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

In the Matter of the Accusation Against: **Francis Gerard D'Ambrosio, M.D.** **Physician's and Surgeon's Certificate No. G 73590** **Respondent.**	**Case No.: 800-2018-040023**

DECISION

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

This Decision shall become effective at 5:00 p.m. on September 16, 2022.

IT IS SO ORDERED: August 18, 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
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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: **FRANCIS GERARD D'AMBROSIO, M.D.** **22603 Pacific Coast Highway #793** **Malibu, California 90265** **Physician's and Surgeon's Certificate** **No. G 73590,** Respondent.	Case No. 800-2018-040023 OAH No. 2021040674 **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 Francis Gerard D'Ambrosio, M.D. (Respondent) is represented in this proceeding by attorneys Peter R. Osinoff and Derek F. O'Reilly-Jones, Bonne Bridges Mueller O'Keefe & Nichols, 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071-1562.

3. On or about March 10, 1992, the Board issued Physician's and Surgeon's Certificate No. G 73590 to Francis Gerard D'Ambrosio, 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. 800-2018-040023, and will expire on February 29, 2024, unless renewed.

4. The parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of Accusation No. 800-2018-040023 and Medical Board of California Case No. 800-2020-067626.

JURISDICTION

5. Accusation No. 800-2018-040023 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 30, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

6. A copy of Accusation No. 800-2018-040023 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-040023. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

8. 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.

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

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CULPABILITY

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2018-040023 and that he has thereby subjected his license to disciplinary action.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2018-040023 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

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

CONTINGENCY

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

14. 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. 800-2018-040023 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.

15. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 73590 issued to Respondent Francis Gerard D'Ambrosio, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible

medical benefits resulting from the use of marijuana.

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. Respondent shall also maintain a record indicating that he has referred a patient to another physician for recommendation or approval for the personal medical purposes of possession or cultivation of marijuana, 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 referrals for recommendation or approval for the personal medical purposes of possession or cultivation of marijuana 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. MONITORING – PRACTICE. Respondent shall not engage in any direct patient care without first submitting to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including

but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

Prior to engaging in any direct patient care, 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 prior to engaging in direct patient care, Respondent shall not engage in direct patient care.

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

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

replacement monitor is approved and assumes monitoring responsibility.

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

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

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

9. SUPERVISION OF PHYSICIAN ASSISTANTS 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.

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; and Quarterly Declarations.

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

16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and

carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2018-040023 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff, 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: 12-9-21

FRANCIS GERARD D'AMBROSIO, M.D.
Respondent

I have read and fully discussed with Respondent Francis Gerard D'Ambrosio, 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: 12/9/21

PETER R. OSINOFF, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: December 10, 2021

Respectfully submitted,

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

Christine R. Friar

CHRISTINE R. FRIAR
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2018-040023

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

In the Matter of the Accusation Against: **FRANCIS GERARD D'AMBROSIO, M.D.** **22603 Pacific Coast Highway #793** **Malibu, California 90265-5036** **Physician's and Surgeon's Certificate** **No. G 73590,** Respondent.	Case No. 800-2018-040023 **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 March 10, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 73590 to Francis Gerard D'Ambrosio, 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 February 28, 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 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 contendere 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.

....

(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.

....

7. 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. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care."

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8. Section 2242.1 of the Code states:

(a) No person or entity may prescribe, dispense, or furnish, or cause to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices, as defined in Section 4022, on the Internet for delivery to any person in this state, without an appropriate prior examination and medical indication, except as authorized by Section 2242.

(b) Notwithstanding any other provision of law, a violation of this section may subject the person or entity that has committed the violation to either a fine of up to twenty-five thousand dollars ($25,000) per occurrence pursuant to a citation issued by the board or a civil penalty of twenty-five thousand dollars ($25,000) per occurrence.

(c) The Attorney General may bring an action to enforce this section and to collect the fines or civil penalties authorized by subdivision (b).

(d) For notifications made on and after January 1, 2002, the Franchise Tax Board, upon notification by the Attorney General or the board of a final judgment in an action brought under this section, shall subtract the amount of the fine or awarded civil penalties from any tax refunds or lottery winnings due to the person who is a defendant in the action using the offset authority under Section 12419.5 of the Government Code, as delegated by the Controller, and the processes as established by the Franchise Tax Board for this purpose. That amount shall be forwarded to the board for deposit in the Contingent Fund of the Medical Board of California.

(e) If the person or entity that is the subject of an action brought pursuant to this section is not a resident of this state, a violation of this section shall, if applicable, be reported to the person's or entity's appropriate professional licensing authority.

(f) Nothing in this section shall prohibit the board from commencing a disciplinary action against a physician and surgeon pursuant to Section 2242 or 2525.3.

9. 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

(Repeated Negligent Acts)

10. Respondent Francis Gerard D'Ambrosio, M.D. 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, 5, 6, 7, and 8.[1] The circumstances are as follows:

[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.

11. Since 2014, Respondent has owned and operated a solo medical practice called, "Dr. Frank." Respondent's practice consists of evaluating patients for medical cannabis recommendation letters. Respondent sees approximately one hundred (100) patients a day, both adult and pediatric. Respondent conducts all of his patient visits via telemedicine from an office in his home.

12. Respondent receives patient referrals and treats patients through several different websites, including 420 Recs and NuggMD. Respondent hires these websites to give him access to patients through a telemedical portal. Prior to connecting Respondent with a patient, the patient has completed an intake form and paid for the visit with Respondent through the website. Respondent, in turn, pays these websites for the patient referrals.

13. At the conclusion of a visit, Respondent has the option to "accept" or "reject" the patient for a medical marijuana recommendation. If Respondent rejects the patient, and does not issue a medical marijuana recommendation, the patient is not charged for the visit.

14. The standard of care in the medical community requires that an appropriate examination be conducted on a patient prior to recommending marijuana. An appropriate medical marijuana evaluation should include: a history and good faith examination of the patient; development of a treatment plan with objectives; provision of informed consent including discussion of side effects; periodic review of the treatments efficacy; consultation, as necessary; and proper record keeping that supports the decision to recommend the use of medical marijuana.

15. When presented with a patient with a potential psychiatric condition, a good faith examination requires that an adequate psychiatric history and mental status examination be conducted prior to recommending marijuana. A mental status examination includes evaluation of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perceptions, cognition, insight and judgment.

16. The standard of care in the medical community requires that medical marijuana evaluations include adequate documentation that supports the decision to recommend marijuana. Clinical details are an integral part of adequate medical records. Documentation should reflect the physician's initial history and physical/mental status exam, evaluation of each condition in

question, and the diagnosis or differential diagnosis. When recommending any medication or treatment, including medical marijuana, the risks and benefits must be weighed and consideration should be given to other treatments tried in the past, in order to perform an independent, objective evaluation of the appropriateness of the course of treatment. These clinical factors should be documented in the patient's record.

17. The standard of care in the medical community requires adequate review of a patient's past medical record to find corroborating evidence of diagnoses and past medical and psychiatric history when determining whether a patient is appropriate for a medical marijuana recommendation.

Patient 1

18. On or about October 29, 2017, Respondent had an initial consultation with Patient 1, a 19-year-old male, via telemedicine.

19. Patient 1 was referred to Respondent through the website NuggMD.

20. According to Respondent's records, Patient 1's self-reported "medical conditions" were "anxiety, migraines, [and] stress." Respondent's medical records for Patient 1 do not contain any other clinical information about Patient 1's health history, these conditions, Patient 1's current state, or any examination(s) performed.

21. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 1. The recommendation was valid for one year.

22. Respondent's care and treatment of Patient 1 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 1 prior to recommending marijuana. For example, Patient 1 reported anxiety, a potential psychiatric condition, and Respondent failed to perform and/or document an adequate psychiatric history and mental status examination on Patient 1.

23. Respondent's care and treatment of Patient 1 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 1. Specifically, Respondent did not document any clinical assessment of Patient 1. For example, there is no discussion in the record of the therapeutic

benefits of marijuana versus its potential adverse effects and risks in a patient with anxiety and why its therapeutic benefits outweigh the risks for Patient 1. There is also no documentation of any alternative therapies tried by Patient 1 and/or how long they were tried, whether these therapies were effective or ineffective, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. For Patient 1's three medical conditions listed – anxiety, migraines and stress – Respondent failed to document any details about the conditions, such as when they were diagnosed, level of severity, or impact on quality of life.

24. Respondent's care and treatment of Patient 1 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 1's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to make any attempt to request any of Patient 1's prior medical records or to speak with any of Patient 1's prior treaters before recommending marijuana. Respondent should have sought confirmation of Patient 1's self-reported medical conditions, as anxiety, migraines and stress are subjective conditions that typically do not have physical confirmatory signs or symptoms. Patient 1's young age also increases the risk that his self-reported clinical history contained inaccuracies further necessitating the need for confirmation.

Patient 2

25. On or about March 24, 2018, Respondent had an initial consultation with Patient 2, an 18-year-old male, via telemedicine.

26. Patient 2 was referred to Respondent through the website NuggMD.

27. According to Respondent's records, Patient 2 self-reported his "medical problem(s)" as "anxiety and migraines." Patient 2 further reported that he was currently taking Concerta, a Schedule II stimulant used to treat attention deficit/hyperactivity Disorder ("ADHD"), Lexapro, a selective serotonin reuptake inhibitor ("SSRI"), and that he had received medical marijuana recommendations in the past. Respondent's medical records for Patient 2 do not contain any further clinical information about Patient 2's health history, these conditions, Patient 2's current

state, or any examination(s) performed.

28. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 2. The recommendation was valid for one year.

29. According to Respondent's records, on or about April 5, 2019, and again on May 8, 2020, Respondent renewed Patient 2's recommendation for medical marijuana. Respondent's medical records for Patient 2 do not contain any further clinical information about Patient 2's health history, these conditions, Patient 2's current state, or any examination(s) performed at the time of these renewals.

30. Respondent's care and treatment of Patient 2 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 2 prior to recommending marijuana. For example, Respondent failed to perform and/or document an adequate psychiatric history and mental status examination of Patient 2, even though Patient 2 had reported anxiety, a potential psychiatric condition, and taking two psychiatric medications, Concerta and Lexapro, typically used to treat ADHD, depression, and anxiety.

31. Respondent's care and treatment of Patient 2 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 2. Specifically, Respondent did not document any clinical assessment of Patient 2, including any information about his psychiatric history. For example, though Patient 2 reported taking Lexapro, there is no information documented in the record regarding any clinical details, such as how long Patient 2 has been taking Lexpro, whether it has been effective for anxiety, or if medical marijuana is needed as additional therapy because Lexapro is not effective. Likewise, there is no clinical detail regarding Patient 2's prescription for Concerta. Additionally, there is no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with anxiety and why its therapeutic benefits outweigh the risks for Patient 2. There is also no documentation of any other therapies tried, how long they were tried, their effectiveness, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. Finally, for Patient 2's

medical conditions listed – anxiety and migraines– Respondent failed to document any details about the conditions, such as when they were diagnosed, level of severity, and impact on quality of life.

32. Respondent's care and treatment of Patient 2 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 2's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to make any attempt to request any of Patient 2's prior medical records or to speak with any of Patient 2's prior treaters before recommending marijuana. Patient 2 reported taking two other psychiatric medications, rendering him a high risk patient for recommendation for another substance with potential psychoactive effects like marijuana. Respondent made no attempt to communicate with any of Patient 2's other treaters to obtain pertinent clinical information or to alert them to the new treatment that Patient 2 would be commencing. Respondent should have sought confirmation of Patient 2's self-reported medical conditions, as anxiety and migraines are subjective conditions that typically do not have physical confirmatory signs or symptoms. Patient 2's young age also increases the risk that his self-reported clinical history contained inaccuracies further necessitating the need for confirmation.

Patient 3

33. Patient 3 is an older sibling of Patient 2.

34. On or about April 5, 2018, Respondent had an initial consultation with Patient 3 via telemedicine.

35. Patient 3 was referred to Respondent through the website NuggMD.

36. At the initial consultation, Patient 3's self-reported "medical problem(s)" were documented as "anorexia, anxiety and other condition PTSD." Patient 3 further reported currently taking Zoloft (an SSRI antidepressant), Rexulti (an atypical antipsychotic medication that modulates serotonin and dopamine), and Lamicital (an anticonvulsant medication that can also be used as a mood stabilizer). Patient 3 also reported having experienced hallucinations. Respondent's medical records for Patient 3 do not contain any further clinical information about

Patient 3's health history, these conditions, Patient 3's current state, or any examination(s) performed.

37. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 3. The recommendation was valid for one year.

38. According to Respondent's records, on or about October 13, 2019, Respondent renewed Patient 3's recommendation for medical marijuana. During that consultation, Patient 3's self-reported "medical problem(s)" were documented as "chronic pain, migraines, and other condition ADHD." Patient 3 reported that he was not currently taking other medication. Patient 3 again reported having experienced hallucinations. Respondent's medical records for Patient 3 do not contain any further clinical information about Patient 3's health history, these conditions, Patient 3's current state, or any examination performed.

39. Respondent's care and treatment of Patient 3 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 3 prior to recommending marijuana. Patient 3 had reported anxiety, anorexia, and PTSD, which are significant psychiatric conditions. Patient 3 further reported taking three psychiatric medications. Respondent failed to perform and/or document an adequate psychiatric history and mental status examination of Patient 3 prior to recommending marijuana.

40. Respondent's care and treatment of Patient 3 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 3. Specifically, Respondent did not document any clinical assessment of Patient 3, including any information about his psychiatric history. For example, Patient 3 reported taking three other medications – Zoloft, Rexulti, Lamicital. There is no information documented in the record, however, regarding any clinical details pertaining to these medications, such as how long Patient 3 has been taking these medications, whether they have been effective for his multiple psychiatric conditions, or if medical marijuana is needed as additional therapy because they are not effective for those conditions. There is also no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with anxiety, anorexia and PTSD and why its therapeutic benefits outweigh the risks

for Patient 3. There is also no documentation of any other therapies tried, how long they were tried, their effectiveness, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. Additionally, for Patient 3's medical conditions listed – anxiety, anorexia, PTSD and hallucinations – Respondent failed to document any details about each condition, such as when it was diagnosed, the level of severity, and impact on quality of life.

41. Respondent's care and treatment of Patient 3 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 3's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to make any attempt to request any of Patient 3's prior medical records or to speak with any of Patient 3's prior treaters before recommending marijuana. Patient 3 reported taking three other psychiatric medications and hallucinations, rendering him a high risk patient for recommendation for another substance with potential psychoactive effects like marijuana. Respondent made no attempt to communicate with any of Patient 3's other treaters to obtain pertinent clinical information or to alert them to the new treatment that Patient 3 would be commencing. Respondent should have sought confirmation of Patient 3's self-reported medical conditions, as anxiety, anorexia and PTSD are subjective conditions and/or typically do not have physical confirmatory signs or symptoms.

Patient 4

42. On or about April 16, 2018, Respondent had an initial consultation with Patient 4, an 18-year-old male, via telemedicine.

43. Patient 4 was referred to Respondent through the website NuggMD.

44. At the initial consultation, Patient 4's self-reported "medical problem(s)" were documented as "insomnia," "other condition," and "depression." Patient 4 provided photos of two prescription bottles, appearing to be for Trazadone for insomnia and Clonidine, a sedative and antihypertensive medication. Respondent's medical records for Patient 4 do not contain any further clinical information about Patient 4's health history, these conditions, Patient 4's current state, or any examination(s) performed.

45. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 4. The recommendation was valid for one year.

46. Respondent's care and treatment of Patient 4 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 4 prior to recommending marijuana. For example, Respondent failed to perform and/or document an adequate psychiatric history and mental status examination of Patient 4. Patient 4 reported depression, thus, necessitating such assessment, prior to recommending medical marijuana.

47. Respondent's care and treatment of Patient 4 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 4. Specifically, Respondent did not document any clinical assessment of Patient 4, including any information about his psychiatric history. There is no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with depression and why its therapeutic benefits outweigh the risks for Patient 4. There is also no documentation of other therapies tried, how long they were tried, their effectiveness, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. For example, Patient 4 provided photos of two prescription bottles of medication he was purportedly taking, likely Trazadone and Clonidine. The photos of the prescription bottles are difficult to read and provide little information. There is no information documented in the record regarding any clinical details pertaining to these medications, such as how long Patient 4 has been taking these medications, whether they have been effective for his conditions, or if medical marijuana is needed as additional therapy because they are not effective for those conditions. Additionally, for Patient 4's medical conditions listed – insomnia and depression – Respondent failed to document any details about each condition, such as when it was diagnosed, the level of severity, and impact on quality of life.

48. Respondent's care and treatment of Patient 4 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 4's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to

make any attempt to request any of Patient 4's prior medical records or to speak with any of Patient 4's prior treaters before recommending marijuana. Respondent should have sought confirmation of Patient 4's self-reported medical conditions, as insomnia and depression are subjective conditions and/or typically do not have physical confirmatory signs or symptoms. Patient 4's young age also increases the risk that his self-reported clinical history contained inaccuracies further necessitating the need for confirmation.

Patient 5

49. On or about January 19, 2019, Respondent had an initial consultation with Patient 5, an 18-year-old male, via telemedicine.

50. Patient 5 was referred to Respondent through the website NuggMD.

51. Patient 5's self-reported "medical conditions" are documented as "insomnia, migraines, stress." Respondent's medical records for Patient 5 do not contain any other clinical information about Patient 5's health history, these conditions, Patient 5's current state, or any examination(s) performed.

52. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 5. The recommendation was valid for one year.

53. Respondent's care and treatment of Patient 5 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 5 prior to recommending marijuana. For example, Patient 5 reported insomnia and stress and Respondent failed to perform and/or document an adequate psychiatric history and mental status examination on Patient 5.

54. Respondent's care and treatment of Patient 5 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 5. Specifically, Respondent did not document any clinical assessment of Patient 5. For example, there is no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with insomnia, migraines and stress and why its therapeutic benefits outweigh the risks for Patient 5. There is also no documentation of any alternative therapies tried by Patient 5 and/or how long they were

tried, whether these therapies were effective or ineffective, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. For Patient 5's three medical conditions listed – insomnia, migraines and stress – Respondent failed to document any details about the conditions, such as when they were diagnosed, level of severity, or impact on quality of life.

55. Respondent's care and treatment of Patient 5 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 5's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to make any attempt to request any of Patient 5's prior medical records or to speak with any of Patient 5's prior treaters before recommending marijuana. Respondent should have sought confirmation of Patient 5's self-reported medical conditions, as insomnia, migraines and stress are subjective conditions that typically do not have physical confirmatory signs or symptoms. Patient 5's young age also increases the risk that his self-reported clinical history contained inaccuracies further necessitating the need for confirmation.

Patient 6

56. On or about June 17, 2019, Respondent had an initial consultation with Patient 6, an 18-year-old male, via telemedicine.

57. Patient 6 was referred to Respondent through the website NuggMD.

58. Patient 6's self-reported "medical conditions" are documented as "anxiety, insomnia, migraines, nausea and stress." Respondent's medical records for Patient 6 do not contain any other clinical information about Patient 6's health history, these conditions, Patient 6's current state, or any examination(s) performed.

59. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 6. The recommendation was valid for one year.

60. According to Respondent's records, on or about June 23, 2020, Respondent renewed Patient 6's recommendation for medical marijuana. Respondent's medical records for Patient 6 do not contain any further clinical information about Patient 6's health history, these conditions,

Patient 6's current state, or any examination(s) performed at the time of this renewal.

61. Respondent's care and treatment of Patient 6 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 6 prior to recommending marijuana. For example, Patient 6 reported anxiety, a potential psychiatric condition, and Respondent failed to perform and/or document an adequate psychiatric history and mental status examination on Patient 6.

62. Respondent's care and treatment of Patient 6 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 6. Specifically, Respondent did not document any clinical assessment of Patient 6. For example, there is no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with a psychiatric condition, such as anxiety, and why its therapeutic benefits outweigh the risks for Patient 6. There is also no documentation of any alternative therapies tried by Patient 6 and/or how long they were tried, whether these therapies were effective or ineffective, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. For Patient 6's medical conditions listed – anxiety, insomnia, migraines, nausea and stress – Respondent failed to document any details about the conditions, such as when they were diagnosed, level of severity, or impact on quality of life.

63. Respondent's care and treatment of Patient 6 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 6's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to make any attempt to request any of Patient 6's prior medical records or to speak with any of Patient 6's prior treaters before recommending marijuana. Respondent should have sought confirmation of Patient 6's self-reported medical conditions, as anxiety, insomnia, migraines and stress are subjective conditions that typically do not have physical confirmatory signs or symptoms. Patient 6's young age also increases the risk of that his self-reported clinical history contained inaccuracies further necessitating the need for confirmation.

Patient 7

64. On or about May 25, 2019, Respondent had an initial consultation with Patient 7, a 17-year-old male, via telemedicine.

65. Patient 7 was referred to Respondent through the website NuggMD.

66. Patient 7's self-reported "medical conditions" are documented as "anxiety, insomnia and stress." Wellbutrin is also listed as another medication. Respondent's medical records for Patient 7 do not contain any other clinical information about Patient 7's health history, these conditions, Patient 7's current state, or any examination(s) performed.

67. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 7. The recommendation was valid for one year.

68. Respondent's care and treatment of Patient 7 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 7 prior to recommending marijuana. For example, Patient 7 reported anxiety, a potential psychiatric condition, and Respondent failed to perform and/or document an adequate psychiatric history and mental status examination on Patient 7.

69. Respondent's care and treatment of Patient 7 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 7. Specifically, Respondent did not document any clinical assessment of Patient 7. For example, there is no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with a psychiatric condition such as anxiety, and why its therapeutic benefits outweigh the risks for Patient 7. Though Patient 7 reported taking Wellbutrin, possibly to treat anxiety, there is no information documented in the record regarding any clinical details, such as how long Patient 7 has been taking Wellbutrin, whether it has been effective for anxiety, or if medical marijuana is needed as additional therapy because Wellbutrin is not effective. There is also no documentation of any alternative therapies tried by Patient 7 and/or how long they were tried, whether these therapies were effective or ineffective, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support

the decision to recommend marijuana. For Patient 7's medical conditions listed – anxiety, insomnia and stress – Respondent failed to document any details about the conditions, such as when they were diagnosed, level of severity, or impact on quality of life.

70. Respondent's care and treatment of Patient 7 departed from the standard of care in that Respondent failed to conduct an adequate review of Patient 7's past medical records and history prior to recommending the use of medical marijuana. Specifically, Respondent failed to make any attempt to request any of Patient 7's prior medical records or to speak with any of Patient 7's prior treaters before recommending marijuana. Respondent should have sought confirmation of Patient 7's self-reported medical conditions, as anxiety, insomnia and stress are subjective conditions that typically do not have physical confirmatory signs or symptoms. Patient 7's young age also increases the risk that his self-reported clinical history contained inaccuracies further necessitating the need for confirmation.

Patient 8

71. On or about August 14, 2017, Respondent had an initial consultation with Patient 8, a 52-year-old male, via telemedicine.

72. Patient 8 was referred to Respondent through the website NuggMD.

73. Patient 8's self-reported "medical conditions" are documented as "anxiety, insomnia and other condition." Patient 8 reported under "Problem Description" - "chronic pain in back, knees and feet." Patient 8 is also self-described in the record as "51 year old Veteran/Collegiate Athlete hurts all the time...lol." Respondent's medical records for Patient 8 do not contain any other clinical information about Patient 8's health history, these conditions, Patient 8's current state, or any examination(s) performed.

74. At the conclusion of the consultation, Respondent issued a medical marijuana recommendation to Patient 8. The recommendation was valid for one year.

75. Patient 8 died of an intraoral gunshot wound on September 26, 2017.

76. Respondent's care and treatment of Patient 8 departed from the standard of care in that Respondent failed to perform an appropriate and good faith examination on Patient 8 prior to recommending marijuana. For example, Patient 8 reported anxiety, a potential psychiatric

condition, and Respondent failed to perform and/or document an adequate psychiatric history and mental status examination on Patient 8.

77. Respondent's care and treatment of Patient 8 departed from the standard of care in that he failed to maintain medical records that adequately support his decision to recommend medical marijuana to Patient 8. Specifically, Respondent did not document any clinical assessment of Patient 8. For example, there is no discussion in the record of the therapeutic benefits of marijuana versus its potential adverse effects and risks in a patient with a psychiatric condition such as anxiety, and why its therapeutic benefits outweigh the risks for Patient 8. There is also no documentation of any alternative therapies tried by Patient 8 and/or how long they were tried, whether these therapies were effective or ineffective, previous medication trials and their efficacy, other pertinent positive or negative findings, documentation of medical decision making, or other data that would support the decision to recommend marijuana. For Patient 8's medical conditions listed – anxiety, insomnia and chronic pain – Respondent failed to documented any details about the conditions, such as when they were diagnosed, level of severity, impact on quality of life.

78. Respondent's acts and/or omissions as set forth in paragraphs 11 through 77, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code which harmed patients within the meaning of section 2228.1 of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs Without an Examination)

79. 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, 5, 6, 7, and 8 without appropriate prior examination and/or medical indication. The circumstances are as follows:

80. The allegations contained in the First Cause 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.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs Without an Examination over the Internet)

81. Respondent is subject to disciplinary action under sections 2234, subdivision (a), and 2242.1 of the Code, in that Respondent prescribed dangerous drugs to Patients 1, 2, 3, 4, 5, 6, 7, and 8 over the Internet and without appropriate prior examination and/or medical indication. The circumstances are as follows:

82. The allegations contained in the First and Second Causes for Discipline herein are incorporated by reference as if fully set forth, and represent the prescribing of dangerous drugs over the Internet and without an appropriate prior examination and/or medical indication in violation of Code sections 2234, subdivision (a), and 2242.1. As such, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

83. 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, 5, 6, 7 and 8. The circumstances are as follows:

84. The allegations contained in the First Cause 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.

DISCIPLINARY CONSIDERATIONS

85. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 1, 2007, in a prior disciplinary action titled *In the Matter of the Accusation Against: Francis Gerard D'Ambrosio, M.D.*, Case No. 06-2002-132815, before the Medical Board of California, Respondent's license was revoked. However, the revocation was stayed and Respondent was placed on probation for five (5) years. Respondent's probation terms included completion of the Clinical Competency Program; Prohibited Practice: surgery; Proctoring; Monitoring; and the standard terms and conditions. Respondent had been charged with gross negligence, repeated negligent acts, and incompetence in his care and

treatment of four (4) patients. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 73590, issued to Francis Gerard D'Ambrosio, M.D.;

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

3. Ordering Francis Gerard D'Ambrosio, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Francis Gerard D'Ambrosio, M.D. to provide the disclosure required by section 2228.1 of the Code; and

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

DATED: DEC 30 2020

REJI VARGHESE
DEPUTY DIRECTOR
For: WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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