1's MMSE score was 28 out of 30, which Respondent noted, "is consistent with a normal level of cognitive function in the setting of Parkinson's disease."

16. Respondent's treatment plan for Patient 1 included "start Alprazolam 0.5 mg TID prn anxiety," "[c]ontinue Carbidopa 25 mg and Levodopa 100 mg one tablet 4 times daily," and "continue current medications." Alprazolam, brand name Xanax, is a Schedule IV benzodiazepine. Carbidopa-levodopa, brand name Sinemet, is a dopamine promoter used to treat Parkinson's disease. Respondent's prescription log for Patient 1's January 26, 2015, visit includes "Alprazolam 0.5 mg daily ahs prn insomnia #30 3 refills."

17. On or about March 11, 2015, Respondent documented that Patient 1 returned for a follow up visit. Patient 1 reported "tremor to heart and bilateral upper extremities are getting worse... Amantidine did not help in the past." Respondent started Patient 1 on propranolol, a beta blocker, 20 mg for the tremor. He also increased the dosage of Patient 1's carbidopa-levodopa to one and half tablets 4 times daily and continued Patient 1's other medications.

18. According to Respondent's prescription log entry for Patient 1's March 11, 2015, visit, Respondent also prescribed Patient 1 "Lorazepam 1 mg TID prn #90 3 refills." Lorazepam, generic for Ativan, is a Schedule IV benzodiazepine. The addition of lorazepam to Patient 1's mediation regimen is not reflected in Respondent's March 11, 2015, progress note for Patient 1.

19. According to Respondent's prescription log for Patient 1, on or about April 29, 2015, he prescribed Patient 1 "Alprazolam 0.5 mg daily qhs prn insomnia #30 3 refills."

20. At a July 14, 2015, visit, Respondent documented that Patient 1 stated that "Lorazepam 1 mg TID is superior to Propranolol is relieving tremor." Patient 1 also reported that he is taking carbidopa-levodopa without therapeutic relief. Respondent continued Patient 1's

carbidopa-levodopa dosage of 25 mg 100 mg one and a half tablets 4 times daily and added prescriptions for Rytary, another brand of carbidopa-levodopa, and lorazepam 1 mg. Respondent noted that Patient 1 was advised to "minimize intake of Alprazolam to avoid morning grogginess." According to Respondent's prescription log for Patient 1's July 14, 2015, visit, he prescribed Patient 1, "Lorazepam 1 mg TID prn anxiety #90 3 refills."

21. At an August 18, 2015, visit, Patient 1 complained of lower back pain from a fall at home that occurred over a month prior. Respondent added sciatica to his list of diagnoses for Patient 1. According to Respondent's prescription log for Patient 1's August 18, 2015, visit, he prescribed Patient 1, "Alprazolam 0.5 mg daily qhs prn insomnia #30 3 refills."

22. Patient 1 continued to complain of lower back pain and on October 27, 2015, reported receiving an epidural injection to the lower back that provided significant relief.

23. According to Respondent's prescription log for Patient 1's November 30, 2015, visit, he prescribed Patient 1, "Alprazolam 0.5 mg daily qhs prn insomnia #30 3 refills" and "Norco 5/325 mg tab TID prn back pain #90 no refills." Norco, brand name for hydrocodone 5 mg/325 mg, is a Schedule II opiate. The addition of Norco to Patient 1's medication regime is not mentioned in Respondent's November 30, 2015, progress note.

24. On January 4, 2016, Patient 1 presented to Respondent still complaining of occasional lower back pain. Respondent added meloxicam, a nonsteroidal anti-inflammatory drug (NSAID), and hydrocodone 5 mg/325 mg (Norco) to Patient 1's medication list.

25. At Patient 1's next visit on February 8, 2016, Respondent noted that Patient 1 complained of moderate to severe sciatica and had consulted another physician about surgical options. Respondent continued to include alprazolam, lorazepam and hydrocodone on Patient 1's medication list, in addition to numerous other medications. Respondent's treatment plan included continuing Patient 1's medications and to follow up with his other physician regarding pain management and back surgery options.

26. For the next year, Patient 1's condition was documented as remaining stable without significant changes. Respondent continued him on his medications and consistently diagnosed him with dementia and sciatica with aggravation, among other ailments. According to his

prescription log for Patient 1, Respondent repeatedly prescribed Patient 1 alprazolam during this time period.

27. While Patient 1 was under the care of Respondent, in March 2017, Respondent approached Patient 1 for a loan of $10,000.00.

28. Patient 1 loaned Respondent $5,000.00 and Respondent agreed to repay him.

29. On or about April 4, 2017, Patient 1 presented to Respondent for care and treatment, which he received. On that same day, Respondent also signed a Promissory Note agreeing to pay Patient 1 $5,000, plus interest, in return for a loan of the same amount. Pursuant to the Promissory Note, Respondent was to make monthly payments to Patient 1 at a minimum of interest only. Payments were to be made on the first of each month, commencing on May 1, 2017. The loan was to be paid in full, plus interest by July 1, 2017. A payment received after the 10th of any month would be considered late.

30. By July 1, 2017, Respondent had not made any payments to Patient 1 on the Promissory Note. On that same day, Respondent signed a second Promissory Note again agreeing to pay Patient 1 $5,000, plus interest, in return for the loan. Pursuant to the second Promissory Note, Respondent was to make three payments to Patient 1, each in the amount of $1,666.67, plus interest, commencing on August 1, 2017. The payments were to be monthly and the loan was to be paid in full, plus interest by October 1, 2017. A payment received after the 10th of any month would be considered late and subject to a $15.00 fee.

31. On or about July 10, 2017, Respondent documented that Patient 1 continued to have lower back pain and was following up with his orthopedist regarding surgical and epidural options. In addition to continuing his current medications, Respondent added a MedrolDose, a steroid, to treat Patient 1's sciatica. According to his prescription log, Respondent also prescribed Patient 1 "Alprazolam 0.5 mg daily qhs prn insomnia #30 3 refills" at that visit.

32. Respondent documented that Patient 1 underwent lumbar surgery in August 2017.

33. Respondent made the August 1, 2017, payment on the loan to Patient 1. He did not, however, make the second payment owed to Patient 1 on September 1, 2017.

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34. On or about September 27, 2017, Patient 1 sent Respondent correspondence notifying him that the loan was past due and including a billing statement. Over the course of the next year and a half, Respondent made no payments to Patient 1.

35. At an October 24, 2019, interview with Board, Respondent stated that, "Medicare made unilateral changes in the reimbursement for patient, and my practice went out of business. And I have never recovered an adequate income stream to fully pay back [Patient 1]...." At the time of that interview, Respondent had made only the one payment on the loan in August 2017, and owed Patient the remaining principal, plus interest and late fees.

36. According to Respondent's prescription log for Patient 1, on or about September 28, 2017, he prescribed him "Oxycodone – APAP 7.5/325 Tab TID #90 no refills." Oxycodone is a Schedule II opiate. There is no progress note of this date associated with this prescription or any office visit.

37. On or about October 23, 2017, Respondent documented that Patient 1's lower back is "much relieved" and that he is "doing well in physical therapy." Respondent listed alprazolam and hydrocodone among Patient 1's medications. Oxycodone is not listed. Lorazepam is also not listed. According to Respondent's prescription log, however, he prescribed Patient 1 "[l]orazepam 1 mg TID prn anxiety #90 3 refills" at that visit.

38. Respondent continued to list alprazolam and hydrocodone among Patient 1's medications in his progress notes for Patient 1 through July 10, 2018. According to Respondent's prescription log for Patient 1, he prescribed Patient 1 "Alprazolam 0.5 mg daily qhs prn insomnia #30 3 refills" on January 30, 2018, April 9, 2018, and July 10, 2018. He prescribed "Lorazepam 1 mg TID prn anxiety #90 3 refills" on March 14, 2018.

39. On or about June 9, 2018, Respondent documented discussing with Patient 1 the results from the MMSE conducted at his last visit. Patient 1 scored 27/30, which is "normal." Respondent continued to list dementia as one of Patient 1's diagnoses.

40. The standard of care in the medical community provides that physicians should not borrow money from, or loan money to, patients who are under their care. This is particularly true of patients with dementia.

41. Respondent committed an extreme departure from the standard of care when he asked Patient 1 for a loan and then accepted a loan of $5,000.00 from Patient 1.

42. Respondent's care and treatment of Patient 1 caused Patient 1 harm. Respondent violated the professional boundaries of the doctor-patient relationship when he asked for and accepted a loan from Patient 1. Respondent then failed to pay Patient 1 back as promised, directly causing Patient 1 financial harm.

43. Respondent's acts and/or omissions as set forth in paragraphs 12 through 42, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Dishonest and Corrupt Acts)

44. Respondent is subject to disciplinary action under section 2234, subdivision (e), of the Code, in that Respondent committed dishonest and corrupt acts substantially related to the qualifications, functions, or duties of a physician and surgeon during the course of his care and treatment of Patient 1. The circumstances are as follows:

45. The allegations contained in the First Cause for Discipline herein are incorporated by reference as if fully set forth.

46. More specifically, during the course of his care and treatment of Patient 1, Respondent asked Patient 1 for a loan, borrowed $5,000.00 from Patient 1, and then failed to pay the loan back to Patient 1, as promised.

47. Further, throughout his care and treatment of Patient 1, Respondent had diagnosed Patient 1 with dementia.

48. Respondent's acts and/or omissions as set forth in paragraphs 45 through 47, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute dishonest and corrupt acts substantially related to the qualifications, functions, or duties of a physician and surgeon pursuant to section 2234, subdivision (e), of the Code. As such, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

49. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

Patient 1

50. The allegations contained in the First Cause for Discipline herein are incorporated by reference as if fully set forth.

51. The standard of care in the medical community requires that a diagnosis of dementia should be based on a careful history and neurological examination, as well as imaging of the brain. Patients with dementia typically have an impairment in their ability to carry out their activities of daily living, including making financial decisions, and may be treated with medication to slow the loss of cognitive function.

52. Respondent departed from the standard of care when he diagnosed Patient 1 with dementia, as Patient 1's medical record does not support the diagnosis. At his October 24, 2019, interview with the Board, Respondent stated that the diagnosis was based on his "interaction" with Patient 1 and the MMSE results. Respondent admitted, however, that the diagnosis, which he repeated throughout Patient 1's course of care and treatment, was an "error."

53. The standard of care in the medical community requires that whenever possible benzodiazepines, barbiturates and opiates should not be prescribed concurrently due to the risk of overdose. If they are prescribed concurrently, the patient should be warned about potential dependency and safety issues. As of April 2018, a physician is required to check a patient's CURES Report before prescribing controlled substances.

54. Respondent departed from the standard of care in his prescription of controlled substances to Patient 1. For example, Respondent prescribed Patient 1 two benzodiazepines, alprazolam and lorazepam, simultaneously. Respondent also concurrently prescribed an opiate analgesics, Norco and then oxycodone, to Patient 1, while also prescribing benzodiazepines. On or about July 10, 2018, Respondent prescribed Patient 1 alprazolam without checking his CURES

Report.

Patient 2

55. Patient 2 presented to Respondent on or about September 7, 2015. Respondent documented that Patient 2 was a 27-year-old male presenting with complaints of persistent lower back pain, neck pain, and mid back pain from a work-related accident. Respondent also documented that Patient 2 had a history of ADHD since age 7 (treated with Adderall), generalized anxiety disorder with panic attacks and post-traumatic stress disorder (PTSD) (treated with alprazolam), and chronic pain syndrome secondary to a diaphragmatic hernia at birth. Respondent did not review any of Patient 2's prior treatment records. Respondent performed a physical examination and prescribed Patient 2 Norco (10/325 mg, 150 tablets, no refills), Adderall (a Schedule IV, central nervous system stimulant) (20 mg, 2 times a day, #60, no refills), and alprazolam (2 mg, 2 times a day, #60, 3 refills). According to Respondent's prescription log for Patient 2, but not his patient note, he also prescribed citalopram (generic for Celexa, a selective serotonin reuptake inhibitor (SSRI), an antidepressant) (20 mg, daily, #30, 12 refills).

56. A September 22, 2015, note from an Electromyography (EMG) study diagnosed bilateral carpal tunnel syndrome, but not cervical radiculopathy.

57. An October 5, 2015, follow up note states that Patient 2 is still complaining of upper and lower back pain with radiation to both legs and numbness and tingling. Patient 2 also reported feeling "clumsy" with his hands and fingers. He reported that Norco relieved the pain and that he had been taking more pills lately to get relief. He also reported episodes of panic, anxiety, sadness, lack of interests and insomnia relieved by Adderall and alprazolam. Respondent's diagnoses included thoracic sprain, myofascial pain, lumbosacral sprain, carpal tunnel syndrome, chronic pain syndrome, opioid dependency and benzodiazepine dependency. The treatment plan included prescriptions for Norco and Adderall, continue alprazolam, and follow up for an EMG/Nerve conduction study (NCS) on the lower extremities. Physical therapy and chiropractic therapy were also recommended.

58. A November 2, 2015, EMG report was consistent with bilateral L4-L5 radiculopathy, but showed no evidence of neuropathy.

59. At the November 2, 2015, office visit, Respondent documented Patient 2 as complaining of constant pain and numbness. Respondent's assessment of Patient 2 included Respondent's previous diagnoses of opioid dependency and benzodiazepine dependency, among others. The treatment plan included another EMG/NCS. Respondent prescribed Norco and Adderall.

60. Patient 2 was treated by Respondent again on or about December 1, 2015. Respondent documented that Patient 2's complaints included back pain, clumsiness in the hands and fingers, anxiety, flashbacks and crying spells. Respondent prescribed Norco and Adderall. Patient 2 was to return in four (4) weeks and epidural and facet injections would be considered.

61. Patient 2 returned on or about February 3, 2016. Respondent documented that Patient 2 continued to complain of back pain, clumsiness, anxiety, and suicidal thoughts but no suicidal plans. Respondent renewed his prescriptions for Norco, Adderall and alprazolam (3 refills) and advised Patient 2 to continue with physical therapy and chiropractic.

62. Patient 2 returned on or about April 1, 2016, August 28, 2016, and September 29, 2016. He continued to complain of pain and Respondent continued his medications, including his prescription for citalopram, 12 refills, which Respondent renewed at the August 28, 2016, visit.

63. On or about August 10, 2017, Patient 2 presented to Respondent complaining of abdominal pain and cramping and recent bowel obstruction. Respondent prescribed Patient 2, Norco 60 tablets, at that visit.

64. On or about May 18, 2018, Patient 2 returned to Respondent continuing to complain of back and neck pain and reporting being a passenger in a recent car accident. Respondent performed a neurological examination and prescribed Patient 2, Norco, 90 tablets. Respondent did not document checking Patient 2's CURES Report prior to prescribing the Norco.

65. At no point during his care and treatment did Respondent enter into a written pain contract with Patient 2 or document conducting any urine drug screening to ensure compliance with his medication regimen.

66. The standard of care in the medical community requires that when treating a patient with long-term opioids that the physician ensure compliance with the treatment plan. Pain

contracts and urine testing are often used to ensure that the patient is only getting opioids from one pharmacy, is not asking for additional refills, is not obtaining the same medication from other prescribers and is actually taking the medication as prescribed, as opposed to diverting it. As of April 2018, a physician is required to check a patient's CURES Report before prescribing controlled substances.

67. Respondent departed from the standard of care when he prescribed Patient 2 long-term opioids without requiring him to sign a pain contract, conducting any urine testing or documenting that he checked Patient 2's CURES Report at his May 18, 2018, visit.

68. The standard of care in the medical community requires that when a patient presents for a neurological consult and requires treatment with multiple controlled substances that the physician ensure that the diagnoses are correct and that the use of such medications is appropriate. The physician should not rely exclusively on the medical history as reported by the patient, but instead should request records from the patient's prior physicians.

69. Respondent departed from the standard of care when he diagnosed Patient 2 with ADHD, chronic pain and anxiety, and treated him with multiple controlled substances, based solely on Patient 2's reporting of his conditions, instead of also requesting his prior medical records.

70. The standard of care in the medical community requires that opioids should be minimized or avoided in patients who have suffered a bowel obstruction, as opioids can cause bowel obstruction.

71. Respondent departed from the standard of care when he continued to prescribe Patient 2 Norco, an opioid, after Patient 2 reported suffering from a bowel obstruction without discussing with Patient 2 reducing or stopping his course of opioids.

72. The standard of care in the medical community requires that when a physician recognizes opioid or benzodiazepine dependence in a patient that the physician have a conversation with the patient about the dependency and take steps to address it. Those steps could include trying to wean the patient off the medication, replacing the medication with an alternative, or seeking the help of a pain management physician.

73. Respondent departed from the standard of care when he diagnosed Patient 2 with opioid and benzodiazepine dependency and failed to discuss with him the need to address the dependencies and the steps available.

74. The standard of care in the medical community requires that when managing chronic pain, a physician should attempt to use non-opioid medication when possible, given the known issues with dependence, addiction, and mortality in opioid users. Patients who require opioids should be encouraged to use them over the short-term, as a rescue treatment only.

75. Respondent departed from the standard of care when he failed to document recommending other classes of pain medication, besides opioids, to Patient 2.

Patient 3

76. Patient 3 treated with Respondent from 2015 through 2018. Respondent treated Patient 3 for multiple issues including myofascial pain, anxiety, carpal tunnel syndrome, traumatic brain injury, ADHD, opioid dependency, and erectile dysfunction, as well as several respiratory infections.

77. Patient 3 presented to Respondent on or about November 4, 2015, for an initial consultation. Respondent documented that Patient 3 is a "39-[year-old] right hand dominant [male with] progressive pain to lower back, and neck with radiation to legs and hand and numbness with tingling... He was taking Norco 7.5 mg twice daily but felt that "the pain lately has been more intense." Respondent's diagnoses include rule out cervical radiculopathy, myofascial pain, lumbosacral sprain/strain, rule out carpal tunnel syndrome, chronic pain syndrome, rule out lumbar radiculopathy, traumatic brain injury with concussion syndrome, and coccydynia. Respondent prescribed Norco, 10/325 mg, 150 tablets.

78. On or about December 9, 2015, Respondent documented that Patient 3's pain "is better" controlled on the higher dose of Norco and that the treatment plan is to continue his medications. Respondent refilled Patient 3's Norco prescription.

79. On or about January 27, 2016, Patient 3 reported to Respondent that he was having difficulty focusing at work and "[h]e believe[s] he was told he had ADHD around age 14 but never treated with prescription medication." Respondent prescribed a trial course of Adderall, in

addition to refilling Patient 3's Norco prescription.

80. On or about February 18, 2016, Patient 3 reported that the Adderall was helping him focus. Respondent continued him on Norco and Adderall.

81. Respondent continued Patient 3 on his medications, until May 20, 2016, when he prescribed alprazolam 1 mg BID prn anxiety #60, 3 refills, in addition to Norco and Adderall.

82. On or about July 11, 2016, Patient 3 reported that "his anxiety is not fully relieved with alprazolam 1 mg." Respondent increased his alprazolam dosage to 2 mg twice daily as needed for anxiety. Respondent also refilled Patient 3's prescriptions for Norco and Adderall.

83. On or about August 17, 2016, Respondent decreased Patient 3's Norco dose from 7.5/325 to 5/325, while continuing him on Adderall and alprazolam.

84. On or about September 20, 2016, Respondent prescribed Patient 3 citalopram 20 mg daily #30 refills 12, in addition to Norco and Adderall.

85. On or about October 18, 2016, Respondent documented that Patient 3 was under stress at work and home and that citalopram seemed to help stabilize his mood. According to Respondent's prescription log, he prescribed Patient 3 Norco, Adderall and sildenafil (generic for Viagra) 20 mg daily prn #30 12 refills.

86. On or about November 2, 2016, Patient 3 presented complaining of a low grade fever for the past few days. Respondent prescribed azithromycin (an antibiotic, generic for a Z-Pak) in addition to refilling Patient 3's Norco, Adderall, and alprazolam prescriptions.

87. On or about January 23, 2017, Respondent documented that Patient 3 complained of pain in the hands, neck, and lower back that was "better" controlled on hydrocodone (generic for Norco) twice daily. Respondent diagnosed Patient 3 with myofascial pain, anxiety, lumbosacral strain, bilateral carpal tunnel syndrome, chronic pain syndrome, bilateral lumbar radiculopathy, traumatic brain injury with concussion syndrome, coccydynia, ADHD, opioid dependency, depression and erectile dysfunction. Respondent refilled Patient 3's Norco and Adderall and continued him on alprazolam and citalopram.

88. Patient 3 returned for follow up visits on March 2, 2017, April 12, 2017, May 11, 2017, June 13, 2017, July 24, 2017 and August 29, 2017. Patient 3 reported that the medications

were providing relief and at each visit, Respondent continued him on Norco, Adderall and alprazolam.

89. On or about October 9, 2017, Patient 3 presented to Respondent requesting sildenafil 20 mg (generic for Viagra). Respondent prescribed sildenafil, 20 mg daily prn, #30, 6 refills, in addition to refilling Patient 3's prescriptions for Norco and Adderall.

90. On or about November 2, 2017, Patient 3 presented to Respondent with a productive cough and low-grade fever. Respondent prescribed azithromycin and refilled Patient 2's Norco and Adderall prescriptions. Respondent did not perform a chest x-ray.

91. On or about February 14, 2018, Patient 3 presented to Respondent complaining about difficulty falling asleep at night due to mental stress and lower back pain at night. Patient 3 had the same complaint at his last visit on January 18, 2018. Respondent prescribed trazadone (a SSRI, antidepressant) and refilled his prescriptions for sildenafil, Norco and Adderall.

92. At Patient 3's next visit, on or about March 23, 2018, he reported that the trazadone was helping. Respondent refilled his prescriptions for Norco and Adderall.

93. On or about May 24, 2018, Patient 3 presented to Respondent with cough and congestion for two (2) days. Respondent again prescribed azithromycin, in addition to Norco and Adderall. Patient 3's chest was noted to be clear to auscultation. Respondent did not perform a chest x-ray.

94. Patient 3 presented to Respondent again on or about July 9, 2018, August 10, 2018 and September 14, 2018. At each visit, Respondent refilled Patient 3's medications. At the August 10, 2018 visit, Respondent referred Patient 3 to physical therapy.

95. At no point during his care and treatment did Respondent enter into a written pain contract with Patient 3 or document conducting any urine drug screening to ensure compliance with his medication regimen.

96. Respondent departed from the standard of care in his care and treatment of Patient 3 when he prescribed Patient 3 long-term opioids without requiring him to sign a pain contract, conducting any urine testing or documenting that he checked Patient 3's CURES Report at the May 24, 2018, July 9, 2018, August 10, 2018 and September 14, 2018, visits.

97. Respondent departed from the standard of care when he diagnosed Patient 3 with ADHD, chronic pain, anxiety, and traumatic brain injury, among other diagnoses, and treated him with multiple controlled substances, based solely on Patient 3's reporting of his conditions, instead of also requesting his prior medical records.

98. Respondent departed from the standard of care when he failed to document recommending other classes of pain medication, besides opioids, to Patient 3.

99. The standard of care in the medical community requires that a diagnosis of erectile dysfunction be based on a careful history and physical examination, as well as blood work when indicated.

100. Respondent departed from the standard of care when, instead of referring Patient 3 to his primary care physician for treatment for erectile dysfunction, he prescribed Patient 3 sildenafil without any clear physical examination or work-up of the sexual dysfunction.

101. The standard of care in the medical community requires a proper work up of a respiratory infection prior to prescribing antibiotics. Either referral should be made to the patient's primary care physician or, if pneumonia is considered, chest x-rays should be obtained.

102. Respondent departed from the standard of care when he repeatedly prescribed Patient 3 azithromycin for respiratory infections without referring him to his primary care physician for treatment or obtaining a chest x-ray.

Patient 4

103. Patient 4 treated with Respondent from 2017 through 2018 for multiple problems, including but not limited to restless leg syndrome, insomnia, chronic pain, ADHD, and narcolepsy. Throughout the course of her treatment with Respondent, he prescribed her clonazepam (generic for Klonopin, a Schedule IV benzodiazepine), Norco, dextroamphetamine (a Schedule II central nervous system stimulant), methadone (a Schedule II opiate agonist), and Keppra (an anticonvulsant).

104. On or about November 14, 2017, Respondent documented Patient 4, as a 59-year-old female, with a "past medical history significant for chronic fatigue syndrome from Epstein-Barr and CMV virus infection for more than 20 years, history of narcolepsy, paresthesias... Restless

leg syndrome and headaches." She reported having an MRI done four (4) years prior, which revealed six (6) herniated discs. She reported being evaluated by neurosurgeon who recommended surgery, but she refused. At that visit, Respondent diagnosed her with narcolepsy, restless leg syndrome, cervical radiculopathy, myoclonic epilepsy, lumbar radiculopathy, oral infection, chronic migraine without aura, chronic pain syndrome and obesity. Respondent's plan of care included prescriptions for clonazepam, levofloxacin (an antibiotic), hydrocodone 10/325 mg, TID prn, #90, no refills (Norco), methylprednisolone (a steroid), dextroamphetamine-amphetamine, methadone, Relpax (for migraines) and cyclobenzaprine (a muscle relaxant).

105. On or about December 12, 2017, Respondent documented that Patient 4's restless leg syndrome responded to methadone 10 mg in the past. Respondent prescribed Norco, leveteracetam (for myocolus), methylprednisolone, clonazepam, levofloxacin, Relpax, dextroamphetamine-amphetamine, methadone, and cyclobenzaprine.

106. On or about January 23, 2018, Respondent documented that Patient 4's movement disorder had gotten worse and that pain had increased in her left arm since her last visit. Respondent refilled her medications, including Norco, and discussed adverse effects.

107. At Patient 4's next visit, on or about February 19, 2018, her condition was stable and Respondent refilled her medications, including Norco.

108. At Patient 4's April 5, 2018, May 24, 2018, and June 26, 2018, office visits, she continued to complain of chronic pain. Respondent continued to refill her medications, including Norco. At the May 24, 2018 visit, Respondent documented discussing an MRI of the cervical and lumbar spine with Patient 4.

109. Patient 4 underwent an MRI, and on or about July 24, 2018, Respondent reviewed the results with her. Respondent documented that the MRI showed mild neuroforaminal narrowing and mild narrowing of the central canal at multiple levels. Disc bulges were noted on the MRI of the thoracic spine and the lumbar spine MRI showed mild narrowing of the central canal at L3-4 and mild narrowing of the neuroforaminal at L5-S1. Patient 4 had approval to see a neurosurgeon. Respondent refilled her medications, including Norco.

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110. On or about August 23, 2018, Patient 4 presented to Respondent. She had not consulted with a neurosurgeon. Respondent told her that "her pain intensity appears to be more exaggerated than results found on the MRI." He informed her that he was going to call her primary doctor to go over her care plan and possibly refer her to a pain management specialist. Respondent refiled her medications, including Norco.

111. On or about September 20, 2018, and after she had still not seen a neurosurgeon, Respondent informed Patient 4 that he would no longer prescribe her controlled substances as he is not a pain management specialist. At that visit, he prescribed her methadone, clonazepam, Norco, dextroamphetamine and methadone, among other medications.

112. At no point during her care and treatment did Respondent enter into a written pain contract with Patient 4 or conduct any urine drug screening to ensure compliance with her medication regimen.

113. Respondent departed from the standard of care in his care and treatment of Patient 4 when he prescribed Patient 4 long-term opioids without requiring her to sign a pain contract, conducting any urine testing or documenting that he checked Patient 4's CURES Report at the May 24, 2018, June 26, 2018, July 24, 2018, August 23, 2018 and September 20, 2018, visits.

114. Respondent departed from the standard of care when he diagnosed Patient 4 with restless leg syndrome, insomnia, chronic pain, ADHD, and narcolepsy, among other diagnoses, and treated her with multiple controlled substances, based solely on Patient 4's reporting of her conditions, instead of also requesting her prior medical records.

115. Respondent departed from the standard of care when he failed to document recommending other classes of pain medication, besides opioids, to Patient 4.

Patient 5

116. Respondent treated Patient 5 from 2011 through 2018.[2] Throughout her care and treatment, Patient 5 complained of chronic neck, back and shoulder pain. For years, Respondent prescribed her medications, including Norco and Soma (generic for carisoprodol, a Schedule IV,

[2] Conduct occurring more than seven (7) years from the filing date of the Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

muscle relaxant), on an almost monthly basis.

117. Patient 5 initially consulted with Respondent on or about December 12, 2011. He documented that she was a 62-year-old female with a long-term history of lower back pain, neck pain and bilateral shoulder pain. Respondent's diagnoses included scoliosis, myofascial pain, degenerative joint disease, degenerative disc disease and spinal stenosis. Respondent's treatment plan included starting Patient 5 on Norco, 7.5/325 mg, 150 tablets. Physical therapy was considered.

118. Throughout 2012 and 2013, Respondent refilled Patient 5's prescription for Norco, 7.5/325 mg, 150 tablets, on an almost monthly basis.

119. An EMG Report from May 6, 2014, indicated subacute L5-S1 radiculopathy without neuropathy.

120. Throughout 2014 and 2015, Respondent continued to refill Patient 5's prescription for Norco, 7.5/325 mg, 150 tablets, on an almost monthly basis.

121. On or about January 7, 2016, Respondent documented that Patient 5 reported that her "pain to neck, shoulders and lower back is relieved with Hydrocodone 7.5 mg, and Aleve combination." Respondent's plan was to continue her medications. Respondent entered similar progress notes on or about February 8, 2016, March 8, 2016, April 9, 2016, May 14, 2016, June 21, 2016, August 25, 2016, September 20, 2016, October 28, 2016, November 28, 2016 and December 27, 2016. On each of those dates, according to Respondent's prescription log, Respondent also refilled Patient 5's prescription for Norco, 7.5/325 mg, 150 tablets.

122. At Patient 5's June 21, 2016 visit, Respondent also added a prescription for Soma, one tab daily prn back spasms #30 3 refills, to her medication regimen. He refilled this prescription on or about October 28, 2016, again with three (3) refills, according to his prescription log.

123. On or about January 9, 2017, February 10, 2017, March 13, 2017, April 13, 2017, May 11, 2017, June 10, 2017, July 14, 2017, August 14, 2017, September 14, 2017, October 9, 2017, November 14, 2017, and December 20, 2017, Respondent treated Patient 5 and, according to his prescription log, prescribed Norco, 7.5/325 mg, 150 tablets.

124. At Patient 5's March 13, 2017, July 14, 2017, and November 14, 2017, visits, Respondent also refilled Patient 5's prescription for Soma, with three (3) refills.

125. On or about January 11, 2018, Patient 5 presented to Respondent complaining of increased pain intensity due to cold weather, and fatigue and sadness around the holidays. Respondent diagnosed her with scoliosis, myofascial pain, lumbosacral sprain, chronic pain syndrome, rule out lumbar radiculopathy, traumatic brain injury with concussion, coccydynia, degenerative joint disease, degenerative disc disease, spinal stenosis, hypertension, hypothyroidism, chronic L5-S1 radiculopathy, opioid dependency, moderate bilateral carpal tunnel syndrome, obesity, lumbar radiculitis, spasm, rule out peripheral vascular disease. Respondent's treatment plan included increasing her Norco, from 7.5/325, 150 tablets, to 10/325, 180 tablets, stretching exercises, atenolol (a beta blocker), wrist braces and Aleve for carpal tunnel pain and lower back inflammation; continuing Soma, and Trental ER (an anti-inflammatory and vasodilator).

126. According to his prescription log, Respondent refilled Patient 5's Norco, 10/325 mg, 180 tablets, on February 24, 2018, April 2, 2018, May 7, 2018, June 4, 2018, July 11, 2018, August 16, 2018, and September 13, 2018.

127. At Patient 5's April 2, 2018, and August 16, 2018 visits, Respondent also refilled Patient 5's prescription for Soma, with three (3) refills.

128. At Patient 5's October 12, 2018, visit, Respondent documented that he discussed with Patient 5 the need for her to see a pain specialist or spine surgeon. Respondent informed her that he would no longer be able to continue prescribing her Norco and Soma. Respondent refilled her Trental and atenolol.

129. At no point during her care and treatment did Respondent enter into a written pain contract with Patient 5 or document conducting any urine drug screening to ensure compliance with her medication regimen.

130. When interviewed by the Board about his care and treatment of Patient 5, Respondent stated that he believes she became opioid dependent while under his care. Accordingly, Respondent's care and treatment of Patient 5 - specifically, the manner in which he prescribed

her opiates - caused her harm.

131. Respondent departed from the standard of care in his care and treatment of Patient 5 when he prescribed Patient 5 long-term opioids without requiring her to sign a pain contract, conducting any urine testing or documenting that he checked Patient 5's CURES Report at the May 7, 2018, June 4, 2018, July 11, 2018, August 16, 2018, and September 13, 2018, visits.

132. Respondent departed from the standard of care when he diagnosed Patient 5 with scoliosis, myofascial pain, lumbosacral sprain, chronic pain syndrome, traumatic brain injury with concussion, degenerative joint disease, degenerative disc disease, and spinal stenosis, among other diagnoses, and treated her with multiple controlled substances, based solely on Patient 5's reporting of her conditions, instead of also requesting her prior medical records.

133. Respondent's acts and/or omissions as set forth in paragraphs 50 through 132, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without Appropriate Examination or Medical Indication)

134. Respondent is subject to disciplinary action under section 2242, subdivision (a), of the Code, in that Respondent prescribed dangerous drugs to Patients 1, 2, 3, 4, and 5, without appropriate prior examination and/or medical indication. The circumstances are as follows:

135. The allegations contained in First and Third Causes for Discipline herein are incorporated by reference as if fully set forth, and represent the prescribing of dangerous drugs without an appropriate prior examination and/or medical indication in violation of Code section 2242, subdivision (a). As such, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

136. Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed narcotic medications to Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

137. The allegations contained in the First and Third Causes for Discipline herein are incorporated by reference as if fully set forth, and represent the excessive prescribing of narcotics in violation of Code section 725. As such, cause for discipline exists.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

138. Respondent is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate records relating to the provision of services to Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

139. The allegations contained in the First and Third Causes for Discipline herein are incorporated by reference as if fully set forth, and represent the failure to maintain adequate and accurate records in violation of Code 2266. As such, cause for discipline exists.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 85762, issued to Robert Michael Hutchman, M.D.;

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

3. Ordering Robert Michael Hutchman, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Robert Michael Hutchman, M.D. to provide the disclosure required by section 2228.1 of the Code; and

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

DATED: Jan. 7, 2021

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

REJI VARGHESE
DEPUTY DIRECTOR