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

In the Matter of the First Amended Accusation Against: Eric Colburn Disbrow, M.D. Physician's and Surgeon's Certificate No. G 21038 Respondent.	Case No. 800-2018-045589

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 October 14, 2022.

IT IS SO ORDERED September 14, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
2550 Mariposa Mall, Room 5090
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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 First Amended Accusation Against: **ERIC COLBURN DISBROW, M.D.** **1775 Third Street** **Atwater, CA 95301** **Physician's and Surgeon's Certificate No. G 21038** Respondent.	Case No. 800-2018-045589 OAH No. 2021100436 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, 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 the First Amended Accusation.

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 Lynette D. Hecker, Deputy Attorney General.

2. Eric Colburn Disbrow, M.D. (Respondent) is represented in this proceeding by attorney Marvin Firestone, MD, JD, whose address is: 1700 South El Camino Real, Ste. 408, San Mateo, CA 94402.

3. On or about August 9, 1971, the Board issued Physician's and Surgeon's Certificate No. G 21038 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2018-045589, and will expire on January 31, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-045589 was filed before the Board, and is currently pending against Respondent. The original Accusation and all other statutorily required documents were properly served on Respondent on June 16, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on April 5, 2022. This stipulation shall serve as Respondent's Notice of Defense pursuant to Government Code section 11506, subdivision (a)(4).

5. A copy of the First Amended Accusation No. 800-2018-045589 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 First Amended Accusation No. 800-2018-045589. 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 First Amended 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 understands and agrees that the charges and allegations in First Amended Accusation No. 800-2018-045589, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case or factual basis with respect to the charges and allegations in First Amended Accusation, that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 21038 to disciplinary action, and Respondent hereby gives up his right to contest those charges. Respondent agrees that if in any future case 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 First Amended Accusation No. 800-2018-045589 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.

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

CONTINGENCY

12. 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.

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:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Respondent Eric Colburn Disbrow, M.D., Physician's and Surgeon's Certificate No. G 21038, shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand is issued in connection with Respondent's recordkeeping pertaining to five patients, as set forth in First Amended Accusation No. 800-2018-045589.

1. INVESTIGATION/ENFORCEMENT COST RECOVERY: Respondent is hereby relieved from reimbursing the Board its costs of investigation and enforcement under Code section 125.3.

2. 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. 800-2018-045589 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, Marvin Firestone, MD, JD. 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: 3/30/2022

ERIC COLBURN DISBROW, M.D.
Respondent

I have read and fully discussed with Respondent Eric Colburn Disbrow, 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: 3/31/2022

MARVIN FIRESTONE, MD, JD
Attorney for Respondent

ENDORSEMENT

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

DATED: 3/31/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2018-045589

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

In the Matter of the First Amended Accusation Against: **Eric Colburn Disbrow, M.D.** **1775 Third Street** **Atwater, CA 95301** **Physician's and Surgeon's Certificate No. G 21038,** Respondent.	Case No. 800-2018-045589 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended 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 August 9, 1971, the Medical Board issued Physician's and Surgeon's Certificate Number G 21038 to Eric Colburn Disbrow, 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 January 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

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

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(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.

(d) Incompetence.

(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.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case[1], with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

8. Acetaminophen and hydrocodone bitartrate (Vicodin® and Norco®) is a combination of two medicines used to treat moderate to severe pain. Hydrocodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that

[1] As of November 18, 2021, Section 125.3 of the Code has been amended to remove subsection (k), which precluded the Board from collecting costs. The Board may collect investigation, prosecution, and other costs incurred for a disciplinary proceeding against a licensee beginning January 1, 2022.

increases the effects of hydrocodone. Hydrocodone has a high potential for abuse. Hydrocodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

9. Alprazolam (Xanaz®) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for abuse. Xanax is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

10. Arthralgia is pain in one or more of a person's joints. The pain may be described as sharp, dull, stabbing, burning or throbbing, and may range in intensity from mild to severe. There are many causes of arthralgia, including injury, infection, arthritis, and other ailments.

11. Cervicalgia is a common term used to describe neck pain -- often referred to as a "crick in the neck." General neck pain can arise from various causes including poor posture, muscle fatigue from overuse or even from poor sleeping positions.

12. Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing.

13. Fentanyl transdermal (Duragesic®) patches are a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl transdermal system is a means for conveyance of fentanyl to the patient via a patch that adheres to the skin, releasing the substance via absorption, over time. When properly prescribed and indicated fentanyl transdermal patches are indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long term opioid treatment and for which alternative treatment options are inadequate. The FDA has issued several black box warnings about fentanyl

transdermal patches including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

14. Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Klonipin®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) Klonopin® has a half-life of 20-50 hours such that twice daily dosing is usually sufficient to prevent a build-up of bioavailable medication. Caution is advised when prescribed in combination with hydromorphone due to an increased risk of respiratory depression.

15. Methadone is an opioid medication that has a high potential for abuse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs. It may cause a prolonged QT interval (a rare heart problem that may cause irregular heartbeat, fainting, or sudden death).

16. Myalgia describes muscle aches and pain, which can involve ligaments, tendons and fascia, the soft tissues that connect muscles, bones and organs. Injuries, trauma, overuse, tension, certain drugs and illnesses can all bring about myalgia.

17. Naprosyn is a prescription medicine used to treat the symptoms of pain or inflammation caused by arthritis, ankylosing spondylitis, tendinitis, bursitis, gout or menstrual cramps. Naprosyn may be used alone or with other medications. Naprosyn is a nonsteroidal anti-inflammatory medication (NSAID) and is not a controlled substance.

18. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a

Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The Drug Enforcement Administration ("DEA") has identified opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 41.) Respiratory depression is the chief hazard from all opioid agonist preparations.

19. Peripheral neuropathy refers to the conditions that result when nerves that carry messages to and from the brain and spinal cord from and to the rest of the body are damaged or diseased. The peripheral nerves make up an intricate network that connects the brain and spinal cord to the muscles, skin, and internal organs.

20. Stenosis, which means narrowing, can cause pressure on the spinal cord or the nerves that go from the spinal cord to muscles. Spinal stenosis can happen in any part of the spine but is most common in the lower back. This part of your spine is called the lumbar area.

21. Trigger finger is a condition in which a finger gets stuck in a bent position. The finger may bend or straighten with a snap — like a trigger being pulled and released. Trigger finger is also known as stenosing tenosynovitis because it is caused by a narrowing of the structures around the affected tendon.

FACTUAL ALLEGATIONS[2]

22. Respondent is Board-Certified in family practice and geriatric medicine. Respondent works approximately three days a week at Atwater Medical Clinic and attends to nursing homes the rest of the week. All five of the patients whose care and treatment is the subject of this case came under Respondent's care at Atwater Medical Clinic.

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[2] Events prior to May 2014 are beyond the statute of limitations and are included for background purposes only.

CIRCUMSTANCES RELATED TO PATIENT A[3]

23. Patient A is a 57-year-old male with a history of anxiety, COPD, depression, fatigue, high cholesterol, lumbar disc disease, obstructive sleep apnea, osteoarthritis of the ankle, multiple ankle surgeries, and peripheral neuropathy. Patient A presented to Respondent approximately once a month, or every other month from on or about September 1, 2011, through on or about August 7, 2018, for routine health care for his chronic medical problems, including refills for his Norco and Xanax medications.

24. Respondent's medical records consistently reflect similar and at times identical verbiage in the history of present illness section when describing Patient A's ankle pain. Respondent consistently characterized Patient A's ankle pain as "constant and severe; aggravated with weight bearing; denies ankle instability, numbness, swelling and weakness."

25. The only aspect Respondent documented of Patient A's musculoskeletal condition related to his ankle is "no edema or significant varicosities, gait: affected by limp." Further, while Respondent noted that Patient A was sent for diagnostic imaging studies for his chronic ankle issues, and referred to an orthopedic specialist in or around 2014, Respondent failed to document make any attempts to decrease or otherwise prescribe any non-controlled substances for Patient A. There was insufficient basis documented to support the ongoing prescribing of Norco and Xanax for Patient A.

26. Respondent's records for Patient A variously reflect inconsistencies or lack specific details. For example, in the progress note for a visit on or about July 7, 2015, Patient A was noted to have presented for anxiety and for refills of Norco and Xanax. The history of present illness discusses Patient A's anxiety. However, in the review of systems portion of the progress note, under "psychiatric" the patient was noted as "negative for anxiety and depression."

27. From on or about September of 2012, through on or about August of 2018, Respondent failed to document a specific treatment plan and objectives with discussion of potential side effects of continued prescribing of controlled substances and documentation of

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[3] To protect the privacy of patients, individual names are not identified in this Accusation.

periodic review of the treatment plan based on a clearly documented, problem specific focused history and physical examination which did not have documented inconsistencies for Patient A.

CIRCUMSTANCES RELATED TO PATIENT B

28. Patient B was a 46-year-old female, with a history of chronic pain syndrome, acquired trigger finger, and cervicalgia. From the period of on or about October of 2012, through on or about January of 2019, Patient B presented to Respondent approximately once a month and he consistently prescribed Methadone HCl for Patient B.

29. Respondent utilized similar and at times identical verbiage in the history of present illness section when describing Patient B's shoulder pain. Respondent consistently characterized her pain as "moderate in severity, constant, dull and aching and relieved with Methadone and Naprosyn; aggravated with weight bearing; discomfort increased with repetitive motion . . . ."

30. Additionally, Respondent continuously documented the musculoskeletal portion of the physical examination as "tone and strength 5/5 L, 4/5 R biceps" and for the neurological portion "sensation, hypoesthesia in the bilateral median nerve distribution." Respondent did not clearly document attempts to taper or decrease the prescribed controlled substances for Patient B. There was insufficient basis documented to support Respondent's ongoing prescribing of Methadone for Patient B. Respondent's medical records for Patient B from on or about October of 2012, to on or about January of 2019, do not contain documentation of any treatment plans, nor did Respondent have and document any clear plan or objectives with discussion of potential side effects for the ongoing prescribing of controlled substances for Patient B. Despite this, Respondent repeatedly refilled Patient B's Methadone prescription.

CIRCUMSTANCES RELATED TO PATIENT C

31. Patient C is a male with a history of spinal stenosis, COPD, chronic pain syndrome, colon cancer, osteoporosis, generalized anxiety disorder, lumbar region radiating pain (sciatica), gout, and chronic kidney disease. Respondent saw Patient C approximately monthly and consistently prescribed Alprazolam, hydrocodone, and oxycodone for Patient C from on or about February 12, 2018, through on or about February 3, 2019.

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32. Respondent noted consistently similar, if not identical verbiage in the history of present illness section when describing Patient C's chronic pain conditions at his visits. Respondent's records for Patient C also contain inconsistencies of the documentation within the progress notes. For example, as to Patient C's visit on or about April 4, 2019, Respondent documented that Patient C presented with worsening symptoms of spinal stenosis in the lumbar region. He was noted as complaining of stiffness and paravertebral muscle spasm with reports of constant pain. However, Respondent documented in the musculoskeletal section that Patient C was negative for arthralgias, joint stiffness, and myalgias. Respondent did not clearly document a specific and focused examination of Patient C's spine despite the fact that the patient returned for controlled substances for management of lumbar pain and spinal stenosis and the neurological examination was merely noted as "grossly intact."

33. Further, Respondent failed to clearly document any attempts to decrease Patient C's controlled substances or attempts to prescribe non-controlled substances for Patient C. There was insufficient documentation by Respondent to support the ongoing prescribing of controlled substances to Patient C.

34. From in or about February of 2012, through in or about February of 2019, documentation in the plan of care for Patient C noted his prescribed controlled substances were refilled. However, there is no documentation of any treatment plans, nor did Respondent document any clear plan or objectives with discussion of potential side effects for the ongoing prescribing of controlled substances for Patient C. Respondent's records lacked medical indication for the controlled medications prescribed to Patient C over a period of approximately seven years.

CIRCUMSTANCES RELATED TO PATIENT D

35. Patient D was a male patient with a medical history that included low back pain, generalized anxiety disorder, lumbar disc disease, chronic pain syndrome, and major depressive disorder. Respondent consistently prescribed Oxycodone, Clonazepam, Narcan, and Duragesic transdermal patches for Patient D from in or about February of 2015, through in or about 2019.

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Though Respondent saw Patient D occasionally in or about 2015, 2016, and 2017, he saw Patient D at least monthly in or about 2018 and 2019.

36. Throughout those years, Respondent repeatedly noted consistently similar, if not identical verbiage in the history of present illness section when describing Patient D's chronic pain condition. Respondent's documentation contains inconsistencies. On or about February 7, 2019, Respondent noted Patient D presented with evaluation for low back pain with associated symptoms of "stiffness, radicular right leg pain, and sharp pain going down the leg." However, in the review of systems section, in the musculoskeletal section, Patient D was noted as "negative for arthralgias, joint stiffness, and myalgias." Additionally, Respondent did not consistently document a specific and focused examination of Patient D's spine despite the fact that he was returning for a medical visit for controlled substances for management of the pain in his lower back. Respondent documented on the musculoskeletal portion of the physical examination of this visit "grossly normal tone and muscle strength," but there is no documentation that Respondent performed a neurological examination.

37. On or about January 16, 2019, Respondent's progress note indicated that Patient D presented for treatment of anxiety, which had increased. Yet in the review of systems section of the progress note, Respondent documented that Patient D was "negative for anxiety and depression." Respondent failed to attempt to decrease his prescribing of controlled substances for Patient D. Respondent's records lacked sufficient documentation to support ongoing prescribing of controlled substances to Patient D.

38. From in or about February of 2015, through in or about March of 2019, documentation in the plan of care for Patient D noted his prescribed controlled substances were refilled. However, there is no documentation of any treatment plans, nor did Respondent document any clear plan or objectives with discussion of potential side effects for the ongoing prescribing of controlled substances for Patient D. Respondent's records lacked documented indication for the controlled medications prescribed for Patient D over a period of approximately four years.

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CIRCUMSTANCES RELATED TO PATIENT E

39. Patient E was a female patient with a medical history that included hypertension, morbid obesity, spinal stenosis, low back pain, and generalized muscle weakness. Respondent consistently prescribed Methadone and oxycodone for Patient E from in or about October of 2012, through in or about July of 2019. During this period, Patient E presented to Respondent approximately once a month.

40. Through those years, Respondent repeatedly noted consistently similar, if not identical verbiage in the history of present illness section when describing Patient E's chronic pain condition. Additionally, Respondent's documentation contains inconsistencies. On or about June 26, 2019, Respondent documented that Patient E presented with low back pain with associated stiffness, radicular leg pain, numbness in the right buttock, weakness in the upper legs, and right lower leg swelling. However, in the review of systems section of the progress note, Respondent documented in the musculoskeletal section that the patient was negative for arthralgias, joint stiffness, and myalgias and was negative in the neurological section for weakness and gait disturbance. Additionally, Respondent failed to consistently document a specific and focused examination of the patient's lumbar spine and lower extremities in spite of the fact that she was returning for controlled substances for management of low back pain. Respondent failed to document a focused examination of the lumbar region, though he documented under the musculoskeletal examination that the patient had normal gait with grossly normal tone and muscle strength. Further, Respondent failed to document any attempts to decrease Patient E's controlled substance prescriptions or attempt to prescribe any non-controlled substances for Patient E. There was insufficient documentation by Respondent to support the ongoing prescribing of controlled substances to Patient E.

41. From in or about October of 2012, through in or about July of 2019, documentation in the plan of care for Patient E noted her prescribed controlled substances were refilled. However, there is no documentation of any specific treatment plan, nor did Respondent have and document any clear plan or objectives with discussion of potential side effects for the ongoing prescribing of

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controlled substances for Patient E. Respondent's records lacked medical indication for the controlled substances prescribed for Patient E over approximately six years.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

42. Respondent has subjected his Physician's and Surgeon's Certificate No. G 21038, to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), in that he engaged in repeated acts of negligence in his documentation practices as to Patient A, Patient B, Patient C, Patient D, and Patient E. The circumstances are set forth in paragraphs 22 through 41, above, which are incorporated here by reference as if fully set forth.

43. The standard of care requires a medical history and physical exam, which includes an assessment of the patient's pain, including physical and psychological status and function; substance abuse history; history of prior pain treatments and assessment of any other underlying or co-existing conditions. Finally, it should include documentation of recognized medical indications for the use of controlled substances.

44. Regarding Patient A, Respondent's documentation of consistently similar if not identical verbiage in the history of present illness, and the inconsistencies in the medical records constitute negligence. Respondent's lack of sufficient documentation in the medical records to support the ongoing prescribing of Norco and Xanax to Patient A over a period of multiple years constitutes negligence.

45. Regarding Patient B, Respondent's documentation of consistently similar if not identical verbiage in the history of present illness constitute negligence. Respondent's lack of sufficient documentation in the medical records to support the ongoing prescribing of a controlled substance to Patient B over a period of multiple years constitutes negligence.

46. Regarding Patient C, Respondent's documentation of consistently similar if not identical verbiage in the history of present illness constitute negligence. Respondent's lack of sufficient documentation in the medical records to support the ongoing prescribing of controlled substances to Patient C over a period of multiple years constitutes negligence.

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47. Regarding Patient D, Respondent's documentation of consistently similar if not identical verbiage in the history of present illness, and the inconsistencies in the medical records constitute negligence. Respondent's lack of sufficient documentation in the medical records to support the ongoing prescribing of controlled substances to Patient D over a period of multiple years constitutes negligence.

48. Regarding Patient E, Respondent's documentation of consistently similar if not identical verbiage in the history of present illness, and the inconsistencies in the medical records constitute negligence. Respondent's lack of sufficient documentation in the medical records to support the ongoing prescribing of controlled substances to Patient E over a period of multiple years constitutes negligence.

49. The standard of care requires the medical records contain stated objectives that may include relief of pain or relief of the medical condition requiring controlled substances and/or improved physical or psychological function or ability to perform certain tasks or activities of daily living. This should also include any plans for further diagnostic evaluations and treatments, such as rehabilitation programs.

50. Respondent's failure to document a specific treatment plan for Patient A constitutes negligence. Respondent's lack of documentation of a specific treatment plan, aside from refilling of controlled substances, in Patient A's records from in or about September of 2011, through in or about August of 2018, constitutes negligence.

51. Respondent's failure to document a specific treatment plan for Patient B constitutes negligence. Respondent's lack of documentation of a specific treatment plan, aside from refilling of controlled substances, in Patient B's records from in or about October of 2012, through in or about January of 2019, constitutes negligence.

52. Respondent's failure to document a specific treatment plan for Patient C constitutes negligence. Respondent's lack of documentation of a specific treatment plan, aside from refilling of controlled substances, in Patient C's records from in or about February of 2018, through in or about February of 2019, constitutes negligence.

53. Respondent's failure to document a specific treatment plan for Patient D constitutes

negligence. Respondent's lack of documentation of a specific treatment plan, aside from refilling of controlled substances, in Patient D's records from in or about February of 2015, through in or about March of 2019, constitutes negligence.

54. Respondent's failure to document a specific treatment plan for Patient E constitutes negligence. Respondent's lack of documentation of a specific treatment plan, aside from refilling of controlled substances, in Patient E's records from in or about October of 2021, through in or about July of 2019, constitutes negligence.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

55. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 21038 to disciplinary action under sections 2227 and 2234, as defined by section 2266, in that he failed to maintain adequate and accurate medical records in his care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E. The circumstances are set forth in paragraphs 22 through 41, above, which are incorporated here by reference as if fully set forth.

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 21038, issued to Eric Colburn Disbrow, M.D.;

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

3. Ordering Eric Colburn Disbrow, M.D., to pay the Board the reasonable costs of the enforcement of this case incurred beginning on January 1, 2022, and if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: APR 0 5 2022

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

FR2020304777