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

In the Matter of the First Amended Accusation Against: Michael David Gruber, M.D. Physician's & Surgeon's Certificate No. G 61040 Respondent.	Case No. 800-2018-044577

DECISION AFTER NON-ADOPTION

The attached Proposed Decision is hereby adopted by Operation of Law as the Decision 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 February 6, 2023.

IT IS SO ORDERED: January 6, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D. Chair
Panel A

BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation Against:

MICHAEL DAVID GRUBER, M.D., Respondent

Case No. 800-2018-044577

OAH No. 2021080200

PROPOSED DECISION

Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on June 7 through 10, and 14, 2022, from Sacramento, California.

Ryan Yates, Deputy Attorney General, represented and appeared on behalf of William J. Prasifka (complainant) in his official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department).

Nicholas Jurkowitz, Attorney at Law, represented Michael David Gruber, M.D. (respondent), who was present.

Evidence was received, the record closed, and the matter submitted for decision on June 14, 2022.

FACTUAL FINDINGS

1. On August 17, 1987, the Board issued Physician's and Surgeon's Certificate No. G 61040 (license) to respondent. The license expired on August 31, 2019, and has not been renewed.[1]

Respondent's Education, Experience, and Background

2. Respondent earned his medical doctorate from the Chicago Medical School in 1986. He then completed a three-year residency and internship at the University of San Francisco – Fresno campus. He is board-certified in family medicine. He is presently licensed to practice medicine in California and Colorado. He was previously licensed in New Mexico (1994-2008), where he was in private practice.

3. In 2008, respondent was incapacitated following a car accident and was unable to practice for 18 months. He was thereafter hired by Valley Wide Health Systems in Colorado, where he worked for over a year. He then served as the medical director for the Southern Ute Indian Tribe Health Center for two years. He returned to Valley Wide as a staff physician from 2011 to 2015. Respondent moved to California in early 2016 to care for his ailing father. He worked for six months as a staff physician at Culver City Urgent Care. In August 2016, he was hired as a staff physician and medical director by Adventist Health in Corning (Adventist), where he remained until August 2018. Respondent then returned to Colorado where he has worked as the medical

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[1] The expiration of a medical license does not deprive the Board of its authority to bring disciplinary action against it. (Bus. & Prof. Code, § 118, subd. (b).)

director and staff physician for Valor Healthcare, a community based outpatient clinic (CBOC) for the Veterans Affairs Department (VA).

4. While at Adventist, respondent co-chaired a task force, a subcommittee of the Opioid Oversight Committee. Providers referred patient cases with MMEs[2] of 300 or greater to the task force for review and the task force would issue its recommendations to reduce the level of narcotics. None of the patients involved in the instant matter were referred to the task force.

Investigation and Accusation

5. In 2018, the Board received an online complaint from staff at Saint Elizabeth Community Hospital (St. Elizabeth) regarding respondent's care and treatment of Patient A. The Board subsequently conducted an investigation and identified five chronic pain patients, including Patient A, whose care and treatment by respondent between August 2016 and November 2018 allegedly departed from the standard of care.

6. On May 30, 2019, complainant made and served the instant Accusation in his official capacity. The Accusation seeks to discipline respondent's license based on allegations of gross negligence, repeated negligent acts, excessive prescribing, incompetence, general unprofessional conduct, and failure to maintain adequate and accurate medical records. Respondent timely filed a Notice of Defense. This hearing followed.

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[2] MME stands for morphine milligram equivalents, representing the potency of an opioid dose relative to morphine.

PATIENT A[3]

7. Patient A was a 64-year-old man with multiple medical problems and severe chronic pain due to neck procedures. He also suffered from anxiety, depression, encephalopathy, and benign prostatic hypertrophy. He had surgeries for herniated cervical disks in 1993 and 1996, and had advanced degeneration of both knees. Patient A began treatment with respondent sometime in 2016.[4] At that time, his existing pain medication regimen from his prior physician included Tramadol[5] 50mg (eight tablets per day). Other pain medications included Fentanyl[6] 50mcg/hr patch (every 72 hours),

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[3] To protect their privacy, the five patients at issue in this Decision are referred to as Patients A through E.

[4] The first visit in the medical record provided is December 5, 2016. However, the notations in that chart indicate respondent had seen Patient A prior to that date.

[5] Tramadol is the generic name for Ultram, an opioid used to treat moderate to severe pain. Tramadol is a Schedule IV controlled substance (Code Fed. Reg., tit. 21, § 1308.14, subd. (b)), and a dangerous drug (Bus. & Prof. Code, § 4022).

[6] Fentanyl is a synthetic opiate used to treat severe pain. It is a Schedule II controlled substance (Code Fed. Reg., tit. 21, § 1308.12; Health and Safe Code, § 11055, subd. (c)), and a dangerous drug (Bus. & Prof. Code, § 4022).

Opana ER[7] 20mg (every 12 hours). Finally, Patient A took Lyrica 75mg (twice daily), and Celebrex 200mg (twice daily).[8]

8. A CURES report showed that, from December 21, 2016, to June 19, 2018, respondent prescribed or refilled Patient A's pain medications including: Percocet[9] 325/5mg (one tablet every six hours); Dilaudid[10] 120mg (50 tablets); and, Tramadol 50mg (four tablets a day).

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[7] Opana ER (extended release) is a brand name for oxymorphone, an opioid used to treat moderate to severe pain. Oxymorphone is a Schedule II controlled substance (Code Fed. Reg., tit. 21, § 1308.12; Health and Safe Code, § 11055, subd. (d)), and a dangerous drug (Bus. & Prof. Code, § 4022).

[8] Lyrica is a brand name for pregabalin, a pain medication, used to treat nerve and muscle pain, and seizures. Celebrex is a brand name for celecoxib, a nonsteroidal anti-inflammatory medication to treat pain.

[9] Percocet is the brand name for oxycodone with acetaminophen, a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone is a Schedule II controlled substance (Code Fed. Reg., tit. 21, § 1308.12; Health & Saf. Code, § 110055, subd. (b)), and a dangerous drug (Bus. & Prof. Code, § 4022).

[10] Dilaudid is a brand name for hydromorphone hydrochloride (HCL), a short-acting opioid used to treat severe pain. Oxymorphone is a Schedule II controlled substance (Code Fed. Reg., tit. 21, § 1308.12; Health and Safe Code, § 11055, subd. (b)), and a dangerous drug (Bus. & Prof. Code, § 4022).

9. On December 5, 2016, Patient A saw respondent for a follow up visit regarding chronic pain. He denied current alcohol and tobacco use, or historic or current substance abuse. In the medical chart, under "History of Present Illness," respondent documented:

> Has had 2 neck operations, herniated disc 2 levels 1993, 2nd 1996 opened and fused multiple levels. Both knees, now knees advanced degeneration. At one time he was taking oxymorphone and getting good relief. He has tremendous pain. The pain keeps him from participating in activities of daily living. He is extremely depressed with this. There has been discussion back and forth about his issues and concerns. At one point he threatened to take all his pills. These were not the pain pills he was referring to but after all that there has been hesitancy and prescribing him pain control on the last visit we attempted to use fentanyl patches. These did not stick very well to his skin and did not provide adequate pain relief. It is difficult to use the patches in the setting when they will not stay on the skin and you are not supposed to take them. I asked him what gave him his best relief over time. He states oxymorphone. His wife is present during this conversation and support everything he said.

Notwithstanding the above, Patient A denied having any suicidal ideations. Respondent performed a physical examination and noted no abnormal findings. In his assessment and plan, respondent noted:

> ... There is some suicidal gesture which seems to be about desperation from the unremitting pain. I discussed with him the notion that if he had adequate pain relief he would [not] be suicidal [and] he endorses this idea, his wife endorses this idea. I have elected to start him on oxymorphone from the next week. He has tramadol at home for breakthrough. He will follow-up in one week's time and we will again discuss these issues. Once again his wife is supportive of this plan.

10. On January 19, 2017,[11] Patient A saw respondent for a follow-up visit. Respondent performed a physical examination with similar findings. Patient A had no suicidal ideations. In the medical chart, respondent noted that Patient A had started on Percocet at the last visit, and "he feels very comfortable on four Percocets and four tramadol a day." Patient A requested the Percocet be increased to 10mg, but respondent declined, noting his desire "to keep the dosage per tablet low." Respondent included Percocet and doxycycline on the medication list, but did not list the Fentanyl patches or Dilaudid. In his assessment, respondent noted Patient A is improved, "smiling and laughing for the first time in months." His function is also improved. Respondent noted his plan to continue the current treatment.

11. On March 12, 2017, Patient A came in for a follow-up visit with respondent. In the medical chart, respondent noted that Patient A's medication "works

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[11] This Decision does not include a summary of every visit with respondent by Patients A through E. Rather, it includes only those visits alleged in the Accusation or which were deemed to explain other evidence.

to a certain extent but does not cover him throughout the whole day." He had no current suicidal ideation. Respondent assessed Patient A as having "inadequate pain control," and doubled the Lyrica prescription to 150mg.

12. On May 11, 2017, Patient A saw respondent for a follow-up after his recent hospitalization in the for what ultimately was deemed to be an accidental overdose. Respondent noted that a toxicology screen from the emergency room was negative for opiate and Tylenol even though Patient A had a Percocet prescription. Respondent further noted that Patient A was agitated and had a contentious relationship with his wife which complicated his treatment. However, he reported no suicidal ideation. In his assessment, respondent noted depression and paranoid thought content. Patient A complained the combination of tramadol with Percocet provided inadequate pain relief. Respondent agreed to prescribe a six-day course of Opana; however, he did not document the formulation, strength, or quantity of medication actually prescribed.

13. On May 17, 2017, Patient A saw respondent for a follow-up visit. Patient A had an "extremely labored and antalgic" gait and walked with a cane. He reported continuing struggle to control pain. Respondent agreed to prescribe Opana ER 30mg (twice daily).

14. On May 25, 2017, respondent documented that Patient A was hospitalized for suspected "hepatic encephalopathy causing alternation level of consciousness." Toxicology screen was positive for opioids. Respondent discussed the patient's pattern of altered level of consciousness over a period of years, noting Nefazodone may be the most likely cause. Respondent discontinued the medication and noted he will refer the patient to neurology if problem persists. He also discontinued the Celebrex and referred the patient to nephrology.

15. On June 16, 2017, respondent noted that Patient A was hospitalized again. He again documented Patient A had suffered from short term memory loss for years. He did not make a neurology referral.

16. On July 10, 2017, respondent documented that Patient A had been hospitalized again. He reported pain in the right hip and both knees. Respondent referred him to a nephrologist and another physician specialist, though he did not specify the specialty.

17. On October 3, 2017, respondent documented that Patient A had been hospitalized in the ER on September 26, 2017. He was required to be physically restrained, appeared to have altered mental status and memory loss, and had abnormal renal function. No cardiac exam, memory test, tachycardia or hypertension were documented in the record. Respondent referred Patient A to a different neurologist and refilled the Opana ER prescription. During a subsequent visit on November 1, 2017, respondent noted Opana ER was no longer available on the market and instead prescribed Percocet 30mg (twice daily) for two weeks, for a reduced MME of 50 percent.

18. On December 13, 2017, Patient A came in for a follow-up visit. Respondent noted he was doing well on the current pain regimen. No cardiac exam was documented. A neurologist had scheduled a brain MRI. Respondent refilled the Percocet prescription as well as Tramadol 5mg (amount unspecified).

19. Patient A was hospitalized on January 11 and 17 through 20, 2018, and twice more before February 21, 2018. Respondent noted that on these dates Patient A experienced loss of consciousness and/or altered mental state.

20. On April 24, 2018, respondent noted Patient A had been hospitalized again for two days, with a dry cough, sweating, and altered mental state. Respondent noted his hope the neurologist "can shed some light on this situation."

21. On July 3, 2018, Patient A came in for a follow-up visit. After the visit, respondent did not accurately document the patient's current medication.

PATIENT B

22. Patient B was a 51-year-old woman suffering from rheumatoid arthritis, chronic pain, tobacco smoking, irritable bowel syndrome, insomnia, opioid-type drug dependence, and obesity. Prior to seeing respondent, Patient B was on a large dosage methadone[12] regimen.

23. A CURES report showed that, from October 28, 2016, to September 21, 2018, respondent prescribed or refilled Patient B's pain medications including: methadone HCL 10mg (14 tablets daily); Percocet 325/10mg; Valium[13] 5mg (daily or as

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[12] Methadone is synthetic opioid used to treat pain and narcotic drug addiction. It is a Schedule II controlled substance (Code Fed. Reg., tit. 21, § 1308.12; Health & Saf. Code, § 11055, subd. (c)) and a dangerous drug (Bus. & Prof. Code, § 4022).

[13] Valium is a brand name for diazepam, a long-acting benzodiazepine used for treating anxiety and panic attacks. Diazepam is a Schedule IV controlled substance (Code Fed. Regs., tit. 16, § 1308.14, subd. (c); Health & Saf. Code, § 11057, subd. (d)) and a dangerous drug (Health & Saf. Code, § 4022).

needed); and Zofran[14] 8mg (three times daily). During his care and treatment of Patient B, respondent never ordered a toxicology screening or noted in the record that he had reviewed the same. Respondent's medical charts also do not reflect that he addressed or considered the possibility of drug diversion.

24. Patient B first saw respondent on October 27, 2016. Following the visit, respondent documented that the patient was "taking huge quantities of methadone" which she had been taking for a long time. She had an existing referral to a nearby pain management clinic. Respondent advised Patient B that he was uncomfortable continuing her on such high doses and he would defer to her pain management specialist regarding pain medication. Respondent further noted, should a pain management specialist not be found and Patient B continue to treat with him, respondent would taper down the methadone slowly. He then refilled her methadone and Zofran prescriptions.

25. On January 10, 2017, Patient B came in for a follow-up visit. Respondent noted that a pain management specialist had not been found to take over her pain medications. Respondent further noted, "[multiple pain management] referrals have been unsuccessful to date [and] in the interim I will continue to provide her with the pain relief medications." He conducted a physical examination, but did not document a cardiac or pulmonary exam. His assessment included nausea and chronic pain syndrome. On February 6, 2017, respondent reduced Patient B's methadone dosage to 390 tablets per month (13 tablets daily).

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[14] Zofran is a brand name for ondansetron, an anti-nausea medication.

26. On March 2, 2017, Patient B saw respondent for a follow-up visit. She reported increased pain following gall bladder surgery. Respondent noted, "I took one pill away and she is having severe pain." There was no abdominal examination documented. Respondent documented she was on "very high doses of narcotic analgesics," including methadone and hydrocodone. Patient B requested a delay in the pain management referral until her acute issues resolved. Respondent increased the methadone to 420 tablets per month, noting:

> The current treatment regimen has been going on for quite some time and I have no problem delay[ing] for a month or 2 referral to pain management however it is clear pain management is ultimate destination for this patient as I have not [been] comfortable prescribing these medications over the long run and feel she needs a decrease in her medications. She, on the other hand, is not at all interested in decreasing her narcotic analgesics.

27. On September 3, 2017,[15] Patient B saw respondent for a follow-up visit. Respondent noted that Patient B had seen by Dr. Pearson, a pain management specialist. Dr. Pearson recommended reducing the methadone to 60mg twice daily with Valium 10mg twice daily. However, he was unable to take over prescribing of these medications. At the visit, respondent noted the following opioid withdrawal

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[15] Paragraph 51 of the Accusation makes allegations concerning an April 6, 2017 visit. However, no record of a visit on this date was in evidence nor discussed in any of the expert reports.

symptoms: palpitations, shortness of breath, insomnia, pain, vomiting, diarrhea, and anorexia.

28. On October 2, 2017, Patient B came in for a follow-up visit. Respondent documented the presence of kidney stones and chronic back pain. He further noted the goal of tapering and "hopefully discontinu[ing]" the methadone over time. Valium was the only medication for withdrawal symptoms that was acceptable to Patient B. Respondent reduced the methadone to 390 tablets at this visit, 360 tablets in November, 330 tablets in December, and 300 tablets in January 2018.

29. On March 26, 2018, Patient B saw respondent for a follow-up visit. Respondent noted the patient felt terrible and was in "active withdrawal." She was experiencing nausea, vomiting and constipation, but was in "no acute distress." A cardiac examination was normal. Respondent's assessment included tachycardia and methadone withdrawal, noting "the methadone has been on an aggressive taper schedule. She got sick last month and I halted the taper. She is no better. She did increase the methadone for a day [or two]. I increased her methadone back to 11 per day." In June 2018, respondent again reduced the methadone to 300 tablets (10 per day) and maintained this dosage through September 2018.

PATIENT C

30. Patient C was a 57-year-old female with hyperthyroidism due to thyroidectomy for papillary thyroid carcinoma, congestive heart failure, restrictive lung disease and asthma, hypertension, morbid obesity, osteoarthritis of the knees and

back, chronic pain, anxiety, and a Vitamin D deficiency. She was seen in person by Dr. Gruber on two occasions only, September 14, 2016, and October 27, 2016.[16]

31. A CURES report showed that, from September 14, 2016, to February 20, 2017, respondent prescribed or refilled various medications for Patient C including: OxyContin (generic: oxycodone) 80mg; Soma[17] 350mg; Norco[18] 10/325 mg; and, Ativan[19] 1mg. During his care and treatment of Patient C, respondent never ordered a toxicology screening or noted in the record that he had reviewed the same.

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[16] Paragraph 63 of the Accusation alleges respondent also treated Patient C on February 18, 2017. However, no such visit is reflected in the medical records provided nor in any of the expert reports.

[17] Soma is a brand name for carisoprodol, a centrally acting skeletal muscle relaxant. Carisoprodol is a Schedule IV controlled substance (Code Fed. Regs., tit. 21, § 130814, subd. (c)), and a dangerous drug (Health & Saf. Code, § 4022).

[18] Norco is a brand name for hydrocodone acetaminophen, an opioid used to treat pain. Hydrocodone is a Schedule II controlled substance (Code Fed. Regs., tit. 21, § 1308.12, subd. (b); Health & Saf. Code, § 11055, subd. (c)), and a dangerous drug (Health & Saf. Code, § 4022).

[19] Ativan is a brand name for lorazepam, a benzodiazepine used to treat seizures and anxiety. Lorazepam is a Schedule IV controlled substance (Code Fed. Regs., tit. 21, § 1308.14, subd. (c); Health & Saf. Code, § 11057, subd. (d)), and a dangerous drug (Health & Saf. Code, § 4022)

Respondent's medical charts also do not reflect that he addressed or considered the possibility of drug diversion.

32. During the initial visit on September 14, 2016, Patient C was in a wheelchair due to back and knee pain. Respondent performed a physical examination, noting her difficulty to raise herself from the wheelchair and that she had a "very unstable and unsafe gait." Patient C denied alcohol and tobacco use or substance abuse. Noting her ongoing chronic pain, respondent refilled her "pain medications." However, he did not document which specific medications he was refilling, their dosages or frequency.

33. On October 27, 2016, Patient C came in for a follow-up visit for chronic pain. Respondent performed a physical examination, with similar findings as the prior visit. Patient C denied suicidal ideations. He did not note in his medical chart whether there was any discussion regarding the patient's current pain.

34. On February 8, 2017, Patient C was admitted to the emergency room (ER) at Enloe Medical Center with chief complaints of left leg wounds and pains with cellulitis. The ER chart noted:

> The patient is a 57-year-old morbidly obese female who has chronic CHF, COPD, hypertension, hypothyroidism, chronic opiate dependence and recent admission here from 1/8 until 1/13 of last month for acute exacerbation of congestive heart failure. The hospital course was complicated by hypoxia felt to be obesity hypoventilation syndrome and also being over narcotized. She did fine

> when pain meds were cutback and she was just on Norco according to her discharge summary.
>
> [¶] ... [¶]
>
> We will need to minimize opiate use. It appears she was over sedated and became hypoxic on her last admission with a higher dose of pain medication.

35. On March 8, 2017, Patient C died. The cause of death was determined to be multiorgan failure, sepsis, and bowel necrosis. Morbid obesity and type 2 diabetes also were noted as contributing factors.

PATIENT D

36. Patient D was a 54-year-old male who suffered from anxiety, depression, back pain, cervical derangements, neck pain, multilevel degenerative disc disease, shoulder pain, migraine headaches, coronary artery disease, hypertension, hepatitis-C, gynecomastia, high blood sugar, lung nodules, and asthma. Before beginning treatment with respondent, Patient D's pain medication regimen included methadone, Norco, tizanidine,[20] and lidocaine patches.[21]

37. A CURES report showed that, from September 23, 2016, to November 14, 2018, respondent prescribed or refilled various medications for Patient D including: methadone HCL 10mg (12 tablets daily); Soma 350mg (four tablets daily); Norco

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[20] Tizanidine is a short-acting muscle relaxer used to treat muscle spasms.

[21] Lidocaine is an anesthetic used to treat pain.

10/325mg (six tablets daily); and, Valium 10mg (two tablets daily). During his care and treatment of Patient D, respondent never ordered a toxicology screening or noted in the record that he had reviewed the same. Respondent's medical charts also do not reflect that he addressed or considered the possibility of drug diversion.

38. Patient D began treatment with respondent on September 14, 2016. He was off of morphine but still suffered withdrawals from it, and asked respondent to refill the methadone and Norco. Respondent conducted a physical examination with normal results. Under assessment, respondent noted chronic cervicalgia on high-dose pain medications and noted the goals of reducing opioid dosage and improving function. He refilled the methadone and Norco medications.

39. On October 12, 2016, Patient D saw respondent for a follow-up visit. Respondent noted that he refilled the pain medication, but did not document what medications were refilled. He also did not include a complete list of current medications in the record.

40. On November 11, 2016, Patient D came in for a follow-up visit. Under history of present illness, respondent documented:

> Gets light flashes behind both eyes that sound and noise let out. [H]e is feeling sick. He is having some blurry vision. We reviewed his old med regimen. [H]e is stating he was using methadone 600/mo, Norco 300/mo, codeine #4 120/mo, soma 180/mo, morphine 120/mo. Now down to methadone 360, soma -120, diazepam 60, Norco 180. [N]o codeine, no morphine.

Under the medication list, respondent included Soma, Phenergan,[22] and tizanidine. Respondent discussed the patient's long history of chronic pain and his "very high dose analgesics and sedatives." They also discussed Patient D's withdrawal from morphine and future tapering of his pain medication.

41. On December 9, 2016, Patient D saw respondent for a follow-up visit. Respondent noted he "refilled his pain medication for two months"; however, he did not specify which medications were refilled. The CURES report shows the patient's medications at that time were methadone, Norco, carisoprodol, and Valium.

42. On March 1, 2017, Patient D came in for a follow-up visit and complained of fatigue and weakness. They discussed lowering the dose of pain medication and Patient D stated he was willing to wean off the methadone. Respondent prescribed OxyContin 40mg (three times daily) for one week, which is "milligram for milligram what he is taking in methadone." Respondent explained, "this is desirable as morphine equivalents of 120mg methadone is 800mg while it is only 120mg of [OxyContin]." Patient D returned on March 9, 2017 for a follow-up. Respondent noted "he did very poorly on the oxy. He was unable to decrease the methadone." Respondent discontinued the OxyContin and destroyed the patient's remaining pills. He then prescribed methadone 10mg (five and one half tablets daily), and noted the plan to decrease the medication by one tablet daily again in one month. Respondent also treated a cyst on Patient D's neck.

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[22] Phenergan is a brand name of promethazine, an antihistamine and antiemetic used to treat nausea and vomiting.

43. On March 13, 2017, Patient D saw respondent for a follow-up visit for his cyst. Respondent failed to document an examination or history portions of the medical record showing the patient was experiencing opioid withdrawal. Respondent noted the cyst was well-healed and not infected. At the patient's request, respondent refilled his pain medications, including methadone, and ordered an MRI of his cervical spine. The medication list included OxyContin and methadone.

44. On April 11, 2017, Patient D came in for a follow-up visit. Respondent documented:

> The patient's chronic pain due to cervical spondylosis and lumbar spondylosis. He has been on extremely high dose narcotic analgesics. We are attempting to bring these doses down. He had very significant withdrawal taking away one of 12 tablets. He is finally getting adjusted to this new dosage we will continue to 11 tablets a day for the next month or 2 and then we will attempt another dosage decrease he will follow-up in 2 months' time. He will continue to pursue his appointment with pain management.

45. On May 15, 2017, Patient D came in for a follow-up visit. Respondent noted the presence of two abscesses on the patient's left forearm. He cleaned and anesthetized them, then drained them and applied a dry dressing. There was no discussion in the record how or why the abscesses were present.

46. On June 21, 2017, Patient D saw respondent for a follow-up visit. He complained of diarrhea for several weeks and reported paranoid thoughts of missing items and "people ... getting into his house." He had considerable weight loss. In the

record, respondent documented his concern regarding the patient's weight and paranoia ideations. He ordered stool studies to determine the etiology of the diarrhea and noted "we'll continue to evaluate the situation." There was no discussion of Patient D's current pain medications.

47. On July 26, 2017, Patient D came in for a follow-up visit. Respondent noted his speech was less overtly paranoid. He had a skin rash that became infected from scratching. Respondent refilled his pain medications but removed the tizanidine without documenting the reason. Respondent then ordered "screening labs" and noted he was "still concerned about [Patient D's] mental health."

48. On August 21, 2017, Patient D came in for a follow-up visit and reported his pain as "fairly stable." Respondent noted he was on "very high-dose narcotic analgesics" including 11 tablets of methadone and six Norco tablets a day, plus "sedative hypnotics like Soma and diazepam [Valium]." Respondent further noted: "Every attempt I have made to cut back on any of these medications is met with extreme resistance. I have tried over a long period of time to get him into pain medicine for referral. I'm going to initiate another attempt to get him into pain referral." Although he mentioned Patient D was taking Valium in the narrative portion of the chart, he did not include this drug in the current medication list.

49. On October 19, 2017, Patient D came in for a follow-up visit complaining of abdominal pain. Respondent noted the CT scan "came back abnormal," and that he was to see a specialist the next day. Respondent refilled his prescriptions for Soma, methadone and Norco, but only listed the Soma refill in the chart.

PATIENT E

50. Patient E was a 52-year-old male with severe arthritis of the right hip, joint pain, back pain, neck pain, insomnia, constipation, hypertension, chronic kidney disease, hepatitis C, hyperlipidemia (high fat concentration in blood), anxiety, and depression/dysthymia. In 2008, at age 45, Patient E suffered a stroke. Since 2003, he experienced neurological deficits in his right arm associated with cervical disc disease. When he started treatment with respondent, Patient E's existing medication regimen included: Dilaudid 8mg (three times daily); Clonidine 0.1mg (twice daily); Lisinopril 20-25mg (four times daily); methadone 10mg (six tablets daily); temazepam 30mg (nightly); and, tizanidine 4mg (six tablets daily).

51. A CURES report showed that, from September 23, 2016, to September 8, 2018, respondent routinely refilled the patient's prescriptions for Dilaudid, methadone, and temazepam. During his care and treatment of Patient E, respondent never ordered a toxicology screening or noted in the record that he had reviewed the same. Respondent's medical charts also did not reflect that he ever addressed or considered the possibility of drug diversion.

52. On December 22, 2016, Patient E saw respondent for a follow-up visit regarding his hip pain. He requested a hip replacement. In the medical record, respondent did not include Clonidine on the current medication list.

53. On March 23, 2017, Patient E came in for a follow-up visit. Patient E reported he saw the orthopedist, who wanted him to stop smoking, stop taking Dilaudid, and "possibly decrease the methadone" before hip replacement surgery. Patient E agreed to reduce the methadone and discontinue the Dilaudid. Respondent

documented: "Today we stopped the [Dilaudid]. He is still on 60mg of methadone." However, the CURES report showed respondent continued to prescribe Dilaudid.

54. Over the next few months, Patient E was treated by respondent for jaundice, pancreatic occlusion, and right leg fracture. Respondent noted edema, redness and warmth below the surgical incision on the leg. On September 15, 2017, respondent noted Patient E was being treated by an orthopedist. He understood Patient E was on "a high dose of pain medications," and was "willing to decrease his dose despite persistent severe pain."

55. On October 9, 2017, Patient E saw respondent for a follow up visit regarding his edema. Respondent noted the cellulitis had improved. The record contains no discussion of his level of pain or tapering of pain medications.

56. Respondent continued to prescribe Dilaudid until February 2018. He documented discontinuing the medication in the medical record for March 23, 2018.

Respondent's Testimony

57. Respondent participated in an administrative interview with the Board on January 21, 2021. He also testified at hearing. His statements during both are summarized below.

58. Respondent was in private practice from 1994 to 2008. During this time, the national narcotics crisis "exploded." Like many family physicians, respondent had patients with a lot of high dose medications. He had to learn, as did the entire medical community, the risks and dangers of high doses of controlled substances. At all relevant times and continuing to the present, respondent does not escalate his patients' pain medications; rather, he tries to taper their medications down. He is not

interested in starting his patients on opioids or escalating their dosage. But he takes the patients as they come. Prior to Adventist, respondent did not have any patients on high dosage opioids, and no legacy patients. He kept the dosages controlled and did his best to decrease any narcotics and sedatives.

59. At Adventist, or any time before, respondent never felt he could not treat and care for a patient. However, he did not hesitate to refer a patient to a specialist where it was warranted. While at Adventist, it became increasingly difficult to have simple requests met, such as an MRI, let alone a specialist referral.

60. Respondent acknowledged the criticism of his charting. His primary goal and purpose in becoming a doctor is caring for his patients. He explained that one 25-minute visit requires him to generate 15 to 20 pages of notes, stating it was "very challenging and disruptive to patient care when you have to type into a computer while talking to your patient." Respondent completes whatever charting he can during the visit, then returns at the end of the day and on Sundays to complete the rest.

61. When respondent started at Adventist, it was not his practice to order regular toxicology screens nor was he fond of pain medication contracts. He explained he does not believe toxicology screens add much value to patient care because its sets up an adversarial relationship with the patient. Rather, he preferred to discuss his expectations with his patients and to develop a relationship of trust with them. When increasing or decreasing a prescription for controlled substances, he always calculates the MME dosage. And when it was absolutely necessary, he ordered a toxicology screen.

62. Upon arriving at Adventist, respondent was in a unique situation and confronted with a large number of patients on huge amounts of narcotics "that I had

never seen before in my life." A guiding principle in treating these patients was not to make any big changes in their care until he understood the whole situation.

63. Respondent recalled Patient A "very well," noting he did not have good pain relief due to failed neck syndrome. Respondent prescribed Percocet instead of Opana because the latter was not available. Patient A did not do well on the Percocet, so respondent prescribed Opana once it became available and Patient A's pain improved. However, Opana was taken off the market two months later and Patient A returned to Percocet. Respondent recalled Patient A frequently complained about how miserable his life was due to pain, which his wife confirmed. When his pain was under control, he was a "more normal person."

Respondent never suspected Patient A's many ER visits were due to drug overdose. Every time he went to the ER, he presented with the same symptoms but was given a different diagnosis. In January 2018, respondent disagreed with the tele-psychiatrist's recommendation to cease pain medications. Respondent explained he had worked "really hard" with Patient A and his wife to keep him out of the hospital, alive, and sane. He saw the patient regularly and was careful about the MME when he changed from one narcotic to another. Respondent also tried different antipsychotic medications to address Patient A's mental illness. By July 2018, Patient A's episodes and bizarre behavior had stopped. He was no longer going to the hospital and he was happy.

Regarding toxicology screens, respondent noted Patient A received a drug screen every time he presented to the ER, which was standard practice. Respondent reviewed the drug screens and sometimes commented on them in the medical chart. Respondent also asserted that Patient A's medical records submitted to the experts

and into evidence were incomplete and did not include ER records, lab results, nurses' notes, or specialist records.

64. Regarding Patient B, respondent explained she was already on a high-dose narcotic regimen, including methadone, when she began treating with him. Respondent recalled the patient had been put on methadone earlier because that was the only long-acting narcotic the government program would cover. Although respondent referred Patient B to a pain management specialist at the first visit, she was unable to see one until the following summer. Respondent found no physical condition warranting the continued use of high dose narcotics. Thus, at each visit, he counseled Patient B about reducing her methadone regimen or referring her to a pain specialist. However, there was no specialist willing to see her. So respondent continued to work on her taper, ultimately reducing her dosage from 140mg to 10mg a day after almost a year. In February 2018, respondent briefly increased Patient B's methadone dosage after she reported severe pain and withdrawal symptoms; additionally, she had physical and emotional trauma as she had been "beat up" and was living out of her car.

65. Regarding Patient C, respondent recalled that she had been on large amounts of medication, including benzodiazepine and Soma, for a long period of time, and he continued those medications. He was not immediately concerned about her pain medications, but was more concerned about her diabetes, COPD, and hypoxia. Patient C was extremely sick. If respondent pushed her too hard on the tapering, he was concerned she would decompensate in other areas. Rather, his focus was to stabilize her and get her medical conditions under control, then institute a taper. He did not suspect Patient C of drug diversion, noting that her regimen was "not totally out of line" with many of the other patients seen at the clinic.

66. When he first met Patient D, respondent recalled he was taking 60 tablets of morphine a month, 120mg methadone a day, as well as other medications. Patient D first presented with complaints of degenerative disc disease and extensive treatments. After a couple months, respondent determined the patient suffered from psychiatric and addiction issues. Believing the patient was overmedicated, respondent shifted his focus to tapering his pain medications. He also discussed referring the patient to a pain management specialist. However, at that time, there was a scarcity of specialists willing to treat difficult patients with high narcotic doses such as Patient D. Withdrawal from methadone is "severe and long-lasting," due to its long half-life, and it can take months to taper down from it. Doing it incorrectly can cause harm or land the patient in hospital. Rather, respondent preferred to work collaboratively with the patient, build a relationship, and taper their medication slowly and intentionally.

By March 2017, Patient D was willing to reduce methadone dosage. Respondent prescribed OxyContin 120mg a day and reduced his methadone by one pill a day, believing this would ease the patient's tapering down. However, Patient D did not respond well to OxyContin. In the summer of 2017, respondent increased the Soma from 90 pills to 120 pills per month. Every single visit, respondent discussed with the patient the importance of reducing his pain medications; however, he was a stubborn and difficult patient. Respondent saw the patient every month. Each time, Patient D had a new complaint that would defer the taper. Respondent also recalled that Patient D had multiple toxicology screens, all appropriate; he could not explain why they were not in the medical record.

67. Regarding Patient E, respondent planned to stop his Dilaudid and decrease the methadone. However, he became sick with pancreatic occlusion and respondent was required to continue the medications for several months to maintain

his homeostasis. The Dilaudid continued until early 2018 when the orthopedic surgeon directed it be stopped. Patient E had had a series of medical complications. Respondent asserted, "If I had thought the Dilaudid was compromising his ability to get over the pancreatic condition, I would have stopped it. But I saw nothing to suggest that, so I focused on his other conditions before tapering his pain medication." Respondent never suspected Patient E of drug diversion.

68. Respondent has been practicing in Colorado since 2018. He has no intent of renewing his California license or practicing medicine in California again. As a VA physician, respondent treats veteran patients only. Many are elderly, very sick, are on multiple medications, and suffer from mental health disorders related to their military service. Colorado maintains a Prescription Drug Monitoring Program (PDMP) that is similar to CURES utilized in California. Since 2018, PDMP reports established that respondent's number of prescriptions per patient for opioids, sedatives and stimulants, and their daily MME, quantity, and duration were lower than average for all Colorado physicians. He has not been the subject of any patient complaints or any investigations or disciplinary action by the Colorado medical board.

Expert Testimony

COMPLAINANT'S EXPERT – ROBERT FRANKLIN, M.D.

69. Dr. Franklin earned his medical degree in 1990 from George Washington University, Washington D.C. Dr. Franklin then completed a three-year residency in family medicine at the University of California, San Francisco. In 1991, he became licensed to practice medicine in California. He is board-certified in family practice. Since 1993, Dr. Franklin has worked for the City of San Francisco's Department of Public Health. He has also taught family medicine and emergency medicine at the

University of San Francisco since 1995; currently, teaching four hours per week. He has extensive training and experience in pain management as a family physician, and teaches it to his students. Dr. Franklin has served as a medical expert for the Board since 2003, and provided opinions in over 200 pain management cases. He also served as a medical expert for the American Medical Forensic Specialists from 2009 to 2021.

70. The Board retained Dr. Franklin to conduct a review of documents and provide an opinion on whether respondent acted within the medical standard of care when he treated Patients A through E, while employed by Adventist Health in Corning from August 2016 to August 2018. Dr. Franklin reviewed the following documents: complaint summary; Board investigative report; CURES reports and pharmacy records for Patients A through E; respondent's chart notes for Patients A through E; and, the transcript of respondent's interview with Board. Dr. Franklin also reviewed and was guided by the following publications: the Board's 2014 Guidelines for Prescribing Controlled Substances for Pain (2014 Guidelines); Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines); the 2016 Center for Disease Control Guidelines for Prescribing Opioids (2016 CDC Guidelines); and, the 2017 Veteran's Affairs / Department of Defense's Clinical Practice Guideline for Opioid Therapy for Chronic Pain (VA Guidelines).

71. Dr. Franklin prepared a report of his findings, dated April 25, 2021, and also testified at hearing.[23] At hearing, he defined the standard of care as "the practice in which a sufficiently and similarly trained doctor would engage in given a clinical

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[23] During testimony and in other expert reports, there are references to a supplemental report, dated January 23, 2022, authored by Dr. Franklin. However, no supplemental report was offered into evidence.

scenario." To formulate the standard of care in the instant case, Dr. Franklin looked to a combination of laws, Board policies, and community practices. Generally, he noted a family physician should: take a thorough history from the patient and seek out external medical records to complete the history; conduct an adequate physical examination to support the decisions made and care rendered; formulate an assessment or working diagnosis "that explains what is going on"; act in a shared decision-making capacity with the patient to formulate a rationale, safe and effective treatment plan; evaluate how effective the plan is; and, document every step taken in the medical record. In the prescription of opioids and other controlled substances, the family physician must "keep an eye out for" drug diversion, abuse and misuse, employing the use of laboratory and imaging studies as necessary.

72. Dr. Franklin opined that, for each of the five patients, respondent departed from the standard of care in the following respects. First, respondent assumed their treatment when he "lacked the necessary skill, training and experience to manage patients taking such enormous doses of opioid medications. Further, respondent did not recognize his lack of knowledge and "did not have the necessary ability to obtain essential consultation with an addiction medicine specialist before the end of the second visit with each patient." Second, respondent failed to consider or document evidence of drug diversion in light of the "massive doses of opioids in use." Third, respondent failed to make and document the diagnosis of opioid use disorder (OUD). Fourth, respondent failed to document a recognized indication justifying each of the opioids prescribed. Fifth, respondent failed to obtain and document toxicological screenings at regular intervals. Each of these failings, Dr. Franklin opined, was a separate extreme departure from the standard of care.

Patient A

73. Dr. Franklin noted that, at the start of respondent's care and treatment, Patient A was taking 30 MME a day. Over the next seven months, respondent increased that to over 90 MME. However, there was no documented rationale or treatment plan in the record to explain this increase. Noting the 2016 CDC Guidelines recommended no more than 50 MME per day, Dr Franklin opined that it was an extreme departure from the standard of care to prescribe Patient A any dose of opioid above 50 MME per day, and a separate extreme departure to prescribe an opioid regimen above 90 MME per day.

74. Dr. Franklin further found it was an extreme departure from the standard of care when respondent failed to obtain regular toxicology screenings for Patient A after the patient had undetectable opioid and Tylenol on May 11, 2017, despite having a prescription for Percocet. Respondent demonstrated a lack of requisite knowledge when he did not document a concern regarding drug diversion. And, on May 11, 2017, it was an "inexplicable extreme departure from the standard of [care]" to prescribe Opana at three times the level of the prior MME per day.

75. After respondent documented Patient A had undetectable opioid and acetaminophen during his ER visit on May 11, 2017, he did not order regular toxicology screenings. Given that Patient A was on Percocet, which contains both of these substances, respondent should have ordered toxicology screenings at regular intervals to rule out possible drug diversion. Dr. Franklin opined the failure to do so was an extreme departure from the standard of care. It was a further extreme departure to prescribe Opana ER to Patient A at 150 percent the prior MME dosage after the May 11, 2017 ER visit.

76. Dr. Franklin opined it was evident that Patient A suffered from OUD, pointing to his opioid use that resulted in "clinically apparent debility or stress." Other indicators included the quadrupling of Patient A's MME dose over a short time, multiple visits to the ER, and the toxicology screen that did not reflect the opioids which should have been in his system based on his current prescriptions.

Patient B

77. From the outset, Dr. Franklin noted that Patient B's sleep apnea and unhealthy state rendered her more at risk for opioid abuse. Although respondent initially advised the patient she would need to taper her opioid medication, she remained at the same level for more than a year. At that time, respondent reduced her methadone but increased the amount of Valium. There was no real treatment plan in the record to explain this.

78. Dr. Franklin described methadone as a "tricky drug" with an analgesic effect of six to eight hours, so it needs to be taken three to four times daily for effective pain relief. This can lead to respiratory suppression and delays repolarization of the heart. When taken in combination with Zofran, it can lead to a fatal arrythmia that occurs without warning.

79. Dr. Franklin opined it was an extreme departure from the standard of care when respondent failed to taper Patient B's opioid dosage for more than a year. It was also an extreme departure from the standard of care when he failed to refer Patient B to an addiction treatment center when it became evident she suffered from opioid use disorder. Dr. Franklin explained that, in California, opioid treatment centers are available to patients with Medi-Cal.

80. Dr. Franklin also found an extreme departure of care when respondent continued prescribing opioids to Patient B without consultation after he documented his discomfort doing so. Thus, each prescription issued after March 2, 2017, is a separate extreme departure. It was a separate extreme departure from the standard of care when he increased Patient B's doses of Valium without documenting the pain management specialist's recommendation to do so.

81. Dr. Franklin also found that respondent failed to accurately assess Patient B's symptoms in 2018 as being inconsistent with opioid withdrawal. Having made the incorrect diagnosis of opioid withdrawal, respondent then committed an extreme departure from the standard of care when he increased the methadone dosage instead of offering her specific treatment for withdrawal.

82. Dr. Franklin found an extreme departure from the standard of care when respondent prescribed Zofran 8m (three times daily) to Patient B when she was already on high dosage of methadone. He also criticized respondent for not documenting his reasoning for increasing methadone and reducing Valium, though he acknowledged respondent was responding to the specialist's recommendation.

83. Dr. Franklin further opined that respondent should have known Patient B had OUD after her first visit, when respondent advised he was uncomfortable prescribing that level of pain medications. The medical record clearly reflects respondent's belief Patient B's pain medications should be tapered down, but he did not know how to achieve it. Nor did he utilize outside resources for assistance.

Patient C

84. Dr. Franklin noted it was impossible to determine from Patient C's medical record why respondent prescribed oxycodone, Ativan, and Soma to the

patient. Failure to document respondent's rationale and treatment plan was an extreme departure from the standard of care in each instance. Moreover, Dr. Franklin pointed out that respondent's prescription of 1,020 MME per day opioids in conjunction with Ativan and Soma to a frail patient is "inexplicable and is evidence of profound, potentially deadly, lack of knowledge." Dr Franklin also found an extreme departure when respondent concomitantly prescribed opioids and benzodiazepines to Patient B, noting it is among the deadliest combinations of drugs.

Patient D

85. Dr. Franklin noted that respondent recognized Patient D was addicted to the pain medications he was prescribed. However, respondent failed to carefully document his rationale and treatment plan for continuing these medications. Thus, Dr. Franklin concluded, it was a separate extreme departure from the standard of care each time respondent prescribed pain medication after November 30, 2016. Respondent's failure to institute a rapid taper of all controlled medications, or refer Patient D to an OUD treatment center, was also an extreme departure.

86. Dr. Franklin opined that it was an extreme departure from the standard of care, and evidence of respondent's lack of knowledge, when respondent documented Patient D was experiencing opioid withdrawal. Respondent failed to recognize the risk to Patient D and his community by continuing to prescribe pain medications.

87. Dr. Franklin noted it was "a particularly egregious" extreme departure from the standard of care to not document a history explaining why Patient D had abscesses on his left arm, or to obtain a toxicology screen on that visit. Respondent's lack of concern for drug diversion at this point, Dr. Franklin opined, evidenced his dangerous lack of knowledge. Dr. Franklin found an extreme departure from the

standard of practice when respondent continued to prescribe Patient D high doses of Soma and Valium, as well as an extreme departure to not document the rationale for continuing said treatment. Finally, Dr Franklin found an extreme departure when respondent concomitantly prescribed opioids and benzodiazepines to Patient D.

Patient E

88. Dr. Franklin found an extreme departure from the standard of care in respondent's overall failure to taper Patient E's opioid treatment, achieving only a seven-percent opioid dose reduction over an 11-month period. It was a separate extreme departure for each instance where respondent prescribed temazepam without documenting it in the medical record.

89. Regarding Patient E's Dilaudid regimen, Dr. Franklin noted it was extreme departure from the standard of care when respondent documented that the medication was discontinued on March 23, 2017, even though the treatment continued thereafter. Each prescription of Dilaudid issued after this date was a separate extreme departure. Finally, Dr Franklin also found an extreme departure when respondent concomitantly prescribed opioids and benzodiazepines to Patient E.

RESPONDENT'S EXPERT – MARIO SAN BARTOLOME, M.D.

90. Dr. San Bartolome received his medical doctorate from the University of California, Irvine in 2003. He thereafter completed a three-year residency in family medicine at Long Beach Memorial. He is board-certified by the American Board of Family Physicians (2006 to present), American Board of Addiction Medicine (2010 to present), and American Board of Preventive Medicine with an addiction medicine subspecialty (2018 to present). He became licensed to practice medicine in California in 2005. He is also a certified as a medical review officer by the American Association

of Medical Review Officers, and a former qualified medical evaluator certified by the Division of Workers' Compensation. He has previously served as a legal consultant and expert witness on cases involving substance use, toxicology, pain management, and other mental health related issues. He sits on the board of directors for the California Society of Addiction Medicine and served on numerous committees for the American Society of Addiction Medicine.

Dr. San Bartolome worked as a family physician in both a clinical setting and private practice for approximately 10 years before specializing in addiction medicine at Arete Health, where he is currently the chief executive officer and president. Arete Health offers full-scope addiction medicine services including inpatient, residential and intensive outpatient services. Dr. Bartolome has been the medical director for several addiction medical programs. Since February 2020, he has also served as a physician and medical director of the MAT (Medication for Addiction Treatment) program at KCS Health Center, a federally qualified health center. The program provides integrated substance use disorder and primary care services with a focus on the expansion of services around medication for addiction treatment in vulnerable populations. Dr. Bartolome currently sees 75 to 80 patients weekly.

Diagnosis of Opioid Use Disorder

91. Dr. San Bartolome disagreed with Dr. Franklin that respondent failed to diagnose OUD in Patients A through E. On the contrary, except for Patient D, Dr. San Bartolome opined that none of these patients met the criteria for OUD. OUD is defined in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-V) as follows:

A problematic pattern of opioid use leading to problems or distress, with at least two of the following occurring within a 12-month period:

1. Taking larger amounts or taking drugs over a longer period than intended.

2. Persistent desire or unsuccessful efforts to cut down or control opioid use.

3. Spending a great deal of time obtaining or using the opioid or recovering from its effects.

4. Craving, or a strong desire or urge to use opioids.

5. Problems fulfilling obligations at work, school or home.

6. Continued opioid use despite having recurring social or interpersonal problems.

7. Giving up or reducing activities because of opioid use.

8. Using opioids in physically hazardous situations.

9. Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids.

10. Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount)

> 11. Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms.
>
> [¶] ... [¶]
>
> Opioid use disorder includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no *legitimate medical purpose or, if another medical condition is present that requires opioid treatment, that are used in doses greatly in excess of the amount needed for that medical condition.* (Emphasis in original.)

92. Dr. San Bartolome opined that the DSM-V criteria are not met with the cases of Patients A, B, C, and E. Being on controlled substances at high doses is insufficient to make an OUD diagnosis. While the risk factors may be higher in such cases, the DSM-V clearly states that OUD is not present "if there is a legitimate medical indication." He further noted that "virtually all" patients on chronic opioids (daily opioids for at least 60 to 90 days) will experience tolerance and withdrawal. Tolerance is the physiological adaptation to a chemical that results in needing higher doses to achieve the same effect. Withdrawal is the "cascade of physiological (nervous system) and psychological effect that one experiences as part of a syndrome of abstinence from the substance." The DSM-V specifically states that experiencing tolerance and withdrawal, without other factors, is insufficient to meet the criteria for OUD. Rather, OUD "revolves around compulsive and problematic use despite negative consequences."

93. In the instant matter, respondent's documentation included history of drug or alcohol use; four of five patients responded in the negative. Patient B had a history of OUD, which respondent documented. Dr. San Bartolome conceded respondent "could have done better" in discussing the implication of having a history of OUD. Nonetheless, "people with histories of OUD also deserve to have pain control." Respondent saw Patient B regularly and the prescriptions were at reasonable intervals. Dr. San Bartolome further noted that respondent was not solely focused on tapering Patient B's pain medications, but on treating "the whole patient."

94. In summary, Dr. San Bartolome did not find that respondent departed from the standard or care or was incompetent by not diagnosing OUD in the subject patients.

Prescribing Large Amounts of Controlled Substances

95. Dr. San Bartolome concurred with Dr. Franklin that "opioids and other medications such as sedative hypnotics can pose dangers and require caution when prescribing alone or together." However, he noted the "simple act of prescribing a certain amount is not wrong in all circumstances." Dr. San Bartolome criticized Dr. Franklin's reliance on the 2016 CDC Guidelines, noting these guidelines were not intended to be applied across the board in all circumstances with thresholds of 50 and 90 MME.[24] Rather, the guidelines were focused primarily on risk mitigation. They are

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[24] Dr. San Bartolome also noted that Dr. Franklin miscalculated the onset MME for Patient A when he began treating with respondent, omitting that he was also taking 50mcg of Fentanyl (120 MME) every 72 hours. Ultimately, respondent reduced Patient A's MME from 150 to 50.

not the law and do not set the standard of care. Moreover, while the MME of a narcotic is an important data point, "it was not meant to be an absolute, rigid, and all-situation encompassing." Rather, each patient brings their own experiences, tolerances, values, and vulnerabilities.

96. Dr. San Bartolome opined that respondent was "unreasonably being accused of managing circumstances" for patients who came to him on high dose and risk regimens with documented histories of pain syndromes, and did so "in a place and time that others would not." Respondent appropriately expressed concern for the high level of pain medications, and properly considered the consequences of changing a regimen already in place. Dr. San Bartolome explained it would be inappropriate to cut off patients from their existing medications, in absence of addiction, as doing so would likely result in hurting the patients. Here, respondent saw his patients regularly and documented struggles with tapering. His overall approach was, appropriately, to reduce overall risk to the patients.

97. Dr. San Bartolome further pointed out that none of these patients had OUD nor was there any dangerous or aberrant behaviors noted in the record which would necessitate drastic intervention. Rather, each had documented pain-related diagnoses which respondent was managing. In particular, Dr. San Bartolome noted the difficulty in tapering down from methadone, noting it is "extremely long-acting" and can last weeks in one's system. Most inpatient treatment programs would not accept such patients and would refer them back to their prescriber for "a slow supervised taper over many months."

Tapering Down Controlled Substances

98. Dr. San Bartolome opined respondent did not deviate from the standard of care in his tapering down of pain medications for Patients A through E. He noted, "there is no single taper protocol that is correct," and that the 2016 CDC Guidelines are not controlling. Tapering can include a rotation of opioids to improve outcome, negotiation of dose changes, and reasonable consideration for the expected effects of withdrawal. Again, Dr. San Bartolome agreed that respondent's documentation of his tapering efforts and plan was lacking. However, he found respondent considered and discussed information gathered from the patient and their families.

99. Dr. San Bartolome further noted there is no one set timetable to risk reduction, and that rapid tapers can have harmful results. Moreover, the decision of how and when to taper is between the physician and the patient. "It is not incompetence to rotate opioids and it is not incompetence to change course when your patient is not coping adequately to your dose change." Rather, it is acceptable to suspend any changes for a period of time and reassess.

Monitoring for Drug Diversion

100. Dr. San Bartolome opined that respondent "lacked the use of the full breadth of tools at his disposal to better detect potential [drug] diversion and could benefit from additional training." Such tools include utilizing CURES reports,[25] random drug testing, pain management contracts, pill counts, and seeing the patient on

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[25] Dr. San Bartolome noted checking CURES reports was not mandated by the Board until October 2018, outside the relevant time period in this case.

regular intervals. While Patient A had drug screening from the ER visits, it would have been useful for respondent to follow up with his own testing. Regarding the negative finding for opiates in the May 2017 ER visit, Dr. San Bartolome explained that Oxycodone is a synthetic opioid and not an opiate, thus will not appear in a urine drug screening.

101. Dr. San Bartolome did not find that respondent was negligent or incompetent in this area overall, as he did not ignore the risks of drug diversion. However, he believes respondent can benefit from additional training on risk mitigation strategies for diversion, drug misuse and abuse, when managing patients on controlled substances.

Medical Record Keeping

102. Dr. San Bartolome agreed that respondent "partially failed to document various elements of his treatment plan and clinical decision-making" with respect to his management of Patients A through E. He believes respondent would benefit from additional training and remediation concerning medical record keeping for patients on controlled substances.

RESPONDENT'S EXPERT – JACK M. BERGER, M.D.

103. Dr. Berger received his medical doctorate from the University of Bologna, Italy, in 1978. He completed residencies in anesthesiology at Los Angeles County University of California Medical Center in 1981, and at University of California, Los Angeles Medical Center in 1982. He became board-certified in anesthesiology in 1984, with added qualifications in pain management in 1994. He did not renew the certification in 2014 due to an age waiver. He was also board-certified by the American Academy of Integrative Pain Management (formerly American Academy of Pain

Management) from 1991 until the organization disbanded in 2019. Dr. Berger has served as a medical consultant for the Board, performed medical legal evaluations, and served as a reviewer for the Motion Picture Health Insurance regarding anesthesia and pain management claims.

Dr. Berger is a professor of anesthesiology and the director of regional anesthesiology fellowship at the pain management clinic at Keck School of Medicine at the University of Southern California (USC) He plans to retire in the summer of 2022. Over the course of his career, he has authored multiple peer-reviewed publications and given lectures regarding pain management and opioid prescription.

104. Dr. Berger was retained by respondent to opine on whether he departed from the standard of care in his treatment of Patients A through E. Dr. Berger reviewed all relevant materials to this case and prepared a written report, dated April 30, 2022. He testified at hearing consistent with his report.

105. As a general matter, Dr. Berger, like Dr. San Bartolome, criticized Dr. Franklin for relying on the 2016 CDC Guidelines to define the standard of care that a non-pain management physician should not prescribe in excess of 50-90 MME per day. Dr. Berger explained, the 2016 CDC Guidelines were never intended to set a standard of care and that the proposed revised guidelines for 2022 "specifically walks [*sic*] back on this dosage recommendation recognizing that some patients may need higher doses and that physicians do inherit 'legacy' patients who are already being prescribed much higher doses of opioids and cannot be rapidly weaned off those medications or weaned to lower doses."

106. Regarding the abscesses on Patient D's left arm, Dr. Berger criticized Dr. Franklin for implying the patient must be "shooting up on drugs," noting such

speculation is not appropriate in an expert report. Concerning the risks of arrythmia with certain drug combinations, Dr. Berger noted:

> I agree that these patients should have baseline ECGs performed by respondent as part of their initial visit workups and upon adding additional medications known to prolong the Q-T interval. But in defense these patients did have ER visits for assorted reasons, and hospitalizations while taking these medications and most likely were put on cardiac monitors. There were no reports of prolonged Q-T intervals ...

107. Regarding respondent's failure to order toxicology screenings for these patients, Dr. Berger again disagreed with Dr. Franklin that such screening were required by the standard of care. Citing medical journals, Dr. Berger noted there was disagreement amongst pain management specialists regarding the value of routine urine toxicology screenings for pain management patients; therefore, community practice did not require regular toxicology screens.

108. Regarding Dr. Franklin's criticism of respondent's finding of opioid withdrawal symptoms, Dr. Berger noted that patients will often report not feeling well when their medication is reduced, even if they do not demonstrate any changes in vital signs or heart rate, or are not vomiting or experiencing diarrhea. With respect to the failure to diagnose OUD, Dr. Berger concurred with Dr. San Bartolome that these patients were opioid dependent but showed no evidence of addiction or OUD. Therefore, referral to an addiction specialist was not required. Further, referring an opioid dependent, but not addicted, patient to a methadone clinic where patients receive one daily dose only, "would have been disastrous and would have failed."

109. Dr. Berger explained that each of the five patients, A through E, was a "legacy" patient, with complex medical problems and already on high dosages of pain medication prior to beginning treatment with respondent. Dr. Berger agreed that respondent's documentation of his prescribing of medications, reasons for medication, and plan for tapering down the levels of opioids was lacking. However, he opined the medical records clearly reflected respondent's intent to decrease each patient's dependence on prescribed opioids.

110. Dr. Berger also disagreed with Dr. Franklin's criticism that respondent did not refer these patients to a pain management specialist. First, there were obstacles with insurance approving the referrals. Second, a referral was unnecessary because, as Dr. Berger explained, "[a]s a pain management specialist, I can testify that I would not have anything to offer these 5 patients except medication management which was already in process by [respondent]." In fact, Patient B was seen by a pain specialist who recommended reducing the dosage of methadone and prescribing Valium.

Character Evidence

RICHARD THORP, M.D.

111. Dr. Thorp has been licensed to practice medicine for over 40 years. He testified at hearing on respondent's behalf. Dr. Thorp has known respondent since 2016, when they worked together at Adventist in Corning and were co-chairs of the clinic's narcotics task force.

112. Dr. Thorp described respondent as providing thoughtful, compassionate care. In his observations of respondent at Adventist, respondent was always trying to taper down the pain medication levels for his patients. Dr. Thorp noted this is difficult to do as most patients believed they were entitled to whatever would relieve their

pain. Specialty consultation was also very difficult to obtain because most patients were on Medi-Cal. It was especially difficult to find a pain management specialist in the area willing to accept patients for monitoring.

LAURA PROBST, M.D.

113. Dr. Probst is a board-certified internal medicine physician in New Mexico who has been practicing for eight years. She testified at hearing and submitted a support letter on respondent's behalf. Dr. Probst currently works as a physician for the VA CBOC in Albuquerque, New Mexico. She has known respondent for roughly three years, meeting him while she was acting chief of her department. Dr. Probst described respondent as very hard-working, dedicated, and well-liked by patients and staff alike. He is an excellent clinician, very easy to work with, and receptive to feedback.

114. Regarding respondent's prescription practices, Dr. Probst noted respondent's number of prescriptions was average to below average compared to similar VA panels. She further noted respondent consistently scored above average in the VA's quality metrics which include: hypertension control in diabetics and non-diabetic patients, appropriate diabetes control, timeliness of diabetic-related screenings, as well as timeliness of prevention metrics including immunizations, cervical, breast and colon cancer screenings.

ADDITIONAL LETTERS OF SUPPORT

115. Respondent also submitted several character letters from former medical directors and colleagues. Overall, these letters praise respondent for providing comprehensive, empathetic, and compassionate care to his patients, and for practicing "good and sound medicine." There were no reported concerns from patients or professional staff at any of his prior positions.

Analysis

STANDARD OF CARE

116. It is well settled that "the standard of care for physicians is the reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470; *Brown v. Colm* (1974) 11 Cal.3d 639, 643.) Importantly, a medical professional is held to the standard of care in his or her own "school" or specialty. Specialists are held to that standard of learning and skill normally possessed by such specialists in the same or similar locality under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Proof of this standard is ordinarily provided by another physician. (*Brown v. Colm, supra*, 11 Cal.3d at p. 643.)

EXPERT TESTIMONY

117. Differences between experts' opinions go to the weight of the evidence. (*In re Marriage of Duncan* (2001) 90 Cal.App.4th 617, 632.) In considering differing opinions, consideration must be given to the qualifications and persuasiveness of each witness, the reasons for each opinion, and the factual basis of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

118. The Accusation alleges that respondent committed gross negligence, repeated negligent acts, general unprofessional conduct, overprescribing, and incompetence with respect to his care and treatment of Patients A through E. Specifically, Dr. Franklin found numerous instances of extreme departures from the

standard of care when respondent: (1) failed to make a diagnosis of OUD and failed to consider the possibility of drug diversion; (2) failed to order regular toxicology screenings; (3) failed to refer patients to a specialist where appropriate; (4) prescribed large amounts of controlled substance without documenting his rationale or treatment plan; and (5) failed to maintain complete, accurate and detailed medical records.

119. Drs. San Bartolome and Berger were very credible and persuasive witnesses. They testified in a clear, concise and forthright manner, and demonstrated their individual and collective wealth of knowledge in the areas of pain management and addiction medicine. They each have decades of experience teaching medical students, their individual clinical experience, and their treatments of hundreds of patients suffering from chronic pain. Their respective testimonies corroborated each other's with regard to establishing what acts and performances fell within the standard of care, and how their review of the medical records established that respondent did not depart from the standard of care with respect to these chronic pain patients.

120. Specifically, both persuasively and credibly established that none of the subject patients were currently suffering from OUD and were all legacy patients, and the difference between opioid dependence versus opioid addiction. Further, Dr. San Bartolome clearly set forth the DSM-V's criteria for an OUD diagnosis and explained how said criteria was not met in the instant matter. Conversely, Dr. Franklin simply stated that family physicians do not always rely on the DSM-V criteria in diagnosing OUD. However, he did not credibly explain why respondent should have deviated from these criteria and diagnosed OUD anyway.

121. Similarly, Drs. San Bartolome and Berger's testimony and reports established that respondent did not depart from the standard of care in the level of pain medication he prescribed to these patients. They persuasively explained that the

2016 CDC Guidelines, which form the basis of Dr. Franklin's findings, do not set the standard of care and were never intended to be strictly applied to all patients across the board. Each of these patients was on a high pain medication regimen when respondent inherited them. Drs. San Bartolome and Berger credibly testified that it would have been inappropriate to suddenly alter their established regimens or rapidly taper down their medications, as doing so could pose significant risk to the opioid dependent patients. Rather, they both found respondent's prescription of pain medication and tapering of the same to be appropriate and justified by the evidence in each patient case.

122. Drs. Franklin and San Bartolome agreed that respondent should have ordered regular, random toxicology screening, as doing so would help him detect possible drug diversion; though, Dr. San Bartolome did not find his failure to do so to amount to negligence or incompetence. Dr. Berger disagreed with the other experts, asserting the effectiveness of toxicology screening in detecting drug diversion was questionable. In this regard, the opinions of Drs. Franklin and San Bartolome are credited over Dr. Berger. At a minimum, respondent should have ensured the toxicology screens from the ER visits, and his review of the same, were input into the record. When the evidence is weighed as a whole, respondent's failures in this regard were simple departures from the standard of care.

123. Finally, all of the experts agreed that respondent's record keeping with respect to the rationale for his decision-making and his treatment plans was lacking in detail. A physician is required to maintain adequate and accurate medical records for his patients so that (1) the doctor has an accurate account of the patient's complaints and the physician's objective findings, assessment, and plan, and (2) another physician can interpret the records accurately and guarantee a continuity of care. This is more

than a mere technicality, and is an essential duty of a treating physician. The oft-cited adage, "if it is not written down, it did not happen," is by no means an absolute truth. However, the more detailed and accurate a medical record is, the less likely there is to be confusion and concern regarding the physician's treatment, assessment, plan, and thought processes.

124. When the evidence is considered as a whole, complainant established that respondent committed repeated negligent acts when he failed to include the ER toxicology screens in the medical record and failed to order toxicology screenings on his own. Complainant further established respondent committed unprofessional conduct by failing to maintain complete accurate medical records for Patients A through E. Complainant failed to establish that respondent was grossly negligent, engaged in overprescribing, or was incompetent in his care and treatment of Patients A through E.

PENALTY

125. The Board has adopted a Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016) (Disciplinary Guidelines) to determine the appropriate level of discipline. The Disciplinary Guidelines recommend, at a minimum, stayed revocation and five years' probation for general unprofessional conduct, repeated negligent acts, and failure to maintain adequate records. The maximum discipline for each of these violations is license revocation. In exercising its disciplinary functions, protection of the public is the highest priority of the Board. (Bus. & Prof. Code, § 2229, subd. (a).) To the extent it is not inconsistent with public protection, disciplinary action taken against a physician should be calculated to aid in his or her rehabilitation. (Bus. & Prof. Code, § 2229, subd. (b).)

126. Here, the evidence established respondent committed simple departures from the standard of care by failing to include ER toxicology screens in the medical records and not ordering toxicology screenings of his own. The evidence further established respondent failed to maintain accurate and complete medical records. The more substantive allegations regarding gross negligence, overprescribing of pain medications, and incompetence were not proven.

127. The proven misconduct was serious. As discussed above, maintaining accurate and complete medical records is essential to providing quality medical care. It was undisputed that respondent's medical record keeping in these five cases was subpar. Likewise his failure to order random toxicology screens on a regular basis, though not gross negligence, was problematic. By 2016, the opioid crisis was a well-known public concern. Respondent was fully aware that these patients were on above-average doses. While it was not established that any of them suffered from OUD or engaged in drug diversion during respondent's period of treatment, respondent had a continuing duty to look out for signs of drug diversion or addictive behaviors, and regular testing is integral component of doing so.

128. In mitigation, respondent's treatment of these five patients took place over four years ago. There was no harm to the public or any patient attributable to respondent. Respondent has practiced medicine for 35 years, in three different states, and has never been the subject of discipline by any reviewing board prior to or since the instant action. Respondent is well-respected and held in high esteem by colleagues and medical directors. Respondent has been treating veterans at a VA CBOC for over for years without incident. Colorado's PDMP reports, similar to CURES reports, from 2018 to present, show that respondent's number of pain medication prescriptions per patient, their MME daily value, quantity, and dosage, was below the

average of all Colorado doctors. This demonstrates respondent has been able to practice consistently in a responsible and appropriate manner since the time period relevant to this action.

129. The imposition of a public reprimand does not fall within the Disciplinary Guidelines' recommended discipline. However, it is within the Board's discretion to issue a public reprimand when the circumstances warrant it. When the evidence is considered as a whole, and in light of the violations actually proven, probation is unnecessary to protect the public. Rather, the issuance of a public reprimand, plus a requirement that respondent complete refresher courses in medical record keeping and prescribing practices for pain management, will be sufficient measure for public protection.

Costs

130. Pursuant to Business and Professions Code section 125.3, complainant has requested an order directing respondent to pay for its enforcement costs ($27,721) and investigation costs ($600) in this matter. However, there is no cost request pled in the Accusation. Complainant's counsel asserted he filed and served a First Amended Accusation requesting costs prior to the start of hearing. However, respondent's counsel denied having ever received a First Amended Accusation nor is there any record of such a document being filed with the OAH. Therefore, the original Accusation remains the current pleading. As it contains no request for costs, none may be awarded.

LEGAL CONCLUSIONS

1. The Medical Practices Act, Business and Professions Code[26] section 2000, et seq., provides that "protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

2. Complainant has the burden of proving each of the grounds for discipline alleged in the Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This is a heavy burden and requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt, and must be sufficiently strong that it commands the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84 [citations omitted].)

Applicable Law

3. Section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act shall: have their license revoked; be placed on suspension or probation; be public reprimanded and required to take educational courses as appropriate; or have any other action taken relating to discipline and as part of an order of probation as the Board may deem proper.

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[26] All further statutory references are to the Business and Professions Code, unless otherwise noted.

4. The Board must "take action against any licensee who is charged with unprofessional conduct." (§ 2234.) "Unprofessional conduct" includes, but is not limited to, gross negligence and repeated negligent acts." (§ 2234, subds. (b) & (c).) "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." (§ 2234, subd. (c).) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care.

5. Unprofessional conduct also includes "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients." (§ 2266.)

Cause for Discipline

6. By reason of the matters set forth in the Factual Findings as a whole, and in particular Factual Findings 119 through 126, cause exists for disciplinary action under sections 2227, 2234, subdivision (c), and 2266. Complainant established, by clear and convincing evidence, respondent engaged in unprofessional conduct by engaging in repeated negligent acts when he failed to include the ER toxicology screenings in the medical records and when he failed to order screenings of his own. Respondent further engaged in unprofessional conduct when he failed to maintain accurate medical records for the period reviewed.

7. As set forth in Factual Findings 116 through 124, no cause exists for disciplinary action under sections 2227 and 2234, based on gross negligence, excessive prescribing, or incompetence.

8. As set forth in Factual Findings 125 through 129, in light of the evidence as a whole, a public reprimand with an order to complete refresher courses in medical record keeping and prescribing practices for pain management, are appropriate and adequate safeguards to protect the public.

Costs

9. Complainant failed to plead for an order of costs in the Accusation. Accordingly, no costs are awarded.

ORDER

1. Physician and Surgeon's Certificate No. G 61040, issued to respondent Michael David Gruber, M.D., is hereby PUBLICLY REPRIMANDED.

2. Prescribing Practices Course. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing

Medical Education (CME) requirements for renewal of licensure. A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Medical Record Keeping Course. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

DATE: July 18, 2022

TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings