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

In the Matter of the Second Amended Accusation Against:	)	
JAMES SANTIAGO GRISOLIA, M.D.	)	**File No. 10-2004-154474**
Physician's and Surgeon's Certificate No. G 42884	)	
Respondent.	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 10, 2007 **.**

IT IS SO ORDERED November 9, 2007 **.**

MEDICAL BOARD OF CALIFORNIA

By: _____
Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
Chair
Panel A
Division of Medical Quality

EDMUND G. BROWN JR., Attorney General
of the State of California
THOMAS S. LAZAR
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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **JAMES SANTIAGO GRISOLIA, M.D.** 4033 Third Avenue, #410 San Diego, CA 92103 Physician's and Surgeon's Certificate No. G 42884 Respondent.	Case No. 10-2004-154474 OAH No. L-2006110388 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Barbara Johnston (Complainant) is the Executive Director of the Medical Board of California and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Samuel K. Hammond, Deputy Attorney General.

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2. Respondent James Santiago Grisolia, M.D. (Respondent) is represented in this proceeding by attorney Barton H. Hegeler, Esq., whose address is 4660 La Jolla Village Drive, Suite 670, San Diego, CA 92122.

3. On or about August 4, 1980, the Medical Board of California issued Physician's and Surgeon's Certificate No. G42884 to James Santiago Grisolia, M.D. The Certificate was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 10-2004-154474 and will expire on April 30, 2008, unless renewed.

JURISDICTION

4. Accusation No. 10-2004-154474 was filed before the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California (Division). On January 6, 2006, a true and correct copy of the Accusation and all other statutorily required documents were properly served on respondent, and respondent timely filed his Notice of Defense contesting the Accusation.

5. First Amended Accusation 10-2004-154474 which superceded Accusation No. 10-2004-154474, was filed before the Division on January 31, 2007. On January 31, 2007, a true and correct copy of the First Amended Accusation was served on respondent.

6. Second Amended Accusation No 10-2004-154474 which superceded First Accusation No. 10-2004-154474, was filed before the Division on September 11, 2007, and is currently pending against respondent. On September 11, 2007, a true and correct copy of the Second Amended Accusation was served on respondent. A true and correct copy of Second Amended Accusation No. 10-2004-154474 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Second Amended Accusation No. 10-2004-154474. Respondent has also carefully read, discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

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8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

10. Respondent admits the truth of each and every charge and allegation in Second Amended Accusation No. 10-2004-154474, and further agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action. Respondent agrees to be bound by the Division's imposition of discipline as set forth in the Disciplinary Order below.

11. The admissions made by respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Division or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Division for its consideration in the above-entitled matter and, further, that the Division shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it.

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Division, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Division may receive oral and written communications

from its staff and/or the Attorney General's office. Communications pursuant to this paragraph shall not disqualify the Division, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Division, in its discretion, does not approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should the Division reject this Stipulated Settlement and Disciplinary Order for any reason, respondent will assert no claim that the Division, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

14. The parties agree that, if accepted by the Division, this Stipulated Settlement and Disciplinary Order shall constitute a complete and final resolution of the charges and allegations contained in Second Amended Accusation No. 10-2004-154474, and also the pending investigation in Case No. 10-2006-174102 involving patient S.P.

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

16. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

17. In consideration of the foregoing admissions and stipulations, the parties agree the Division may, without further notice to or opportunity to be heard by respondent, issue and enter the following Decision and Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G42884 issued to respondent James Santiago Grisolia, M.D., is revoked. However, the

revocation is stayed and respondent is placed on probation for seven (7) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnoses for which the controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Division or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.

2. PRESCRIBING PRACTICES COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. ETHICS COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

If respondent fails to successfully complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent failed to successfully complete the clinical training program.

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Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

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

The Division or its designee shall provide the approved monitor with copies of the Decision and Second Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Second Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and the Second Amended Accusation, and fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

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

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

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It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

7. PROHIBITED PRACTICE During probation, respondent is prohibited from providing care, treatment or management to any patient with chronic pain or to any patient experiencing "intractable pain" as defined in Business and Professions Code section 2241.5. After the effective date of this Decision, the first time that a patient seeking the prohibited services makes an appointment, respondent shall orally notify the patient that respondent does not provide care, treatment or management to patients with chronic or intractable pain. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log as

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defined in the section, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.

In addition to the required oral notification, after the effective date of this Decision, the first time that a patient who seeks the prohibited services presented to respondent, respondent shall provide a written notification to the patient stating that respondent does not provide care, treatment or management to patients with chronic or intractable pain. Respondent shall maintain a copy of the written notification in the patient's file, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the notification for the entire term of probation. Failure to maintain the written notification as defined in the section, or to make the notification available for immediate inspection and copying on the premises during business hours is a violation of probation.

8. NOTIFICATION Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision and Second Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

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

9. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

10. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

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11. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

13. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

14. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the

practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically canceled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be canceled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

15. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

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Respondent's license shall be automatically canceled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

16. COMPLETION OF PROBATION Respondent shall comply with all financial obligations not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

19. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to

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the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Barton H. Hegeler, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G42884. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California.

DATED: 9/12/07

JAMES SANTIAGO GRISOLIA, M.D.
Respondent

I have read and fully discussed with respondent James Santiago Grisolia, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9.13.07

BARTON H. HEGELER, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California.

DATED: 9/13/07

EDMUND G. BROWN JR., Attorney General
of the State of California

THOMAS S. LAZAR
Supervising Deputy Attorney General

SAMUEL K. HAMMOND
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: SD2005701247
80162134.wpd

Exhibit A

Second Amended Accusation No. 10-2004-154474

EDMUND G. BROWN JR, Attorney General
of the State of California
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO September 11, 20 07
BY [signature] ANALYST

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

In the Matter of the Second Amended Accusation Against: **JAMES SANTIAGO GRISOLIA, M.D.** 4033 Third Avenue, #410 San Diego, CA 92103 Physician's and Surgeon's Certificate No. G 42884 Respondent.	Case No. 10-2004-154474 OAH Case No. L-2006110388 **SECOND AMENDED ACCUSATION** (Gov. Code, § 11503)

Complainant Barbara Johnston, as causes for disciplinary action, alleges:

PARTIES

1. Complainant is the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (hereinafter the "Board"), and makes and files this Second Amended Accusation solely in his official capacity.

2. At all times mentioned herein, James Santiago Grisolia, M.D., (hereinafter "Respondent") has been licensed by the Medical Board under Physician's and Surgeon's Certificate No. G 42884. Said certificate was issued by the Board on August 4, 1980, and will expire on April 30, 2008, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Division of Medical Quality ("Division") of the Medical Board of California under the authority of the following laws. [1/]

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

5. Section 2234 of the Code provides that the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. ...

"(d) Incompetence.

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

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

". . ."

6. Unprofessional conduct under California Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or

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1. All section references are to the California Business and Professions Code ("Code") unless otherwise indicated.

conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[2/]

7. Section 2238 of the Code provides that a violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

8. Section 2241.5 of the Code, also known as the "Intractable Pain Act" provides, in pertinent part, that:

"(f) This section shall not affect the power of the Board to deny, revoke, or suspend the license of any physician and surgeon who does any of the following:

"(1) Prescribes or administers a controlled substance or treatment that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or treatment is administered or prescribed or is for a non-therapeutic purpose in a non-therapeutic manner.

"(2) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Controlled Substances Act or of controlled substances scheduled in, or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

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

"(4) Prescribes, administers, or dispenses in a manner not consistent with public health and welfare controlled substances listed in the California Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

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2. *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

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

9. Section 2242 of the Code provides, in pertinent part, that the prescribing, dispensing, or furnishing dangerous drugs, as defined in section 4022 of the Code, without a good faith examination and medical indication therefor, constitutes unprofessional conduct.

10. Section 2262 of the Code provides that the altering or modifying of the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

11. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FIRST CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence)

12. Respondent has subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action under sections 2227 and 2234 as defined by 2234, subdivision (b) of the Code, in that he was grossly negligent in the medical care he rendered to patients L.G., I.G., W.W., D.D., J.L. and A.S. The circumstances are as follows:

Patient L.G.

A. Patient L.G. was respondent's spouse. She died on October 23, 2003, at the age of 52, at the home she shared with respondent. An autopsy determined the cause of death to be accidental due to intoxication from morphine, Vicodin, Celexa, Benadryl, and Restoril. The coroner concluded L.G.'s death was attributed to the combined effect of multiple sedative prescription medications. Toxicological studies revealed that the levels of some of the drugs found in L.G.'s system were above the usual therapeutic range.

B. Respondent and L.G. were married in or about 1990. Prior to their marriage, and dating back to at least 1987, L.G. had been diagnosed with a variety of

medical conditions that included syncopal episodes and drop attacks for which she had been taking Dilantin, an anticonvulsant medication. She also had been diagnosed with migraine headaches and complex partial seizures, both also controlled with Dilantin. These conditions, including a post-traumatic headache disorder, dated back to a minor head injury in or about 1987. In addition to these conditions, L.G. had been diagnosed with difficulty in sleeping, arthritis, anxiety disorder, chronic allergies, and possible depression.

C. Respondent, a neurologist by specialty, participated in L.G.'s medical care prior to and following their marriage, including prescribing medications for her various medical conditions. In addition to respondent, L.G. also received medical care from several other physicians as well from 1987 through 2003.

D. Respondent's medical records for L.G. were virtually non-existent and consist of only five pages of notes, dated between April 9, 1987[3] through October 20, 2003, three days before L.G.'s death. There are no notes consistent with an initial evaluation of L.G., either dictated or handwritten. There are gaps in the evaluations that do exist between May 21, 1987, to September 20, 1988, and from November 3, 1988, to May 2, 1989, with a final note on June 5, 1999. Thereafter, there are no more notes until the two final notes shortly before the patient's death, one dated March 8, 2003, and the other dated October 20, 2003. Respondent's brief medical records that do exist for L.G. indicate that respondent assumed the primary responsibility for L.G.'s medical care in or about May 1998, based on a chart notation that L.G., then respondent's wife, trusted respondent to take care of her and that she did not want to see any other physician.

E. Respondent's chart note for L.G., dated March 8, 2003, states that L.G.'s headaches and seizures were well controlled.

F. Respondent's chart note for L.G., dated October 20, 2003, three days before her death, is quite extensive and appears to be the longest note in

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3. Statements pertaining to treatment respondent provided to this patient prior to 1999 are informational only and are not the basis for discipline.

respondent's chart with respect to the care he provided to L.G. In this note, respondent indicated that L.G. had a single seizure, typical epileptic drop with postictal confusion witnessed by him. L.G. had not been taking Neurontin for two days and had sleep loss from her trip back home. She had the onset of right hip pain four days prior to the note, and she was given morphine sulfate 30 mg. every four hours from an old prescription that respondent had at his home. Also, respondent gave L.G. Prednisone. On the evening prior to L.G.'s death, respondent admitted giving L.G. Benadryl, Restoril, and morphine sulfate.

G. Respondent prescribed many medications to L.G. during the years he treated her. Specifically, between July 13, 2001, and October 20, 2003, respondent prescribed multiple prescriptions for Vicodin, as well as prescriptions for Restoril, Prempro, Xenical, Beconase, Celexa, Indocin, Fioricet, Diflucan, Advair, chromalin sodium, Retin-4 Motrin, Compazine, Septra, Azmacort, clindamycin, and Alupent. In addition, at various other times, respondent also prescribed to L.G. Benadryl, morphine sulfate, Valium, hydrocodone, Esgic, Effexor, and Neurontin. In addition, L.G. was also receiving Lorazepam and morphine prescribed by other doctors as well.

Patient I.G.

H. On or about July 7, 1999, patient I.G., then 49 years old, made a visit to respondent's clinic with complaints of neck pain radiating to both extremities and cramping in both hands. As medical history, patient I.G. stated that he suffered a ruptured disc from an automobile accident in 1996, that a cervical MRI was performed at the San Diego VA Hospital and that he was taking 4-10 tablets of Percocet[4/] a day. Respondent examined the patient. His impression included cervical strain and bilateral carpal tunnel syndrome. He ordered a cervical MRI and prescribed 60 tablets of Percocet and Prednisone for the patient. On or about July 13, 1999, patient I.G. made a return visit

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4. Percocet (oxycondone and acetaminophen) is a Schedule II controlled substance as defined in section 11055, subdivision (b)(1)(N) of the Health and Safety Code.

during which respondent reviewed the MRI films and prescribed 200 tablets of Percodan for the patient.

I. Beginning in August 1999 and continuing until about September 2001, patient I.G. made nearly monthly visits to respondent's clinic. With some exceptions, respondent prescribed 200 tablets of Percocet 5 mg. for patient I.G. on each visit.[5/] On most of these visits, respondent noted the patient's complaint as "increased neck pain" or "no change." During this period, patient I.G. was also receiving treatment and other medications from the Pain Clinic at the San Diego VA Hospital. Beginning in October 2001, patient I.G.'s visits changed to every other month. Between about October 1, 2001 and about January 23, 2002, respondent prescribed 400 tablets of Percocet 5 mg. every other month for patient I.G. However, beginning with the visit on or about March 18, 2002, respondent increased the dosage to 600 tablets of Percocet 5 mg. every other month. Respondent continued to prescribe 600 tablets of Percocet 5 mg. every other month until patient I.G.'s final visit on or about August 3, 2005. Despite the large amount of controlled substances prescribed, there is no documentation of ongoing physical examination of patient I.G. during the period of treatment, and there is no documentation of an established treatment plan of treatment of the patient's cervical and neck pain. Moreover, respondent failed to obtain and note patient I.G.'s informed consent for the prolonged treatment with narcotics, failed to discuss and/or note he discussed other pain treatment modalities with the patient, and failed to conduct periodic reviews to determine the effectiveness of large amounts of controlled substances he was prescribing for the patient.

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5. For example, respondent prescribed 300 tablets of Percocet 5 mg. for the patient on the visit on or about October 19, 1999.

Patient W.W.

J. On or about November 16, 1993,[6] patient W.W., a 45-year-old male, made a visit to respondent's clinic with a complaint of low back pain. As medical history, the patient W.W. stated he underwent a lumbar laminectomy at the UCSD Medical Center in about 1991, and was again hospitalized at the San Diego VA hospital in October 1993. Patient W.W. also stated that he abused street drugs for 15 years but stopped in about 1991, and that he was on Motrin 75 mg. daily. Respondent examined the patient. His impression was "arachnoiditis." Respondent wrote a prescription for several medications including 30 tablets of Tylenol #4[7] for the patient. On patient W.W.'s next visit, respondent noted the patient's pain was unchanged and he prescribed 50 tablets of Tylenol #4 for the patient. On or about January 3, 1994, respondent was informed that a pharmacy had denied patient W.W.'s request for 60 tablets of Tylenol #4.

K. On or about March 27, 1995, the patient W.W. presented with lower back pain radiating to both lower extremities. On this visit, the patient specifically requested the drug Doriden.[8] Respondent prescribed 30 tablets of Doriden to the patient on this visit. Thereafter, patient W.W. made monthly visits during 1995. On all of these visits, respondent wrote prescriptions for Dilaudid[9] and Valium[10] for the patient. On the visit of about November 8, 1995, respondent noted patient W.W. had forged a prescription to obtain Tylenol #3 at UCSD. Patient W.W. made nearly monthly visits

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6. Statements pertaining to treatment respondent provided to this patient and patients W.W., J.L., D.D. and A.S. prior to 2000 are informational only and are not the basis for discipline.

7. Tylenol #4, acetaminophen and codeine, is a Schedule III controlled substance under section 11056, subdivision (e)(3) of the Health and Safety Code. It is indicated for treatment to severe pain.

8. Doridan is a drug that is highly desired by drug abusers. It is said to reproduce the sensation of intravenous heroin when combined with Tylenol #4. On the "streets," the combination is referred to as "Doors and Fours."

9. Dilaudid, hydromorphone and hydrochloride, are Schedule II controlled substances under section 11055, subdivision (b)(1)(K) of the Health and Safety Code.

10. Valium, a brand name for Diazepam, is a Schedule IV controlled substance under Health and Safety Code section, subdivision 11057(d)(7).

during 1996, 1997 and 1998. On most of these visits, respondent noted the patient's back pain was worsening. On most visits he prescribed 200 tablets of Dilaudid, 100 tablets of Tylenol #4 and 100 tablets of Valium for the patient. On or about April 2, 1998, respondent noted patient W.W.'s house had burned down. On or about May 12, 1998, patient W.W. reported he was assaulted by "gang members" and suffered a "minor traumatic brain injury." On the visit on or about August 3, 1998, patient W.W. reported that someone attempted to obtain drugs from a pharmacy by impersonating the patient. On the visit on or about September 2, 1998, respondent commenced prescribing Methadone 80 mg. instead of the Dilaudid drug. Thereafter and continuing through about December 1999, respondent monthly prescription for patient W.W. included Methadone, Tylenol #4 and Valium.

L. Patient W.W. made monthly visits from January 2000 to November 2000. During this period, respondent continued to prescribe 250 tablets of Methadone 10 mg., 100 tablets of Valium and 100 tablets of Tylenol #4 on each visit for treatment of patient W.W's back pain. During this period, patient W.W. was also been treated at the San Diego VA Hospital where he was diagnosed with Post Traumatic Stress Syndrome. On or about April 4, 2001, patient W.W. checked himself to the ER at Scripps Mercy Hospital complaining he was being poisoned at the hotel in which he resided.

M. Patient W.W. resumed his visits to respondent's clinic on or about August 20, 2003, when he complained of "left upper extremity swelling." On this visit, respondent noted patient W.W. "went to Mercy Hospital" and "was followed (sic) by San Diego VA Hospital" and "was on Methadone 10 mg. up to 20 per day." Respondent wrote a prescription for medications that included 600 tablets of Morphine Sulphate (MS) 30 mg.,[11/] 100 tablets of Valium 10 mg. On patient W.W.'s follow-up visit on or about September 22, 2003, respondent prescribed 600 tablets of long acting Morphine Sulphate

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11. Morphine Sulphate is a Schedule II controlled substance under section 11055, subdivision (b)(1)(M) of the Health and Safety Code.

(MSIR) 30 mg. and 600 tablets of Methadone 10 mg. for the patient. Respondent repeated this prescription on the patient's visits on October 20, 2003, December 2, 2003, and December 23, 2003. There is no notation of the medical justification for the morphine sulphate medications.

N. Patient W.W. continued his monthly visits throughout 2004, and from January 2005 until the final visit on or about September 13, 2005. On most visits, respondent noted "low back pain" or "increased back pain" as the patient's complaint. On nearly all visits, respondent prescribed 600 tablets of MS 30 mg., 600 tablets of Methadone 10 mg. and 100 tablets of Valium 5 mg. for patient W.W. On or about March 18, 2004, respondent noted he had received a telephone call from a police officer stating patient W.W. was "delusional, confused and paranoid." On the visit on or about June 21, 2005, respondent noted patient W.W. underwent a psychological evaluation at UCSD. His impression on this visit was patient W.W. suffered a "paranoid reaction."

O. Respondent prescribed large amounts of controlled substances to patient W.W. over a prolonged period without performing and documenting adequate ongoing physical examinations and without establishing and documenting a treatment plan for the patient's lower back pain. Respondent also failed to obtain and note the patient W.W.'s informed consent for the prolonged treatment with narcotics, failed to discuss and/or note he discussed other pain treatment modalities with the patient. Respondent also failed to conduct periodic reviews to determine the effectiveness of large amounts of controlled substances he was prescribing for patient W.W. In spite of the clear signs of addiction, respondent failed to take and note steps he took to determine whether patient W.W. was addicted to pain medication, and failed to obtain a pain specialist or an addictionologist consult for the patient at any time during the period of treatment.

Patient J.L.

P. On or about August 11, 1994, at the request of her attorney, patient J.L., then 39 years old, consulted with respondent for a "neurologic disability"

evaluation in connection with a breast implant litigation. Patient J.L. reported, among other things, that she underwent a cervical laminectomy procedure in 1983 and a bilateral silicone breast implantation in 1987, and that in 1991, she began to suffer pain in her shoulders and neck, left arm tingling and numbness, memory loss, chronic fatigue and depression. Patient J.L. denied taking any medications for her medical problems, denied smoking or drinking and denied using recreational drugs. After evaluating the patient, respondent reported his impressions and diagnosis in a Neurologic Comprehensive Evaluation report addressed to the patient's attorney. His impressions and diagnosis included "Atypical Neurologic Disease Syndrome," polyneuropathy, arthralgias, myalgias, sustained balance disturbance and progressive memory loss. Respondent concluded patient J.L. was unable to perform any vocational or avocational activities and has been disabled since 1992.

Q. On or about August 31, 1994, patient J.L. returned to respondent's clinic complaining of increased neck pain. Respondent prescribed Prednisone 20 mg. Patient J.L. made a return visit in which she reported the Prednisone medication caused anxiety, sweatiness and tachycardia. Respondent prescribed Klonopin[12/] for the patient. On the visit on or about November 7, 1994, respondent noted patient J.L could not afford Klonopin. On this date, respondent prescribed Ativan, Valium and 10 refills of Vicodin. Thereafter, the patient J.L. made roughly monthly visits through 1996 during which the patient received prescriptions for Vicodin and Valium. On most visits, respondent noted patient J.L. complained of pain in the neck, headaches and auditory and visual hallucinations. In 1995, in the course of its disability evaluation, the Department of Social Services (DDS) found that patient J.L. suffered from both depressive and anxiety disorders. In March 1996, DDS noted patient J.L. carried a diagnosis of personality disorder and active alcohol abuse. On patient J.L.'s visit on or about April 19, 1996, respondent noted the patient was drinking beer to relieve the pain. In 1997, patient J.L.

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12. Klonopin (Clonazepam) is a Schedule IV controlled substance under section 11057, subdivision (d)(6) of the Health and Safety Code.

made approximately 16 visits, and in 1998, she made approximately 18 visits. Respondent prescribed Vicodin and Valium for the patient on nearly every visit, and on some visits, respondent added prescriptions for Zoloft, Klonopin, Ritalin and Zyprexa.[13] On patient J.L.'s visit on or about February 12, 1997, respondent noted the patient requested more Vicodin which was denied. On the visit on or about October 23, 1998, respondent noted patient J.L. was using marijuana. In November 1998, respondent began prescribing Fentanyl for patient J.L. Patient J.L. was admitted to the hospital on numerous occasions during 1996 through 1998.

R. Patient J.L. made approximately 22 office visits during 1999. On most of the visits, respondent continued to prescribe Vicodin, Valium, Trazadone, Ritalin, Fentanyl and Klonopin for the patient. In February, April, June and October, patient J.L. was hospitalized for visual and auditory hallucinations and for exacerbation of her dymelination autoimmune disorder. Patient J.L. was noted to have a history of schizophrenia and schizoaffective disorder during these hospitalizations. Beginning in December 1999, respondent commenced prescribing Oxycontin for the patient. There is no notation that patient J.L. complained of pain on any of the visits in 1999.

S. Patient J.L. made approximately 27 office visits during 2000. Respondent prescribed Oxycontin (160 mg. per day), Valium, Klonopin for the patient throughout the year. With the exception of 5 visits (visits on March 20 and 29, June 14, August 7 and November 1) there is no notation patient J.L. complained of pain during these visits. On the visit on or about April 10, 2000, respondent noted patient J.L. was "hearing increased voices" telling her to "kill herself." On or about May 9, 2000, respondent noted that patient J.L. had checked herself into the detox facility at Charter Hospital for Valium detoxification. At the hospital, patient J.L. admitted she had been obtaining Valium from Mexico. On the visit on or about August 7, 2000, respondent noted patient J.L. "threw out" her Oxycontin medication, and on the December 29, 2000,

13. Zyprexa is indicated for the treatment of schizophrenia.

visit, respondent noted patient J.L. "threw away" all her prescription drugs upon observing her brother use IV drugs.

T. Patient J.L. made approximately 30 office visits during 2001. Respondent prescribed Oxycontin, Klonopin and Valium for the patient during this period. On or about April 4, 2001, patient J.L. reported her Oxycontin medication was seized by a US Border Patrol agent as she crossed the border. In May of 2001, respondent increased the Oxycontin dosage to 240 mg. a day. On or about June 18, 2001, respondent noted patient J.L. fell and hit her head while riding her bicycle. On or about August 8, 2001, respondent noted patient J.L. fell in a river. On or about August 30, 2001 patient J.L. reported that her friend had been "pressuring" her for prescription drugs and that some of the patient's drugs were missing. On or about September 12, 2001, respondent noted patient J.L. crashed her bike.

U. Patient J.L. made approximately 28 office visits in 2002. Respondent prescribed Oxycontin 240 mg. per day for the patient on nearly every visit. He also continued the prescriptions for Valium and Klonopin. On or about June 25, 2002, respondent's staff noted patient J.L. called the office claiming she lost two days of medications. This same day, another physician called the respondent's office and instructed respondent's staff that patient J.L. should not be prescribed any medication because her "story was unbelievable." On or about November 11, 2002, respondent noted he prescribed Klonopin for patient J.L. so the patient would no longer use marijuana, and on December 9, respondent noted patient J.L. was "staying away from marijuana."

V. Patient J.L. made approximately 30 office visits in 2003. Respondent prescribed Oxycontin 240 mg. per day for the patient on nearly every visit. Respondent also continued the prescription for Klonopin, and on some occasions, added Prednisone. On the visit on or about February 24, 2003, patient J.L. reported her friend had stolen her medication. Respondent wrote another prescription for Oxycontin on this visit. On or about March 24, 2003, patient J.L. called respondent's staff requesting more medication because she spilled water on her medications. On the April 23 visit, patient

J.L. reported that her friend had stolen and used "a lot" of the patient's medication. On or about May 12, 2003, patient J.L. called respondent's office requesting an early refill of her Klonopin medication claiming the Klonopin had been "washed" away. Respondent ordered a refill of the Klonopin medication. On the visit on or about May 20, 2003, patient J.L. again reported she "lost" her Klonopin. On or about June 23, 2003, patient J.L. called respondent's office requesting an early refill claiming she "accidentally" took double the prescribed dosage. On the visit on or about September 22, 2003, respondent prescribed 50 tablets of Percocet for patient J.L. in addition to the Oxycontin medication. On the visit on or about November 11, 2003, respondent noted that patient J.L. was "desperate," "confused" and "psychotic" and that he instructed the patient to "slow down on Oxycontin."

W. Patient J.L. made approximately 25 office visits in 2004. Patient J.L.'s complaints were related to her psychiatric problems on most of these visits. Respondent prescribed Oxycontin for patient J.L. on nearly every visit. He also prescribed Klonopin, Ambien Seroquel, Stratera and Neurontin for the patient during the year. On the visit on or about January 20, 2004, respondent noted patient J.L. had "increasing psychosis and paranoia." On the visit on or about March 11, 2004, patient J.L. reported she fell and hit her head and neck. On the visit on or about April 20, 2004, respondent noted patient J.L. was using less marijuana. On or about July 30, 2004, patient J.L. called respondent's staff claiming she "lost" all her medications. On the visit on or about August 3, 2004, respondent increased the Oxycontin dosage to 480 mg. per day, and on the visit on or about August 13, 2004, he increased the Oxycontin dosage to 640 mg. per day. Thereafter, respondent prescribed 640 mg. per day for patient J.L. on each visit. On the visit on or about November 17, 2004, respondent noted patient J.L. stated she was "disintegrating and falling apart." On the visit on or about December 15, 2004, patient J.L. reported she fell on her head five days before the visit.

X. Patient J.L. made approximately 19 visits in 2005, and made her final visit on or about September 23, 2005. Patient J.L.'s complaints on most visits

related to her psychiatric problems. Respondent prescribed Oxycontin 640 mg. per day for patient J.L. on each visit. He also continued to prescribe Klonopin, Percocet, Xanax and other drugs for the patient during the year. On the visit on or about January 11, 2005, patient J.L. reported she "threw away" her Klonopin medication. On or about March 30, 2005, patient J.L. reported all her medications had been destroyed in a "wash." On the visit on or about May 12, 2005, respondent noted patient J.L. was "holding marijuana." In or about July or August 2005 patient J.L. called respondent's staff requesting refill of her Klonopin prescription 12 days earlier than ordered. On or about September 9, 2005, respondent's staff noted patient J.L. reported her house had been broken into and her medication had been stolen.

Y. Respondent prescribed large amounts of controlled substances to patient J.L. over a prolonged period without performing and documenting adequate ongoing physical examinations, and without establishing and documenting a treatment plan for the patient's pain. Respondent also failed to obtain and note patient J.L.'s informed consent for the prolonged treatment with narcotics, failed to discuss and/or note he discussed other pain treatment modalities with the patient. Respondent also failed to conduct periodic reviews to determine the effectiveness of large amounts of controlled substances he was prescribing for patient J.L. In spite of the clear signs of addiction, respondent failed to take any steps to determine whether patient J.L. was addicted to pain medication and failed to obtain a pain specialist or addictionologist consultation for the patient. Further, in spite of the clear evidence patient J.L. was obtaining other prescription drugs and marijuana from other sources, respondent failed take and note steps he took to determine the patient was not abusing prescription medications and "street" drugs.

Patient D.D.

Z. On or about December 11, 1995, patient D.D., then 40 years old, consulted with respondent. Patient D.D. complained of excruciating pain in the back and legs and a headache. She stated the pain was controlled by large amounts Vicodin and

Valium. On or about May 17, 1995, patient D.D. made a follow-up visit at which time respondent reviewed the patient's medical records including an MRI, and formulated the impression of cervical multiple sclerotic lesion. Thereafter, patient D.D. made regular office visits during 1996 through 1999. Respondent's standard prescriptions for the patient during this period included Oxycontin, Vicodin and Valium. The initial dosage of the Oxycontin was 80 mg. per day. This was increased to 160 mg. per day in 1997, and to 240 mg. per day in 1998, and to 480 mg. per day by 1999. Respondent also increased the dosages for the Valium and Vicodin for patient D.D. during this period. During this period, patient D.D. declined to follow respondent's suggestion that she undergo a procedure for the placement of an opiate pump.

AA. Patient D.D. made regular office visits between January 2000 and September 2005. During 2000, patient D.D. made approximately eight visits during which respondent continued to prescribe 480 mg. Oxycontin per day, along with 200 tablets of Extra Strength Vicodin (Vicodin ES) and 120 tablets of Valium per month. Patient D.D. made monthly visits during 2001. On the January 2001 visit, respondent increased the dosage of the Oxycontin to 600 mg. per day. However, on the following visit on or about February 26, 2001, respondent replaced the Oxycontin with Morphine Sulphate Controlled Release Contin (MS Contin) 150 mg. per day, and this dosage was increased to 210 mg. per day. In addition, respondent prescribed 100 tablets of Vicodin ES and 180 tablets of Valium 10 mg. per month for the patient. Patient D.D. made approximately seven visits in 2002, approximately seven visits in 2003, approximately six visits in 2004 and five visits in 2005. During this period respondent increased the patient's MS Contin to 480 mg. per day in addition to the Vicodin and Valium prescriptions.

BB. Respondent prescribed large amounts of controlled substances to patient D.D. over a prolonged period without performing and documenting adequate ongoing physical examinations, and without establishing and documenting a treatment plan for the patient's pain. Respondent also failed to obtain and note patient D.D.'s

informed consent for the prolonged treatment with narcotics, failed to discuss and/or note he discussed other pain treatment modalities with the patient. Respondent also failed to conduct periodic reviews to determine the effectiveness of large amounts of controlled substances he was prescribing for patient D.D.

Patient A.S.

CC. On or about December 12, 2002, patient A.S., then 38 years old, consulted with respondent for evaluation of the patient's chronic headaches. As history, the patient stated her headaches started at age five and had worsened over time, and were occurring almost daily. Patient A.S. reported that she had been followed by several physicians, that multiple CT scans of the head had been normal, that in the past she had been treated with several different medications including Inderol, Neurontin and Depakote, and that her current medications included Wellbutrin, Zoloft and Ultram. On this visit, respondent performed a neurologic examination. His impression was "migrainous headaches disorder."

DD. Beginning in January 2003, patient A.S. commenced office visits for treatment. On or about January 6, 2003, patient A.S. made an office visit complaining of "increased headache postpartum." Respondent prescribed one month supply of Tofranil, 30 tablets of Fioricet (with no refills) and 30 tablets of Vicodin (with no refills) for the patient. Patient A.S.'s next contact with respondent's office was on July 16, 2003, when she called respondent's staff requesting early refill of her Vicodin medication. On the visit on or about August 5, 2003, respondent noted the Tofranil and Cardizem medications did not result in an improvement of the headaches. Respondent also noted patient A.S. was obtaining medications such as Wellbutrin and Lortab from other sources. On this visit, respondent prescribed Fioricet, Vicodin and Sansert for patient A.S., and noted he explained the benefits and risks associated with the Sansert medication to the patient. Patient A.S. made visits in October, November and December 2003, during which respondent wrote prescriptions Lortab, Norco, Xanax and Zonergram for the patient. On the visit on or about October 14, 2003, Patient A.S. reported she was unable

to obtain the Sansert medication but was taking the drug Ativan. Respondent failed to inquire how the patient obtained the Ativan medication. On the visit on or about December 17, 2003, respondent noted patient A.S. would have to undergo Zonergram detoxification.

EE. Patient A.S. made approximately nine office visits during 2004. During this period, respondent prescribed Norco, Xanax and Prednisone for the patient's headaches on nearly every visit. On the visit on or about February 17, 2004, respondent noted patient A.S. would have to undergo Norco detoxification. On or about July 24, 2004, respondent's staff noted that a Wal-Mart Pharmacy had denied patient A.S.'s request for a refill of her Norco medication. On or about July 28, 2004, patient A.S. attempted to obtain a refill of her Norco prescription by use of an "old prescription." On the visit on or about November 8, 2004, respondent noted patient A.S. might have to undergo detoxification in the following spring.

FF. The patient made approximately three visits in 2005. Respondent added Percocet to the patient's medication during this period. On the visit on or about February 7, 2005, respondent noted he would "hold detox until things blow up." On the visit on or about April 4, 2005, respondent admonished patient A.S. for overusing the Percocet medication. On or about May 6, 2005, respondent's staff noted patient A.S. had attempted to obtain Norco from the Wal-Mart pharmacy through forgery. On or about May 6, 2005, a Sav-On Pharmacy notified respondent that patient A.S. had obtained a refill for Norco without authorization. On patient A.S.'s final visit on or about May 23, 2005, respondent noted the patient was obtaining prescriptions from different sources.

GG. Respondent prescribed large amounts of controlled substances to patient A.S. over a prolonged period without performing and documenting adequate ongoing physical examinations and without obtaining a definitive diagnosis of the patient's pain. Respondent also failed to establish and document a treatment plan for patient A.S.'s pain, failed to obtain and note patient A.S.'s informed consent for the prolonged treatment with narcotics, and failed to discuss and/or note he discussed other

pain treatment modalities with the patient. Respondent also failed to conduct periodic reviews to determine the effectiveness of large amounts of controlled substances he was prescribing for patient A.S. In spite of the clear signs of addiction, respondent failed to take any steps to determine whether patient A.S. was addicted to pain medication, failed to obtain a pain specialist or addictionologist consultation for the patient, and failed to refer the patient to a detox program. Further, in spite of the clear evidence patient A.S. was obtaining other prescription drugs from other sources, respondent failed take and note steps he took to determine whether patient A.S. was not abusing prescription medications drugs.

13. Respondent committed gross negligence in his care and treatment of patients L.G., I.G., W.W., J.L., D.D. and A.S. which included, but was not limited to, the following:

Patient L.G.

A. Paragraphs 12(A) through 12(G) are hereby incorporated by reference as if fully set forth herein.

B. Between on or about March 26, 1987 through on or about October 23, 2003, respondent treated L.G. for chronic headaches and epilepsy and failed to obtain and record a full history and physical examination, as well as record any physical findings during his follow-ups until 1989, with no further visits recorded until on or about March 8 and October 20, 2003.

C. Between on or about March 26, 1987 and on or about October 23, 2003, respondent issued to L.G. in excess of 90 prescriptions for dangerous drugs and/or controlled substances and/or failed to conduct and record a prior good faith examination on each occasion.

D. Between on or about March 26, 1987 and on or about October 23, 2003, respondent treated L.G. for chronic recurrent headaches and epilepsy and failed to maintain adequate medical records for her.

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E. Between on or about March 26, 1987 and on or about October 23, 2003, respondent treated L.G. for documented chronic pain and repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as specified in Business and Professions Code section 2241.5.

Patient I.G.

F. Paragraphs 12(H) through 12(I) are hereby incorporated by reference as though fully set forth.

G. Respondent failed to perform and note periodic reviews of his treatment of the patient to determine the effectiveness and appropriateness of the large amount of controlled substances he prescribed for the patient.

H. Respondent treated this patient with controlled substances over a prolonged period without establishing and documenting a treatment plan for the patient's cervical and neck pain.

I. Respondent treated this patient with controlled substances over a prolonged period without performing and documenting ongoing adequate physical examinations.

J. Respondent failed to obtain and document the patient's informed consent for treatment with narcotics over a prolonged period, and failed to discuss and/or note he discussed other treatment modalities with the patient.

K. Respondent treated this patient for documented chronic pain and repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as specified in Business and Professions Code section 2241.5.

Patient W.W.

L. Paragraphs 12(J) through 12(O) are hereby incorporated by reference as if fully set forth herein.

M. Respondent failed to perform and note periodic reviews of his treatment of the patient to determine the effectiveness and appropriateness of the large amount of controlled substances he prescribed for the patient.

N. Respondent failed refer this patient for treatment by a pain management specialist or an addictionologist at any time during the period of treatment.

O. Respondent treated this patient with controlled substances over a prolonged period without performing and documenting ongoing adequate physical examinations.

P. Respondent failed to obtain and document the patient's informed consent for treatment with narcotics over a prolonged period, and failed to discuss and/or note he discussed other treatment modalities with the patient.

Q. Respondent treated this patient for documented chronic pain and repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as specified in Business and Professions Code section 2241.5.

Patient J.L.

R. Paragraphs 12(P) through 12(Y) are hereby incorporated by reference as if fully set forth herein.

S. Respondent failed to perform and note periodic reviews of his treatment of the patient to determine the effectiveness of the large amount of controlled substances he prescribed for the patient.

T. Respondent failed refer this patient for treatment by a pain management specialist or an addictionologist at any time during the period of treatment.

U. Respondent treated this patient with controlled substances over a prolonged period without performing and documenting ongoing adequate physical examinations.

V. Respondent failed to obtain and document the patient's informed consent for treatment with narcotics over a prolonged period, and failed to discuss and/or note he discussed other treatment modalities with the patient.

W. During the period of treatment, respondent failed to take and note steps he took to determine whether the patient was abusing prescription medications and

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"street" drugs despite the clear evidence the patient was obtaining other prescription drugs and marijuana from other sources.

X. Respondent treated this patient for documented chronic pain and repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as specified in Business and Professions Code section 2241.5.

Patient D.D.

Y. Paragraphs 12(Z) through 12(BB) are hereby incorporated by reference as if fully set forth herein.

Z. Respondent failed to perform and note periodic reviews of his treatment of the patient to determine the effectiveness and appropriateness of the large amount of controlled substances he prescribed for the patient.

AA. Respondent treated this patient with controlled substances over a prolonged period without performing and documenting ongoing adequate physical examinations.

BB. Respondent failed to obtain and document the patient's informed consent for treatment with narcotics over a prolonged period, and failed to discuss and/or note he discussed other treatment modalities with the patient.

CC. Respondent treated this patient for documented chronic pain and repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as specified in Business and Professions Code section 2241.5.

Patient A.S.

DD. Paragraphs 12(CC) through 12(GG) are hereby incorporated by reference as if fully set forth herein.

EE. Respondent failed to perform and note periodic reviews of his treatment of the patient to determine the effectiveness and appropriateness of the large amount of controlled substances he prescribed for the patient.

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FF. Respondent failed refer this patient for treatment by a pain management specialist or an appropriate specialist any time during the period of treatment.

GG. Respondent treated this patient with controlled substances over a prolonged period without performing and documenting ongoing adequate physical examinations.

HH. Respondent failed to obtain and document the patient's informed consent for treatment with narcotics over a prolonged period, and failed to discuss and/or note he discussed other treatment modalities with the patient.

II. During the period of treatment, respondent failed to take and note steps he took to determine whether the patient was abusing prescription medications and "street" drugs despite the clear evidence the patient was obtaining other prescription drugs from other sources.

JJ. Respondent treated this patient for documented chronic pain and repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as specified in Business and Professions Code section 2241.5.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c) of the Code, in that he engaged in for repeated negligent acts in his care and treatment of patients L.G., I.G., W.W., J.L., D.D. and A.S. as more particularly alleged in paragraphs 12 and 13, above, and which are hereby incorporated by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Good Faith Prior Examination)

15. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2242 of

the Code, in that he repeatedly prescribed both dangerous drugs and controlled substances to patients L.G., I.G., W.W., J.L., D.D. and A.S. without a documentation of medical indication and without conducting and documenting a good faith prior medical examination, as more particularly alleged in paragraphs 12 and 13, above, and which are hereby incorporated by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

16. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2266 of the Code, in that he failed to maintain adequate and accurate medical records for patients L.G., I.G., W.W., J.L., D.D. and A.S. as more particularly alleged in paragraphs 12 and 13, above, and which are hereby incorporated by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Violation of State or Federal Drug Statutes)

17. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2238 of the Code, in that he has violated state or federal drug statutes in the manner in which he prescribed both dangerous drugs and controlled substances to patients L.G., I.G., W.W., J.L., D.D. and A.S. as more particularly alleged in paragraphs 12 and 13, above, and which in their entirety are hereby incorporated by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged herein, and that following the hearing, the Division of Medical Quality, Medical Board of California, issue its Decision and Order:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 42884, heretofore issued by the Board to James Santiago Grisolia, M.D.

2. Revoking, suspending or denying respondent's approval authority to supervise physician's assistants pursuant to Code section 3527;

3. Ordering respondent to pay the costs of probation, if placed on probation; and

4. Taking such other and further action as the Board deems necessary and proper.

DATED: 9/11/07.

Samuel K. Hammond, For
BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

SKH/ Grisolia Second Amended Accusation .wpd