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

In the Matter of the First Amended Accusation Against: Patrick Shannon Thompson, M.D. Physician's and Surgeon's Certificate No. G 45100 Respondent.	Case No.: 800-2019-052907

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 January 5, 2023.

IT IS SO ORDERED: December 6, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
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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: **PATRICK SHANNON THOMPSON, M.D.** **26538 Moulton Pkwy, Suite 38E** **Laguna Hills, CA 92653** **Physician's and Surgeon's Certificate No. G 45100,** Respondent.	Case No. 800-2019–052907 OAH No. 2021120670 **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 A. Rhee, Deputy Attorney General.

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2. Respondent Patrick Shannon Thompson, M.D. (Respondent) is represented in this proceeding by attorney Christopher M. Freistedt, Esq., whose address is: 101 W. Broadway, Ste. 1400, San Diego, California 92101.

3. On or about July 1, 1981, the Board issued Physician's and Surgeon's Certificate No. G 45100 to Respondent. Physician's and Surgeon's Certificate No. G 45100 was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019–052907, and will expire on April 30, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2019–052907 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on February 8, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of First Amended Accusation No. 800-2019–052907 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. 800-2019–052907. 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. Having had the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. 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 First Amended Accusation No. 800-2019-052907, and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination of probation 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. 800-2019-052907 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 probationary terms 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.

ADDITIONAL PROVISIONS

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-listed matter.

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 45100 issued to Respondent PATRICK SHANNON THOMPSON, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years from the effective date of the Board's Decision and Order on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the Schedule II of the California Uniform Controlled Substances Act until the successful completion of the Clinical Competence Assessment Program.

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. 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.

3. 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 First Amended 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

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have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

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

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

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

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

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice, 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.

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

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent

shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended 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. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $7,435.00 (seven thousand, four hundred and thirty-five dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

12. 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.

13. 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.

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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.

14. 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.

15. 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

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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.

16. 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. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. 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.

18. 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 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.

19. 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.

20. 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 First Amended Accusation No. 800-2019-052907 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, Christopher M. Freistedt, 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: 10/6/22

PATRICK SHANNON THOMPSON, M.D.
Respondent

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I have read and fully discussed with Respondent Patrick Shannon Thompson, 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: 10/6/22

CHRISTOPHER M. FREISTEDT, 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: _____

Respectfully submitted,

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

CHRISTINE A. RIEB
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Respondent Patrick Shannon Thompson, 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: _____

CHRISTOPHER M. FREISTEDT, 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: October 6, 2022

Respectfully submitted,

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

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019–052907

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Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
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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: **PATRICK SHANNON THOMPSON, M.D.** **26538 Moulton Pkwy., Suite 38E** **Laguna Hills, CA 92653-8232** **Physician's and Surgeon's Certificate No. G 45100,** Respondent.	Case No. 800-2019-052907 **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 July 1, 1981, the Board issued Physician's and Surgeon's Certificate No. G 45100 to Patrick Shannon Thompson, 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 April 30, 2023, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on October 28, 2021, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

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

> 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 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:
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> ...

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(C) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

...

6. Section 725 of the Code states, in pertinent part:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment... as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon...

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

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

...

(b) Gross negligence.

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

(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.

...

8. Section 2242 of the Code states, in pertinent part:

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

9. Section 2266 of the Code states that 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.

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COST RECOVERY

10. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may 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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

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(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

11. Respondent has subjected his Physician's and Surgeon's Certificate No. G 45100 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, C, and D,[1] as more particularly alleged hereafter:

Patient A

12. On or about November 11, 2013,[2] Respondent saw Patient A for an initial visit. Patient A had been treated by another physician who had left the practice. At the time of this visit, Patient A was a 60-year-old woman with a history of breast cancer, chronic pain, and generalized anxiety disorder. Her daily medications at this time included the following: (1) 300 mg of morphine sulfate;[3] (2) 8 mg of hydromorphone;[4] (3) 30 mg of diazepam;[5] and (4) 15 mg of temazepam.[6] Patient A reported that she had restarted chemotherapy. Respondent ordered labs and refilled Patient A's medications.

13. From on or about December 6, 2013 through August 20, 2014, Respondent continued to see Patient A for regular office visits and prescribe morphine sulfate, hydromorphone, diazepam, and temazepam to Patient A. During this period of time, Patient A underwent radiation therapy and started the process to undergo right breast reconstruction surgery.

14. On or about September 11, 2014, Patient A returned to the office and saw

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[1] Names of the patients have been omitted to protect their privacy.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation or more than three (3) years from notification to the Board is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] Morphine sulfate, brand name MS Contin, is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

[4] Hydromorphone, brand name Dilaudid, is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

[5] Diazepam, brand name Valium, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[6] Temazepam, brand name Restoril, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

Respondent. Respondent's diagnoses for Patient A included chronic pain syndrome, anxiety, depression, polyneuropathy, Parkinson's disease, and a vertebrae fracture. His plan was for Patient A to continue with her prescribed medications.

15. According to CURES,[7] on or about September 6, 2014, Patient A filled a prescription for 40 tablets of 5-325 mg oxycodone acetaminophen,[8] written by A.D., M.D.

16. On or about September 16, 2014, Respondent's office received a notification that Patient A had been discharged from the hospital. Patient A scheduled a follow-up appointment with Respondent for October 8, 2014.

17. On or about October 8, 2014, Patient A returned to the office and saw M.C., M.D., who was covering for Respondent. M.C., M.D., noted that Patient A had chronic upper back pain, cervical pain, and sciatica. M.C., M.D., documented that Patient A had tried seeing a pain management specialist, but due to recent stressors, she had stopped going. She also had tried physical therapy. Patient A reported that she had finished chemotherapy and that she had a follow-up with a plastic surgeon the following week. M.C., M.D., noted that Patient A had a history of alcohol dependence and that he encouraged Patient A to restart physical therapy and treatment with a pain management specialist. M.C., M.D., gave Patient A medication refills for one week and documented that he was concerned for the risk of addiction and increased tolerance. She received one week's supply of medication refills on or about October 8, 2014, from M.C., M.D.

18. On or about October 14, 2014 and November 10, 2014, Patient A returned to the office and saw Respondent. Patient A was recovering from reconstructive surgery and had completed chemotherapy. At both visits, Respondent refilled Patient A's prescriptions for morphine sulfate, hydromorphone, diazepam, and temazepam.

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[7] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

[8] Percocet is a brand name for oxycodone acetaminophen. Oxycodone, brand name OxyContin, is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

19. According to CURES, on or about November 19, 2014, Patient A filled a prescription for 15 tablets of 5-325 mg hydrocodone acetaminophen[9] written by J.S., M.D. On or about November 28, 2014, Patient A filled another prescription for 40 tablets of 5-325 mg oxycodone acetaminophen written by A.D., M.D.

20. According to CURES, from on or about December 5, 2014 through April 3, 2016, Patient A continued to fill monthly prescriptions written by Respondent for morphine sulfate, hydromorphone, diazepam, and temazepam. During this period of time, Patient A underwent additional reconstructive surgeries and continued to be followed by her oncologist and plastic surgeon.

21. On or about November 9, 2015, Patient A returned to the office and saw Respondent. Since on or about August 3, 2015, Patient A reported some mechanical falls and complained of knee pain. Patient A was taking 400 mg of ibuprofen daily for the pain.

22. On or about January 29, 2016, Patient A returned to the office and saw Respondent. Patient A continued to complain of left knee pain due to degenerative joint disease. Respondent gave Patient A a referral for an orthopedist.

23. On or about April 16, 2016, Patient A returned to the office and saw Respondent. Patient A reported that she recently had an arthrocentesis and steroid injections in her left shoulder and left knee. Respondent's plan was to continue Patient A's chronic medications.

24. According to CURES, from on or about March 28, 2016 through July 6, 2016, Patient A continued to fill monthly prescriptions written by Respondent for morphine sulfate, hydromorphone, diazepam, and temazepam.

25. On or about August 4, 2016, Patient A underwent a left knee arthroscopy with L.G., M.D.

26. Respondent's medical records indicate that Patient A returned to the office and saw Respondent on August 8, 2016. Respondent's related progress note, however, was dated on or about September 8, 2016. Respondent documented that Patient A needed refills and there was no

[9] Norco is one of the brand names for hydrocodone acetaminophen. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

change in her status. Respondent discontinued Patient A's pain medications and issued a new prescription for fentanyl[10] patches. Respondent also discontinued Patient A's prescriptions for diazepam and temazepam.

27. According to CURES, on or about August 8, 2016, Patient A filled a prescription written by Respondent for five transdermal patches of 12 mcg/hour fentanyl.

28. On or about August 29, 2016, Patient A returned to the office and saw Respondent. Without documenting his rationale, Respondent restarted Patient A on a daily regimen of 300 mg morphine sulfate, 8 mg hydromorphone, 30 mg diazepam, and 15 mg temazepam.

29. According to CURES, from on or about August 20, 2016 through March 4, 2017, Patient A continued to fill prescriptions written by Respondent for morphine sulfate, hydromorphone, diazepam, and temazepam.

30. On or about March 8, 2017, Patient A returned to the office and saw Respondent. Respondent noted that he encouraged Patient A to decrease the doses of her chronic medications.

31. On or about March 28, 2017, Patient A returned to the office and saw Respondent. Respondent again encouraged Patient A to try to wean down medication use.

32. Despite his recommendation, Respondent continued to prescribe morphine sulfate, hydromorphone, diazepam, and temazepam to Patient A at the same doses. According to CURES, from on or about March 11, 2017 through December 27, 2018, Patient A continued to fill prescriptions written by Respondent for those controlled substances.

33. On or about November 15, 2017, Patient A returned to the office and saw Respondent. Respondent noted that he discussed referring Patient A to a pain management specialist, physical therapy, and/or a psychologist. Patient A declined all referrals.

34. On or about April 16, 2018, Patient A's husband called Respondent's office. He reported that Patient A had fallen and went to the emergency room. Patient A had fractured her left patella.

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[10] Fentanyl is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c).

35. On or about August 7, 2018, Patient A returned to the office and saw Respondent. She reported that she was having frequent falls and that she was having left-sided chest pain.

36. On or about January 10, 2019, Patient A called Respondent's office. She complained of a squeezing sensation in her left upper arm and a fast heartbeat. Staff at Respondent's office advised Patient A to call 911 and processed a stat cardiology referral.

37. On or about January 17, 2019, Patient A returned to the office and saw Respondent. Patient A had gone to a cardiologist for bilateral arm and chest pressure, but the symptoms did not appear to be heart-related. Respondent talked to Patient A about weaning down her opioid medication "due to constraints of new California prescribing laws." Patient A agreed to start decreasing her opioid use.

38. On or about February 15, 2019, Patient A returned to the office and saw Respondent. Respondent again documented that he spoke to Patient A about decreasing her opioid use. Respondent still gave Patient A refills for morphine sulfate, hydromorphone, diazepam, and temazepam.

39. On or about May 6, 2019, Patient A returned to the office and saw Respondent. Respondent documented that Patient A was to decrease her daily morphine sulfate use to two tablets twice a day. Respondent's plan was for Patient A to continue to decrease one morphine sulfate tablet per month until she was taking 120 mg per day, and then start decreasing by milligrams. Respondent also planned to reduce Patient A's temazepam dose starting the following month. Patient A was given a pain management referral. Patient A submitted to a urine drug screen which showed results consistent with the medications she was being prescribed.

40. According to CURES, on or about May 21, 2018, May 22, 2018, and May 26, 2018, Patient A refilled her temazepam, morphine sulfate, hydromorphone, and diazepam prescriptions, respectively. Despite advising Patient A to decrease her morphine sulfate use, Respondent continued to prescribe 150 tablets of morphine sulfate per month, equating to up to five tablets per day.

41. According to CURES, from on or about June 19, 2018 through April 16, 2019, Patient A continued to fill prescriptions written by Respondent for temazepam, morphine sulfate,

hydromorphone, and diazepam. Respondent did not decrease the dosages for any of Patient A's medications.

42. On or about January 17, 2019, Patient A returned to the office and saw Respondent. Respondent documented that he had a "[l]ong discussion with patient regarding attempting to wean off of opioids due to constraints of new California prescribing laws" and that Patient A would attempt to decrease her opioid use. Respondent gave Patient A a prescription for naloxone[11] in case of overdose.

43. On or about February 15, 2019, Patient A returned to the office and saw Respondent. Once again, Respondent noted that "[r]ecent changes in California opioid prescribing laws discussed with patient at length" and that he recommended that Patient A reduce her opioid medications. Respondent refilled Patient A's medications.

44. On or about May 6, 2019, Patient A returned to the office and saw Respondent. Respondent set up a schedule to reduce Patient A's controlled substance medications. According to his plan, Patient A was to decrease her daily morphine sulfate use to four tablets per day, then decrease by one tablet per month. Respondent's plan was to start decreasing Patient A's temazepam use starting the following month. Respondent gave Patient A a referral to a pain management specialist and ordered a urine drug screen. A urine sample was taken on or about May 8, 2019 and was consistent with Patient A's prescribed medications.

45. According to CURES, from on or about June 11, 2019 through March 20, 2020, Patient A continued to fill prescriptions written by Respondent for temazepam, hydromorphone, and diazepam at the same dose. During this period of time, Patient A filled prescriptions for morphine sulfate at a reduced dose of up to four tablets per day.

46. On or about September 25, 2019 Patient A returned to the office and saw Respondent. She reported that she was "having some success" in reducing her use of temazepam.

47. On or about November 26, 2019, Patient A returned to the office and saw Respondent. She reported that another treatment provider prescribed her gabapentin.[12]

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[11] Naloxone, brand name Narcan, is used to treat opioid overdose.

[12] Gabapentin, brand name Neurontin, is an anticonvulsant and nerve pain medication.

48. On or about May 31, 2019, Patient A returned to the office and saw Respondent. Patient A had decreased her morphine sulfate use from five to four tablets per day. Respondent advised Patient A to reduce her morphine sulfate use to three tablets per day. Patient A reported no significant withdrawal symptoms.

49. On or about March 22, 2020, Patient A returned to the office and saw Respondent. She stated that she was trying to decrease her medications but that it had been "fairly unsuccessful."

50. Respondent committed gross negligence in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent prescribed dangerous combinations of controlled substances, namely hydromorphone, morphine sulfate, diazepam, and temazepam, to Patient A, without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation;

b. Respondent failed to perform or document the appropriate necessary monitoring in Patient A's care, given the high dosages of opioids being prescribed over a long-term basis; and

c. For years, Respondent excessively prescribed and refilled opioid medications (greater than over 300 mg per day) to Patient A without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation.

Patient B

51. On or about July 8, 2014, Patient B, then a 67-year-old male, presented to Respondent to establish care. Patient B was a retired professional football player with a number of medical issues including chronic pain syndrome, Type II diabetes, and hypertension. At this visit, Patient B complained of lower extremity swelling and pain. He also needed medication refills. Respondent performed a physical examination and gave Patient B a referral to a podiatrist. Respondent also refilled Patient B's daily medications, which included up to six tablets of 10-325 mg oxycodone acetaminophen.

52. According CURES, on or about July 8, 2014, Patient B filled a prescription written by Respondent for 180 tablets of 10-325 mg oxycodone acetaminophen.

53. On or about July 21, 2014, Patient B sent Respondent an electronic message about his medication doses. Patient B told Respondent that he "took more than normal pain meds."

54. On or about July 23, 2014, Patient B called Respondent's office to request an early refill for oxycodone acetaminophen. Patient B reported that he had run out of his medication and that he was taking about nine tablets per day. Respondent denied Patient B's refill request, noting that a refill was not due for another 10 days.

55. On or about August 5, 2014, Patient B returned to the office and saw Respondent. Respondent gave Patient B an oxycodone acetaminophen refill and told him to try to decrease his opiate dose. Respondent documented that Patient B had right shoulder degenerative joint disease, decreased range of motion, and positional pain.

56. According to CURES, on or about August 5, 2014, Patient B filled a prescription written by Respondent for 180 tablets of 10-325 mg oxycodone acetaminophen.

57. On or about August 14, 2014, staff at Respondent's office learned that Patient B had been hospitalized for a hypoglycemic episode and that Patient B's hospitalist wanted to speak to Respondent.

58. On or about August 18, 2014, Patient B returned to the office and saw Respondent. Patient B told Respondent that he was taking between six to eight oxycodone acetaminophen per day for his right shoulder pain. Respondent ordered a right shoulder MRI and provided a referral for an orthopedist. He also switched Patient B from Percocet to OxyContin for better pain control.

59. According to CURES, on or about August 18, 2014, Patient B received 90 tablets of 80 mg oxycodone.

60. On or about August 21, 2014, Patient B's wife called Respondent's office and reported that Patient B was behaving bizarrely. She reported that within the past week, Patient B had been in the emergency room for chest pain, and that since his pain medication had been changed, Patient B was disoriented, awake all night, and dressed strangely. Respondent

recommended that Patient B discontinue taking oxycodone for 24 hours and that she observe Patient B. Respondent noted that Patient B may be experiencing withdrawal hallucinations from discontinuing oxycodone acetaminophen.

61. On or about September 12, 2014, Patient B sent a message to Respondent's office and requested a refill for oxycodone acetaminophen, even though Respondent had switched Patient B to oxycodone. On or about the same day, Patient B also requested an oxycodone refill. He stated that he needed the refill early because he was in more pain and that he had gone to the hospital. Respondent gave Patient B an oxycodone refill on or about September 15, 2014.

62. On or about September 15, 2014, Patient B received 60 tablets of 80 mg oxycodone.

63. On or about October 17, 2014, Patient B called Respondent's office to make an appointment. He said that a follow-up was needed after his last hospitalization.

64. On or about October 20, 2014, Patient B sent Respondent an electronic message informing him that he had been hospitalized. He also inquired about the use of pain patches instead of pills or medical marijuana. Respondent responded on or about October 23, 2014, and stated, in part, that they could discuss the use of pain patches at Patient B's next appointment.

65. On or about October 21, 2014, Patient B called Respondent's office and requested non-narcotic medications to treat his knee and shoulder pain. Respondent documented that there was no non-narcotic medication that could treat Patient B's pain effectively, and that Patient B had problems overdosing on narcotics in the recent past.

66. On or about October 22, 2014, Patient B called Respondent's office and requested a pain medication refill.

67. On or about October 27, 2014, Patient B called Respondent's office and requested an appointment to follow up on another hospitalization.

68. On or about October 29, 2014, Patient B returned to the office and saw Respondent. Respondent noted that Patient B had been hospitalized for overdosing on sleeping medications. Patient B was in an induced coma for a few days for withdrawal. Respondent documented that he reviewed the hospital records, although a copy of these records were not in Respondent's records. Respondent gave Patient B a prescription for an inhaler to treat shortness of breath. For pain

medication, Respondent prescribed diclofenac[13] transdermal patches and 200 mg of tramadol[14] per day.

69. According to CURES, on or about October 29, 2014, Patient B filled a prescription written by Respondent for 90 tablets of 50 mg tramadol.

70. On or about November 6, 2014, Patient B returned to the office and saw I.Y., M.D., for a sleep evaluation. I.Y., M.D., noted that Patient B was treated for pneumonia and respiratory failure in or around September 2014 and was in the ICU on a ventilator for eight days and in the hospital for approximately 45 days. Patient B complained of difficulty breathing, especially when lying down. I.Y., M.D., ordered a sleep study and made recommendations regarding Patient B's sleep hygiene.

71. On or about November 6, 2014, Patient B called Respondent's office requesting a prescription medication for pain. Patient B said that he had previously received a prescription for oxycodone from a physician, and wanted Respondent to call in a prescription for Tylenol with codeine.[15] Respondent refused to give Patient B a narcotic prescription.

72. On or about November 15, 2014, Patient B called Respondent's office. He stated that his oxygen saturation had been dropping from the eighties to the sixties that afternoon and that he was feeling weak and a little dizzy. He also reported that he was in the emergency room the night before with leg pain. Office staff advised Patient B to call 911.

73. On or about November 17, 2014, Patient B's wife called Respondent's office and reported that Patient B had been admitted to the hospital for pneumonia.

74. On or about November 24, 2014, Respondent gave Patient B a prescription for tramadol. On or about November 25, 2014, Patient B filled the prescription for 90 tablets of 50 mg tramadol.

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[13] Diclofenac is a nonsteroidal anti-inflammatory drug (NSAID).

[14] Tramadol, brand name Ultram, is a centrally acting opioid analgesic used to treat moderate to severe pain. It is a Schedule IV controlled substance pursuant to the Controlled Substances Act.

[15] Codeine is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

75. On or about November 28, 2014, Patient B messaged Respondent's office and complained of right rotator cuff pain. Respondent's office staff replied, stating that Patient B would be informed when a referral had been submitted.

76. On or about December 1, 2014, Patient B called Respondent's office and requested more pain medication for his shoulder. Respondent's staff informed Patient B that Respondent was out of the office until December 3, 2014.

77. On or about December 3, 2014, Respondent sent Patient B an electronic message and notified him that a referral to an orthopedist had been re-submitted. Respondent also recommended that Patient B walk for exercise, wear support hose, and elevate his legs when resting. Respondent also transmitted a tramadol prescription to the pharmacy.

78. Later that same day, on or about December 3, 2014, Patient B called Respondent's office and explained that he was not requesting tramadol, but that he wanted an anti-inflammatory medication to treat his knee, which was swelling. On or about December 4, 2014, Respondent transmitted a prescription for Celebrex[16] to the pharmacy.

79. On or about December 12, 2014, Patient B sent Respondent an electronic message. Patient B asked Respondent to postpone an operation until he got his heartbeat regulated and stated that he had been at the hospital for approximately six days. Respondent's office staff responded and asked for clarification about the referenced operation.

80. On or about December 22, 2014, Patient B asked Respondent for an oxycodone prescription.

81. On or about December 23, 2014, Patient B sent Respondent an electronic message about his pain medication. He explained that he had been hospitalized three times in the past month for chest congestion and that he was given oxycodone in the hospital. He requested to renew his pain medications and change from tramadol. Three days later, on or about December 26, 2014, Patient B called Respondent's office and requested a tramadol refill, explaining that he had run out of his medication. Respondent authorized a tramadol refill on or about December 26, 2014.

[16] Celebrex, brand name for celecoxib, is an NSAID used to treat pain.

82. According to CURES, on or about December 26, 2014, Patient B filled a prescription written by Respondent for 90 tablets of 50 mg tramadol. On or about January 21, 2015, Patient B filled another prescription written by Respondent for 90 tablets of 50 mg tramadol.

83. On or about January 27, 2015, Patient B returned to the office and saw Respondent. Patient B complained of shortness of breath with minimal activity and reported that his leg swelling had improved. He had appointments to see a cardiologist and pulmonologist following his most recent hospitalization. Respondent conducted a physical examination and assessed Patient B with chronic obstructive pulmonary disease, pneumonia, degenerative joint disease in his right shoulder, and chronic pain syndrome. Respondent told Patient B to continue using oxygen and doing his nebulizer treatments and requested that Patient B follow up in one month. He refilled Patient B's medications, including his prescription for tramadol.

84. On or about January 28, 2015, Patient B sent Respondent an electronic message and stated that he had fallen off a chair, landing on his head. Patient B requested to increase his tramadol use by one tablet per day.

85. According to CURES, on or about January 31, 2015, Patient B filled a prescription for 20 tablets of 10-325 mg oxycodone acetaminophen written by L.P., M.D.

86. On or about February 4, 2015, Patient B contacted Respondent's office and requested oxycodone acetaminophen. On or about the same day, in a separate electronic communication, Patient B sent Respondent a message stating that he could not walk and had trouble breathing. On or about February 5, 2015, Respondent messaged Patient B back and asked for an update on Patient B's condition.

87. On or about February 5, 2015, Patient B filled another prescription for 20 tablets of 5-325 mg oxycodone acetaminophen written by K.R., M.D.

88. On or about February 15, 2015, Patient B sent Respondent an electronic message. He told Respondent that tramadol was not providing effective pain relief, and that doctors at the hospital had given him 5-325 mg oxycodone acetaminophen, which he took every four to six hours. Patient B requested that Respondent change his pain medication prescription from tramadol to oxycodone acetaminophen.

89. According to CURES, on or about February 27, 2015, Patient B filled a prescription for 60 tablets of 15 mg morphine sulfate[17] written by M.S. On or about March 5, 2015, Patient B filled two more prescriptions for 12 suppositories of belladonna/opium and 30 tablets of 15 mg morphine sulfate, both written by H.E., M.D. On or about March 17, 2015, Patient B filled a prescription for 100 tablets of 15 mg morphine sulfate written by D.L., M.D.

90. On or about March 29, 2015, Patient B sent an electronic message to Respondent. Patient B explained that he had been "out of the hospital for two weeks" and that he was out of some of his medications and needed refills. Notably, Patient B requested gabapentin, which was a new prescription. On or about March 30, 2015, after receiving a refill request from a pharmacy, Respondent rejected the request, stating that there was no history of that medication being prescribed.

91. According to CURES, on or about April 5, 2015, Patient B filled a prescription for 60 tablets of 15 mg morphine sulfate written by Y.T.

92. On or about April 9, 2015, Patient B returned to the office and saw Respondent. During the visit, Patient B's oxygen levels were measured at 82%, and he was treated with three liters of oxygen. Respondent documented that Patient B had recurrent hospitalizations for emphysema, congestive heart failure, and peripheral edema. Patient B requested that Respondent prescribe him morphine for joint pain in his shoulders and knees. Respondent gave Patient B a prescription for 15 mg morphine sulfate to be taken every four hours as needed for pain. Respondent advised Patient B to follow up with cardiology, pulmonology, and neurology as scheduled. On or about the same day, Patient B's wife called Respondent's office and said that Patient B was doing fine on morphine and that she was controlling his medication use.

93. According to CURES, on or about April 13, 2015, Patient B filled a prescription written by Respondent for 90 tablets of 15 mg morphine sulfate.

94. On or about April 27, 2015, Patient B called Respondent's office and requested a morphine refill. He said that he was taking his last dose on that day.

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[17] Morphine is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

95. According to CURES, on or about April 27, 2015, Patient B filled a prescription for 20 tablets of 5-325 mg hydrocodone acetaminophen written by J.S.

96. On or about April 28, 2015, Respondent's office notified Patient B that a refill was ready to be picked up. Patient B picked up a prescription for 90 tablets of 15 mg morphine sulfate on or about the same day.

97. According to CURES, on or about May 11, 2015, Patient B filled a prescription for 20 tablets of 30-300 mg acetaminophen codeine written by L.P, D.D.S.

98. On or about May 12, 2015, Patient B called Respondent's office and requested a morphine refill. He said that he had one more day's supply of medication left. He also asked whether Respondent thought it would be safe to be under general anesthesia for a tooth removal. On or about the same day, Respondent issued the refill and advised Patient B against general anesthesia because of his medical conditions. On or about May 13, 2015, Patient B filled the prescription for 120 tablets of 15 mg morphine sulfate.

99. On or about May 29, 2015, Patient B called Respondent's office and requested a morphine refill. He said he ran out of his medication. Respondent denied the request because the refill was too early. Respondent's staff informed Patient B that it was too early to receive a refill and recommended that he take Motrin.[18]

100. According to CURES, on or about May 30, 2015, Patient B filled a prescription for 15 tablets of 15 mg morphine sulfate written by S.C., M.D.

101. On or about June 1, 2015, Patient B called Respondent's office and reported that over the prior weekend, he had fallen and hit his head. In the emergency room, Patient B was advised that his Coumadin[19] level was too low and that he should notify his primary care provider. Respondent ordered a lab test and issued a medication refill.

102. According to CURES, on or about June 4, 2015, Patient B filled a prescription for 20 tablets of 10-325 mg oxycodone acetaminophen written by R.M, D.D.S.

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[18] Motrin, brand name for ibuprofen, is an NSAID.
[19] Coumadin, brand name for warfarin, is a blood thinner.

103. On or about June 8, 2015, Patient B returned to the office and saw Respondent. Patient B's leg edema and breathing had improved, although he had a urinary tract infection that was being treated with antibiotics. Respondent switched Patient B's pain medication from morphine sulfate to oxycodone acetaminophen without documenting his rationale for doing so. On or about the same day, Patient B filled a prescription written by Respondent for 90 tablets of 10-325 mg oxycodone acetaminophen.

104. On or about June 10, 2015, Patient B called Respondent's office and reported that his blood sugar was above 600. Respondent's office staff told Patient B to go to the emergency room immediately.

105. According to CURES, on or about June 22, 2015, Patient B filled a prescription for 20 tablets of 10-325 oxycodone acetaminophen written by R.M., D.D.S.

106. According to CURES, on or about June 25, 2015, Patient B filled a prescription for 20 tablets of 5-325 mg oxycodone acetaminophen written by A.J., M.D.

107. According to CURES, on or about July 7, 2015, Patient B filled a prescription for 30 tablets of 10-325 mg oxycodone acetaminophen written by R.C., M.D.

108. On or about July 8, 2015, Patient B returned to the office and saw Respondent. Respondent noted that Patient B had recently been hospitalized for leg swelling and had a right foreleg ulceration. Patient B requested a referral for a portable oxygen tank and a morphine refill for bilateral knee pain. Respondent gave Patient B a morphine refill. According to CURES, on or about the same day, Patient B filled a prescription written by Respondent for 120 tablets of 15 mg morphine sulfate.

109. On or about July 15, 2015, Patient B's wife called Respondent's office and reported that she would like to turn in oxycodone tablets to the office to exchange the prescription for morphine sulfate. Patient B was experiencing shortness of breath. Respondent approved this request and wrote a new prescription for morphine sulfate.

110. According to CURES, on or about July 25, 2015, Patient B filled a prescription for 20 tablets of 7.5-325 mg hydrocodone acetaminophen written by N.M., N.P.

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111. According to CURES, on or about July 28, 2015, Patient B filled a prescription for six tablets of 5-325 hydrocodone acetaminophen written by L.P., M.D.

112. On or about July 28, 2015, L.P., M.D., called Respondent's office and reported that Patient B was in the emergency room. L.P., M.D., left a message asking for Respondent to call him back. Respondent's records do not show that he ever spoke to L.P., M.D.

113. According to CURES, on or about August 2, 2015, Patient B filled a prescription for 20 tablets of 2 mg hydromorphone written by J.W.

114. On or about August 8, 2015, Patient B returned to the office and saw Respondent. Patient B reported that he had been hospitalized again and that he had been told his aortic valve needed to be replaced. Respondent gave Patient B a cardiothoracic surgery referral and refilled his medications. On or about the same day, Patient B filled a prescription written by Respondent for 120 tablets of 15 mg morphine sulfate.

115. On or about August 24, 2015, Patient B called Respondent's office and requested a prescription for hydromorphone for severe pain. Without documenting any rationale for switching Patient B's pain medications, Respondent approved this request. On or about August 25, 2015, Patient B filled a prescription written by Respondent for 120 tablets of 2 mg hydromorphone.

116. According to CURES, on or about September 2, 2015, Patient B filled a prescription for 30 tablets of 10-325 mg oxycodone acetaminophen written by N.W., P.A. On or about September 6, 2015, Patient B filled a prescription for 10 tablets of 10-325 mg hydrocodone acetaminophen written by L.P., M.D.

117. On or about September 8, 2015, Patient B returned to the office and saw Respondent. Patient B requested a pain management referral and wanted to switch back to morphine. Respondent noted that Patient B had follow-up appointments with a heart surgeon and endocrinologist to address his other health issues. Respondent gave Patient B a prescription for morphine sulfate and a referral to a pain management specialist. On or about the same day, Patient B filled a prescription written by Respondent for 120 tablets of 15 mg morphine sulfate.

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118. According to CURES, on or about September 18, 2015, Patient B filled a prescription for 20 tablets of 10-325 mg oxycodone acetaminophen written by J.A, M.D. On or about September 25, 2015, Patient B filled a prescription for 21 tablets of 10-325 mg oxycodone acetaminophen written by P.M., M.D. On or about October 4, 2015, Patient B filled two prescriptions written by T.L. for 21 tablets of 30 mg morphine sulfate and 30 tablets of 2 mg hydromorphone. On or about October 5, 2015, Patient B filled a prescription for eight tablets of 15 mg morphine sulfate written by J.L.

119. On or about October 6, 2015, Patient B's wife called Respondent's office to request an appointment. Patient B had been hospitalized again and required a follow-up visit. On or about the same day, Respondent gave Patient B a prescription for hydromorphone for severe pain.

120. According to CURES, on or about October 9, 2015, Patient B filled prescriptions for 60 tablets of 30 mg morphine sulfate and 120 tablets of 2 mg hydromorphone. Respondent wrote both prescriptions.

121. On or about October 12, 2015, Patient B returned to the office and saw Respondent. Patient B's latest hospitalization was for a traumatic intracranial bleed. Patient B fell asleep while sitting on a bar stool and struck his left shoulder and head. A subsequent CT scan showed occipital intracranial hemorrhage. Respondent refilled Patient B's prescriptions and ordered a brain MRI.

122. According to CURES, on or about October 23, 2015, Patient B filled a prescription for 15 tablets of 30-300 mg acetaminophen codeine written by H.T. On or about October 24, 2015, Patient B filled a prescription for 20 tablets of 10-325 mg oxycodone acetaminophen written by N.W., P.A. On or about October 27, 2015, Patient B filled a prescription for 25 tablets of 7.5-325 mg oxycodone acetaminophen written by M.G., M.D.

123. According to CURES, on or about November 2, 2015, Patient B filled a prescription for 40 tablets of 15 mg morphine sulfate written by Y.T.

124. According to CURES, on or about November 4, 2015, Patient B filled a prescription for 120 tablets of 2 mg hydromorphone written by Respondent. This prescription was not documented in Respondent's records.

125. According to CURES, on or about November 9, 2015, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D. On or about November 14, 2015, Patient B filled a prescription for 10 tablets of 4 mg hydromorphone written by S.C., M.D. On or about November 16, 2015, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D. On or about November 21, 2015, Patient B filled a prescription for 30 tablets of 2 mg hydromorphone written by J.Y, M.D. On or about November 22, 2015, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D.

126. On or about November 24, 2015, Patient B returned to the office and saw Respondent. Patient B had a scrotal rash and infection that was being followed by an infectious disease specialist. Respondent gave Patient B a refill for 30 mg morphine sulfate to be taken every 12 hours. Respondent noted that Patient B's narcotic dependency was stable.

127. According to CURES, on or about November 28, 2015, Patient B filled a prescription for 60 tablets of 30 mg morphine sulfate written by Respondent.

128. According to CURES, on or about December 7, 2015, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D. On or about December 13, 2015, Patient B filled a prescription for 15 tablets of 15 mg morphine sulfate written by S.C., M.D. On or about December 15, 2015, Patient B filled a prescription for 60 tablets of 30 mg morphine sulfate written by M.G., M.D.

129. On or about December 22, 2015, Patient B returned to the office and saw Respondent. Respondent gave Patient B a morphine sulfate prescription, which Patient B filled on or about December 25, 2015.

130. According to CURES, on or about January 1, 2016, Patient B filled a prescription for 60 tablets of 15 mg morphine sulfate written by Y.T., D.D.S. On or about January 5, 2016, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D.

131. On or about January 8, 2016, Patient B called Respondent's office and requested a morphine prescription for his open heart surgery, which was scheduled to happen in a few weeks. On or about January 10, 2016, Respondent authorized the prescription.

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132. During the period of time between when Patient B requested a morphine refill from Respondent to when Respondent authorized the prescription, Patient B filled a prescription for 10 tablets of 30 mg morphine sulfate written by N.W., P.A., on or about January 9, 2016.

133. On or about January 12, 2016, Patient B called Respondent's office and requested that his pain medication be switched to hydromorphone. Patient B stated that he was having four teeth extracted, in addition to the scheduled open heart surgery. Respondent approved this change, and on or about January 13, 2016, Patient B filled the prescription from Respondent for 120 tablets of 2 mg hydromorphone.

134. According to CURES, on or about January 17, 2016, Patient B filled a prescription for 20 tablets of 10-325 mg oxycodone acetaminophen written by R.M., D.D.S. Two days later, on or about January 19, 2016, Patient B filled another prescription written by R.M., D.D.S., for 30 additional tablets of 10-325 mg oxycodone acetaminophen. Two days after that, on or about January 21, 2016, Patient B filled another prescription written by R.M., D.D.S, for 30 tablets of 10-325 mg oxycodone acetaminophen.

135. According to CURES, on or about January 23, 2016, Patient B filled a prescription for 20 tablets of 10-325 mg hydrocodone acetaminophen written by M.G., M.D.

136. According to CURES, on or about January 24, 2016, Patient B filled a prescription written by Respondent for 60 tablets of 30 mg morphine sulfate. This prescription was not documented in Respondent's records.

137. According to CURES, on or about January 31, 2016, Patient B filled a prescription for 20 tablets of 5-325 mg hydrocodone acetaminophen written by V.D., M.D.

138. On or about February 1, 2016, Patient B called Respondent's office and left a message. He stated that he would not be able to see Respondent before his heart surgery on or about February 2, 20216, but that he wanted to request pain medication, specifically oxycodone. On or about the same day, Respondent authorized a prescription for morphine sulfate.

139. According to CURES, on or about February 3, 2016, Patient B filled prescriptions for 60 tablets of 15 mg morphine sulfate and 30 tablets of 15 mg morphine sulfate. Both prescriptions were written by M.S., M.D. On or about February 13, 2016, Patient B filled a

prescription for 20 tablets of 5 mg diazepam written by E.C., M.D. On or about February 14, 2016, Patient B filled a prescription for 10 tablets of 15 mg morphine sulfate written by C.B., P.A. On or about February 16, 2016, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D.

140. On or about February 16, 2016, Patient B called Respondent's office and requested a referral to a pain management specialist. Respondent's office submitted the referral request on or about February 17, 2016.

141. According to CURES, on or about February 23, 2016, Patient B filled a prescription written by Respondent for 60 tablets of 30 mg morphine sulfate.

142. On or about February 26, 2016, Patient B returned to the office and saw Respondent. Patient B reported recovering well from his heart surgery in early February. He requested a new combination of pain medications that were prescribed in the hospital by a pain management specialist. Respondent refilled Patient B's morphine sulfate prescription and gave him new prescriptions for meloxicam,[20] cyclobenzaprine,[21] and methadone.[22]

143. According to CURES, on or about February 27, 2016, Patient B filled a prescription written by Respondent for 90 tablets of 10 mg methadone.

144. On or about March 12, 2016, D.M., M.D., a physician from a hospital's emergency department, called Respondent's office. Patient B had gone to the hospital after falling and hitting his head. Patient B complained of increased back pain to D.M., M.D., and asked for pain medications.

145. On or about March 14, 2016, Patient B's wife called Respondent's office. She reported that her husband had gone to the hospital two times over the weekend for back spasms, and that he was in so much pain that he did not recognize the people around him.

146. According to CURES, on or about March 17, 2016, Patient B filled a prescription written by Respondent for 60 tablets of 30 mg morphine sulfate.

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[20] Meloxicam is an NSAID.

[21] Cyclobenzaprine is a muscle relaxant.

[22] Methadone is an opiate which is also used to treat opiate addiction. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

147. On or about March 22, 2016, Patient B returned to the office and saw Respondent. Patient B and his wife reported that Patient B had significant visual and audio hallucinations while taking cyclobenzaprine. Patient B had been off medications for one week, and replaced cyclobenzaprine with Metaxalone.[23] Respondent's plan was to continue therapy with morphine and Tylox.[24]

148. On or about March 28, 2016, an emergency room physician called Respondent's office and reported that Patient B was in the hospital for chronic pain. The treating physician stated that Patient B needed pain management and an appointment with his primary care physician. On or about the same day, Respondent approved an early refill request for morphine.

149. According to CURES, on or about March 28, 2016, Patient B filled a prescription written by Respondent for 90 tablets of 30 mg morphine sulfate.

150. On or about March 29, 2016, Respondent submitted a request for a pain management referral.

151. On or about April 12, 2016, Patient B contacted Respondent's office and requested another prescription for morphine. The office scheduled Patient B for an appointment with Respondent on or about April 14, 2016.

152. On or about April 13, 2016, Patient B and his wife returned to the office and saw Respondent. Patient B admitted that he was addicted to his medications and that his addiction was getting worse. Respondent noted for the first time that Patient B had a history of addiction to cocaine, morphine, and alcohol. Respondent strongly recommended that Patient B undergo an inpatient detox program followed by rehabilitation, and that he see a pain management specialist. Respondent's plan was to try Wellbutrin,[25] methadone, and morphine. Patient B's wife agreed to administer morphine to her husband. Respondent ordered a referral for a detox program.

153. According to CURES, on or about April 13, 2016, Patient B filled a prescription for 60 tablets of 10 mg methadone written by Respondent. On or about April 24, 2016, Patient B filled another prescription written by Respondent for 90 tablets of 30 mg morphine sulfate.

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[23] Metaxalone is a muscle relaxant.
[24] Tylox is a brand name for Tylenol and oxycodone.
[25] Wellbutrin, brand name for buproprion, is an anti-depressant.

154. On or about April 25, 2016, Patient B returned to the office and saw Respondent. Patient B reported that the methadone was controlling his pain fairly well and that he had some withdrawal symptoms from discontinuing morphine. Patient B reported that he had not taken any morphine in over 17 days, despite filling a morphine prescription the previous day. Respondent's plan was to continue the methadone therapy and possibly reducing the medication in four weeks. On or about the same day, Patient B filled a prescription for 120 tablets of 10 mg methadone.

155. On or about May 16, 2016, Patient B contacted Respondent's office and requested a methadone refill because he had run out of his medications early. He also requested to switch from methadone to hydromorphone. On or about May 18, 2016, Respondent noted that Patient B had to make an appointment to discuss his opioid use.

156. According to CURES, on or about May 20, 2016, Patient B filled a prescription for 30 tablets of 30 mg morphine sulfate written by M.G., M.D.

157. On or about May 23, 2016, Patient B returned to the office and saw Respondent. Patient B said that he was tolerating methadone well. Respondent told Patient B to use methadone sparingly and noted that a pain management consult was coming up.

158. On or about June 14, 2016, a pharmacist called Respondent's office. The pharmacist reported that Patient B had been in the emergency room the day prior and needed a methadone refill. On or about the same day, Patient B called and requested an early refill. He stated that he had fallen the night before and was only given acetaminophen at the hospital. Respondent approved the request on or about June 17, 2016. On or about the same day, Patient B filled a prescription for 120 tablets of 10 mg methadone.

159. On or about June 29, 2016, Patient B called Respondent's office. He reported that he saw a pain management specialist on June 22nd and that they gave him additional medication.

160. On or about July 7, 2016, Patient B called Respondent's office and reported that he had fallen down and gone to the emergency room. Patient B requested medication. Respondent issued a prescription for 60 tablets of 30 mg morphine sulfate.

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161. On or about July 11, 2016, a physician from a hospital called Respondent's office about Patient B. According to CURES, on or about July 11, 2016, Patient B filled a prescription for 12 tablets of 10 mg methadone written by N.K., M.D.

162. On or about July 15, 2016, Patient B returned to the office and saw Respondent. Respondent noted that Patient B was being treated by a pain management specialist. Patient B stated that his most recent fall was not related to drug abuse. Respondent gave Patient B a refill for methadone. On or about the same day, Patient B filled that prescription for 120 tablets of 10 mg methadone.

163. On or about July 20, 2016, Patient B called Respondent's office and reported that his pain management specialist told him to take methadone four times per day. Patient B called Respondent asking what he should do. Respondent noted that his methadone prescription was already for 10 mg to be taken four times per day.

164. On or about July 21, 2016, Patient B called Respondent's office to request an appointment. Patient B had fallen and gone to urgent care the week prior.

165. On or about August 3, 2016, Patient B returned to the office and saw Respondent. Patient B complained of back, knee, and generalized joint pain. Respondent gave Patient B a refill for methadone and ordered an orthopedic referral. According to CURES, Patient B filled the prescription for 120 tablets of 10 mg methadone on or about August 11, 2016.

166. On or about October 4, 2016, Patient B returned to the office and saw Respondent. Patient B reported that he had fallen and gone to the emergency room the week prior. Respondent gave Patient B a prescription for methadone at an increased dose (10 mg to be taken five times per day) and ordered an orthopedic referral.

167. On or about October 31, 2016, Patient B returned to the office and saw Respondent. Patient B complained of wounds on his leg and joint pain related to a recent fall. He asked to increase his methadone use. Respondent ordered referrals to a wound care specialist and a pain management specialist. Respondent also increased Patient B's methadone dose to two 10 mg tablets every eight hours as needed for pain.

168. On or about December 8, 2016, Patient B died from a cardiac arrest.

169. Respondent committed gross negligence in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent prescribed dangerous combinations of controlled substances, namely morphine sulfate, hydromorphone, methadone, oxycodone acetaminophen, and tramadol, to Patient B, without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation;

b. Respondent failed to perform or document the appropriate necessary monitoring in Patient B's care, given the high dosages of opioids being prescribed over a long-term basis; and

c. For years, Respondent excessively prescribed and refilled opioid medications to Patient B without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation.

Patient C

170. As of November 29, 2013, Respondent had been treating Patient C, then a 69-year-old man, as an established patient for a number of years. At that time, Patient C's medical issues included back pain, insomnia, and anxiety. Respondent treated Patient C with 10 to 20 mg of zolpidem tartrate[26] per night and up to 1.5 mg of alprazolam[27] per day. Respondent periodically administered steroid injections at various trigger points to treat Patient C's back pain.

171. From on or about December 24, 2013 through September 23, 2014, Respondent continued to treat Patient C by regularly prescribing zolpidem tartrate and alprazolam.

172. According to CURES, from on or about February 24, 2014 through September 24, 2014, Respondent gave Patient C approximately seven prescriptions for 5-325 mg hydrocodone acetaminophen to be taken up to three times a day for back pain. Respondent also administered periodic steroid injections in Patient C's back to alleviate pain.

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[26] Zolpidem tartrate, brand name Ambien, is a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[27] Alprazolam, brand name Xanax, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

173. On or about June 27, 2014, Respondent gave Patient C a referral to a neurosurgeon for possible back surgery and administered lumbar epidural steroid injections for Patient C's continued back pain. On or about August 18, 2014, the consulting neurosurgeon opined that Patient C was not a suitable candidate for surgery and recommended that Patient C continue conservative care with acupuncture, physical therapy, and lumbar epidural steroid injections.

174. On or about October 1, 2014, Patient C messaged Respondent to request another cortisone shot at his appointment scheduled for the following day. Patient C also reported that the hydrocodone acetaminophen had not been working well and that he wanted to try a different opioid medication.

175. On or about October 2, 2014, Patient C returned to the office and saw Respondent. Respondent administered steroid injections in Patient C's sacroiliac joints and switched Patient C's pain medication to 10-325 mg oxycodone acetaminophen, one tablet to be taken every six hours as needed for pain.

176. On or about January 19, 2015, Respondent spoke to Patient C on the phone. Patient C's wife had died of an overdose during the first week of October 2014. Respondent became aware of Patient C's wife's death in January 2015 when Patient C requested a copy of her medical records.

177. On or about February 10, 2015, Patient C returned to the office and saw Respondent. Respondent administered another steroid injection in Patient C's left piriformis.

178. On or about February 27, 2015, Patient C returned to the office and saw Respondent for his annual physical. Patient C reported that he had discontinued all of his controlled substance medications following his wife's overdose.

179. From on or about March 26, 2015 through August 31, 2015, Respondent continued to administer cortisone injections in Patient C's back and shoulder to alleviate pain.

180. On or about September 30, 2015, Respondent ordered referrals for Patient C for a pain management specialist and physical therapy.

181. According to CURES, from on or about May 18, 2016 through July 18, 2017, Respondent gave Patient C approximately 14 prescriptions for zolpidem tartrate.

182. Respondent committed gross negligence in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent prescribed dangerous combinations of controlled substances, namely hydrocodone acetaminophen, alprazolam, and zolpidem, to Patient C, without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation;

b. Respondent failed to perform or document the appropriate necessary monitoring in Patient C's care, given the high dosages of opioids being prescribed over a long-term basis; and

c. For years, Respondent excessively prescribed Ambien to Patient C without an appropriate initial and ongoing evaluation to justify prescribing, required ongoing monitoring, and appropriate risk mitigation.

Patient D

183. Respondent's treatment of Patient D started on or before November 20, 2012. According to CURES, from on or about January 4, 2013 through December 18, 2013, Respondent prescribed Patient D the following controlled medications: (1) 7.5-325 mg hydrocodone acetaminophen, one tablet to be taken every six to eight hours; (2) 2 mg alprazolam, up to three tablets per day; (3) 10 mg zolpidem tartrate, one tablet at bedtime; and (4) Tussionex.[28]

184. According to CURES, from on or about January 7, 2014 through December 29, 2014, Respondent continued to prescribe hydrocodone acetaminophen, alprazolam, zolpidem tartrate, and Tussionex to Patient D on a regular basis.

185. On or about November 6, 2014, Patient D, then a 55-year-old woman, sent Respondent an electronic message asking about the "policy on the new law for Pain Medication Refills." Patient D also requested a hydrocodone acetaminophen prescription refill for 120 tablets. On or about November 7, 2014, Respondent replied to Patient D's message. Respondent notified Patient D that he wrote her the hydrocodone acetaminophen prescription for the quantity

[28] Tussionex, brand name for hydrocodone-chlorpheniramine, is an opioid cough suppressant and antihistamine.

she requested, but that he saw "no reason why [Patient D] should require 120 tablets every 30 days." Respondent also told Patient D that she needed to make an appointment to see him every three months to continue receiving medication refills.

186. According to CURES, from on or about January 5, 2015 through December 28, 2015, Respondent continued to prescribe hydrocodone acetaminophen, alprazolam, and zolpidem tartrate on a regular basis to Patient D. During this period of time, Respondent also gave Patient D regular prescriptions of Fioricet.[29]

187. On or about January 2, 2015, Patient D requested a referral to a specialist to address her chronic pain issues. Respondent's records do not indicate whether Patient D was given a referral.

188. According to a health questionnaire dated on or about March 16, 2015, Patient D had a history of back pain and related surgeries, chest pain, migraines, high cholesterol, irregular heartbeat, and osteoarthritis in her fingers.

189. On or about March 30, 2015, Patient D called Respondent's office and requested an early refill for alprazolam. She reported having a difficult time with her allergies which was affecting her ability to breathe which, in turn, made her anxious.

190. On or about April 29, 2015, Patient D returned to the office and saw Respondent. Patient D complained of multi-joint pain, primarily in her hands. Respondent gave Patient D a referral to a rheumatologist. Patient D saw that rheumatologist, S.G., D.O., on or about May 27, 2015. The rheumatologist noted Patient D's chronic prednisone use, chronic low back pain, and hand swelling. Patient D was given a Toradol[30] injection at this visit with the rheumatologist. On or about August 31, 2015, the rheumatologist started Patient D on Plaquenil[31] to treat arthritis.

191. On or about October 23, 2015, Patient D returned to the office and saw S.M., M.D., to obtain refills for her medications. S.M., M.D., noted that Patient D stated that she had gone to a pain management specialist in 2011 and the specialist recommended that she continue her current

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[29] Fioricet, brand name for butalbital/acetaminophen/caffeine, is an analgesic often used to treat headaches.

[30] Toradol, brand name for ketorolac, is an NSAID.

[31] Plaquenil, brand name for hydroxychloroquine, is an immunosuppressive drug.

regimen of medications. S.M., M.D., also noted that Patient D was "very motivated to try and decrease her medications."

192. On or about November 15, 2015, Patient D sent Respondent a message asking for an early refill and a new prescription. She stated that she was experiencing severe sacral and bladder pain and shingles on her chest, which caused her to take more pain medication. She asked for an early hydrocodone acetaminophen refill and asked for a Fioricet prescription with codeine. Respondent wrote Patient D a prescription for 30 tablets of Fioricet with codeine.

193. On or about December 2, 2015, Patient D received a Toradol injection at an office visit with her rheumatologist.

194. On or about December 15, 2015, Patient D returned to the office and saw Respondent. Patient D wanted to discuss pain control. Respondent documented that "[m]edications reviewed and flawlessly and plan of action for pain control reviewed with patient." No other details of this pain control plan of action were documented.

195. On or about December 23, 2015, Patient D sent a message to Respondent asking for another prescription for Fioricet with codeine, stating that she "was able to step down to on the Norco two days when I had the inbetween codeine." Respondent wrote the Fioricet with codeine prescription, but noted that "[w]e have to be careful on the amount of narcotics being used."

196. According to CURES, from on or about January 8, 2016 through December 29, 2016, Respondent continued to prescribe hydrocodone acetaminophen, alprazolam, and zolpidem tartrate to Patient D on a regular basis.

197. On or about July 5, 2016, S.G., D.O., gave Patient D a prescription for tramadol, with 50 mg to be taken every 12 hours as needed for pain. According to CURES, Patient D filled prescriptions written by S.G., D.O., for 60 tablets of 50 mg tramadol on or about July 5, 2016 and August 2, 2016.

198. On or about August 25, 2016, Respondent replaced S.G., D.O., as the treatment provider prescribing tramadol to Patient D. According to CURES from on or about August 28, 2016 through December 27, 2016, Patient D received refills for tramadol that were written by Respondent.

199. According to CURES, from on or about January 5, 2017 through December 31, 2017, Respondent continued to prescribe hydrocodone acetaminophen, alprazolam, zolpidem tartrate, and tramadol to Patient D. On or about August 1, 2017 and September 10, 2017, Patient D filled two prescriptions written by F.M., M.D, each for 40 tablets of 50 mg tramadol.

200. On or about April 11, 2017, Patient D messaged Respondent regarding her pain. She reported that her left foot and leg were swollen and hurting, and that she had gone to the emergency room. Patient D stated that she was taking four hydrocodone acetaminophen tablets per day. She asked Respondent to write her a prescription for tramadol at double the current dose. Respondent gave her a prescription for tramadol at the original dose of one 50 mg tablet every 12 hours as needed for pain.

201. On or about May 22, 2017, Patient D returned to the office and saw Respondent. Respondent reviewed Patient D's recent hospitalization and treatment. He ordered an ultrasound of Patient D's leg and ordered a work up for lymphedema.

202. On or about July 31, 2017, Patient D called Respondent's office and asked to increase her tramadol dose because of increased pain due to a recent back surgery. Respondent gave Patient D a prescription for 90 tablets of 50 mg tramadol, with one tablet to be taken every 8 hours. According to CURES, Patient D filled that prescription on or about September 1, 2017.

203. On or about August 23, 2017, Patient D returned to the office and saw Respondent. Patient D's current medications in this progress note include gabapentin, although it is unclear which treatment provider initially prescribed the medication. According to the progress note, Patient D was to stop taking gabapentin.

204. On or about August 31, 2017, however, Patient D messaged Respondent about pain in her right leg. Patient D explained that she got most pain relief from taking gabapentin and tramadol. Patient D requested to increase her gabapentin dose. Respondent advised Patient D that she could increase her gabapentin dose by two additional tablets daily. According to CURES, Patient D filled a prescription written by Respondent for an increase dose of tramadol, for up to 150 mg per day.

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205. On or about September 6, 2017, Patient D returned to the office and saw Respondent. Respondent increased Patient D's gabapentin dose to 2,400 mg per day.

206. On or about September 28, 2017, Patient D messaged Respondent and complained of severe pain in her right leg. Patient D reported that of her pain medications, only tramadol provided relief. She requested to increase her gabapentin use and her tramadol dose to 300 mg per day. Respondent replied, saying he sent a revised prescription for tramadol to the pharmacy.

207. According to CURES, from on or about September 28, 2017 through February 17, 2018, Patient D continued to fill prescriptions written by Respondent for hydrocodone acetaminophen, tramadol, alprazolam, zolpidem tartrate, Fioricet, and Tussionex.

208. On or about March 15, 2018, Patient D died of perforated diverticulitis, septic shock, and multi-system organ failure.

209. Respondent committed gross negligence in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent prescribed dangerous combinations of controlled substances, namely hydrocodone acetaminophen, alprazolam, zolpidem tartrate, and tramadol, to Patient D, without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation;

b. Respondent failed to perform or document the appropriate necessary monitoring in Patient D's care, given the combination of controlled substances being prescribed over a long-term basis; and

c. Respondent excessively prescribed and refilled opioid medications to Patient D without an appropriate initial and ongoing evaluation to justify the prescribing, required ongoing monitoring, and appropriate risk mitigation.

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SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

210. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 45100 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereafter:

Patient A

211. Paragraphs 12 through 50, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

212. Respondent committed negligence in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent failed to maintain adequate and accurate records which should include an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances and informed consent, which should include a discussion of the major potential risks of taking controlled substances.

Patient B

213. Paragraphs 51 through 169, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

214. Respondent committed negligence in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent failed to maintain adequate and accurate records which should include an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances and informed consent, which should include a discussion of the major potential risks of taking controlled substances.

Patient C

215. Paragraphs 170 through 182, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

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216. Respondent committed negligence in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent failed to maintain adequate and accurate records which should include an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances and informed consent, which should include a discussion of the major potential risks of taking controlled substances.

Patient D

217. Paragraphs 183 through 209, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

218. Respondent committed negligence in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent failed to maintain adequate and accurate records which should include an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances and informed consent, which should include a discussion of the major potential risks of taking controlled substances.

Patient E

219. In or around November 2014, Patient E, then a 51-year-old male with an intellectual disability, was an established patient at Respondent's practice group. On or about November 26, 2013, Respondent issued a refill for Patient E for 180 tablets of 32.4 mg phenobarbital.[32] On or about January 29, 2014, Respondent issued a refill for Patient E for fenofibrate.[33] On or about May 1, 2014, Respondent authorized another refill for ciclopirox topical solution.

220. On or about June 2, 2014, Respondent authorized refills for phenobarbital and Dilantin.[34] Patient E was taking approximately 250 mg of Dilantin per day.

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[32] Phenobarbital is used to treat and control seizures.
[33] Fenofibrate is a cholesterol medication.
[34] Dilantin, brand name for phenytoin, is an anticonvulsant used to treat and prevent seizures.

221. On or about August 22, 2014, Respondent authorized a refill for dutasteride for Patient E. According to notes to the pharmacy, Patient E needed to follow up with his primary care provider.

222. On or about September 8, 2014, Patient E came to Respondent's office and saw Respondent. Respondent noted that Patient E was tolerating the phenobarbital well and that he had no recent seizure activity. Respondent addressed Patient E's complaints of ankle pain, generalized weakness, and lower extremity edema. He documented that labs, including a test to check Patient E's phenobarbital level, would be ordered in the future.

223. On or about September 12, 2014, Respondent authorized a prescription for 180 tablets of 32.4 mg phenobarbital with three refills.

224. On or about September 17, 2014, Respondent reviewed Patient E's lab results. He documented that Patient E's phenobarbital level was low, but that as long as Patient E was not having seizures, the current phenobarbital dosage was fine. Respondent's plan was to recheck labs in six months.

225. On or about October 15, 2014, Respondent authorized prescription for dutasteride for Patient E with enough refills for six months.

226. On or about October 22, 2014, Patient E's father called Respondent's office. The father reported that Patient E had been having dizzy spells for a few weeks and requested an appointment to check Patient E's seizure medications.

227. On or about October 29, 2014, Patient E returned to Respondent's office to address his symptoms and for a pre-operative clearance for an ankle surgery. Respondent performed a physical examination of Patient E and ordered pre-operative lab tests and a neurology follow-up for Patient E's dizziness.

228. On or about June 3, 2015, Respondent authorized a prescription for 450 tablets of 50 mg Dilantin with three refills. The nurse who initially received the refill request noted that Patient E was due for a follow-up appointment with Respondent as well as a lab test to check his phenytoin level.

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229. On or about November 1, 2015, Respondent authorized a prescription for 90 capsules of 0.5 mg Avodart with three refills. On or about November 10, 2015, Respondent authorized a prescription for 90 tablets of 160 mg fenofibrate, despite the fact that Patient E's last office visit was over a year prior.

230. Over six months later, on or about May 13, 2016, Respondent authorized a prescription for 450 tablets of 50 mg Dilantin with three refills.

231. On or about October 19, 2016, Respondent authorized a prescription for 90 tablets of 160 mg fenofibrate with three refills.

232. On or about November 13, 2016, Respondent authorized a prescription for 90 capsules of 0.5 mg dutasteride with three refills.

233. On or about May 11, 2017, Respondent authorized a prescription for 450 tablets of 50 mg Dilantin with three refills.

234. On or about September 25, 2017, Respondent authorized a prescription for 90 tablets of 160 mg fenofibrate with three refills.

235. On or about October 10, 2017, Respondent authorized a prescription for 90 capsules of 0.5 dutasteride with three refills.

236. On or about May 21, 2018, Respondent authorized a prescription for 450 tablets of 50 mg Dilantin with three refills.

237. On or about August 9, 2018, Respondent authorized a prescription for 90 tablets of 160 mg fenofibrate with three refills.

238. On or about November 19, 2018, Respondent authorized a prescription for 90 capsules of 0.5 dutasteride with no refills.

239. On or about February 8, 2019, a staff member from Respondent's office spoke to Patient E's wife. The staff member explained that Patient E had to make an appointment and see Respondent before any more medication refills would be given, as Patient E had not been seen by a medical provider in over four years.

240. On or about February 13, 2019, Respondent authorized a prescription for 90 capsules of 0.5 dutasteride with no refills.

241. On or about May 13, 2019, Respondent authorized a prescription for 50 mg Dilantin.

242. On or about July 26, 2019, Respondent authorized a prescription for 160 mg fenofibrate.

243. On or about August 2, 2019, Respondent authorized a prescription for 160 mg fenofibrate. Staff members in Respondent's office noted that Patient E's last office visit was five years prior and that Patient E was told to contact his new primary care provider to refill his prescriptions.

244. Respondent committed repeated negligent acts in his care and treatment of Patient E which includes, but is not limited to, the following:

a. Respondent failed to properly monitor Patient E with regard to his Dilantin treatment; and

b. Respondent failed to maintain adequate and accurate records for Patient E.

THIRD CAUSE FOR DISCIPLINE
(Excessive Prescribing)

245. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 45100 to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he repeatedly and excessively prescribed drugs in his care and treatment of Patients A, B, C, and D, as more particularly alleged in paragraphs 12 through 218, above, which are hereby re-alleged and incorporated by reference herein.

FOURTH CAUSE FOR DISCIPLINE
(Prescribing Dangerous Drugs without Appropriate Prior Examination)

246. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 45100 to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed dangerous drugs to Patient E without an appropriate prior examination, as more particularly alleged in paragraphs 219 through 244, above, which are hereby re-alleged and incorporated by reference herein.

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FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

247. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 45100 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records for Patients A, B, C, D, and E, as more particularly alleged in paragraphs 12 through 244, above, which are hereby re-alleged and incorporated by reference herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 45100, issued to Respondent Patrick Shannon Thompson, M.D.;

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

3. Ordering Respondent Patrick Shannon Thompson, M.D., to pay the Board the costs of investigation and enforcement of this case, and if placed on probation, to pay the Board the costs of probation monitoring; and

4. Ordering Respondent Patrick Shannon Thompson, M.D., if placed on probation for a period of five years or more, to disclose the disciplinary order to patients pursuant to Section 2228.1 of the Code; and

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

DATED: FEB 0 8 2022

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