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

In the Matter of the Accusation Against:	)	
WENDELL STREET, M.D.	)	**Case No. 18-2011-220185**
Physician's and Surgeon's Certificate No. A 43837	)	
Respondent	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on April 13, 2016.

IT IS SO ORDERED April 6, 2016.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer

Kimberly Kirchmeyer
Executive Director

KAMALA D. HARRIS
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **WENDELL STREET, M.D.** **14075 Hesperia Road, Suite 205** **Victorville, CA 92395** **Physician's and Surgeon's Certificate No. A 43837,** Respondent.	**Case No. 18-2011-220185** **OAH No. 2015060023** **STIPULATED SURRENDER OF LICENSE 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. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Matthew M. Davis, Deputy Attorneys General.

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2. Wendell Street, M.D. (respondent) is represented herein by Thomas Chapin, Esq., whose address is 232 E. Grand Blvd., Suite 204, Corona, CA 9287

JURISDICTION

3. On or about July 20, 1987, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 43837 to respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, unless renewed.

4. On December 8, 2014, Accusation No. 18-2011-220185 was filed against respondent before the Medical Board of California (Board), Department of Consumer Affairs. A true and correct copy of the Accusation and all other statutorily required documents were properly served on respondent on December 8, 2014. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 18-2011-220185 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENTS, WAIVERS AND RELEASES

5. Respondent has carefully read and fully understands the charges and allegations in Accusation No. 18-2011-220185. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in Accusation No. 18-2011-220185; 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, the California Code of Civil Procedure and other applicable laws, having been fully advised of same by his attorney of record, Thomas Chapin, Esq.

7. Respondent, having the benefit of counsel, hereby voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges and allegations in the First Amended Accusation No. 18-2011-220185 and agrees that cause exists for discipline, and hereby surrenders his Physician's and Surgeon's Certificate No. A 43837 for the Board's formal acceptance.

9. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. A 43837, or if an accusation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 18-2011-220185 shall be deemed true, correct, and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California or elsewhere.

10. Respondent understands that by signing this stipulation he enables the Executive Director of the Medical Board of California to issue an order accepting the surrender of his Physician's and Surgeon's Certificate No. A 43837 on behalf of the Board without notice to, or opportunity to be heard by, respondent.

RESERVATION

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

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license."

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive

Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, 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 Surrender of License and Disciplinary Order, the Executive Director and/or the Board 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 Executive Director, the Board, 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 Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License 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 this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 43837, issued to respondent Wendell Street, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against respondent. This stipulation constitutes a record of the discipline and shall become a part of respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 18-2011-220185 shall be deemed to be true, correct and fully admitted by respondent when the Board determines whether to grant or deny the petition.

5. If respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 18-2011-220185 shall

be deemed to be true, correct, and fully admitted by respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 43837. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, freely and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 2/23/16

Wendell Street

WENDELL STREET, M.D.
Respondent

I have read and fully discussed with respondent WENDELL STREET [redacted], M.D., the terms and conditions and other matters contained in the above Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 2/23/16

THOMAS CHAPIN, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Executive Director of the Medical Board of California of the Department of Consumer Affairs.

Dated: 2/24/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

MATTHEW M. DAVIS
Deputy Attorney General
Attorneys for Complainant

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Stipulated Surrender and Disciplinary Order (Street).docx

Exhibit A

Accusation
No. 18-2011-220185

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **WENDELL STREET, M.D.** **14075 Hesperia Road, Suite 205** **Victorville, CA 92395** **Physician's and Surgeon's Certificate No. A 43837,** Respondent.	Case No. 18-2011-220185 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 20, 1987, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 43837 to Wendell Street, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on January 31, 2015, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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

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

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

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

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . .

"(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.

". . ."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. Section 2238 of the Code states:

"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 2242 of the Code states, in pertinent part:

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

". . ."

9. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

10. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

". . ."

11. Business and Professions Code section 725 states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be

punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

12. Health and Safety Code section 11210 states, in pertinent part, that:

"A physician ... may prescribe for, furnish to, or administer controlled substances to his or her patient when the patient is suffering from a disease, ailment, injury, or infirmities attendant upon old age, other than addiction to a controlled substance.

"The physician ... shall prescribe, furnish, or administer controlled substances only when in good faith he or she believes the disease, ailment, injury, or infirmity requires the treatment.

"The physician ... shall prescribe, furnish, or administer controlled substances only in the quantity and for the length of time as are reasonably necessary."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent has subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients T.C., E.D., "DeAndre Dotson," L.F., T.G., S.J., N.M., V.S., L.S., and "Tasha Thomas," as more particularly alleged hereinafter:

(a) Patient T.C.

(1) Respondent treated patient T.C. from on or about May 12, 2012, to on or about February 6, 2014.

(2) On or about May 12, 2012, patient T.C. presented to respondent with complaints of back pain and anxiety. Respondent noted a history of "chronic pain syndrome" based on a reported history of a gunshot wound to the back. Respondent's physical examination is limited to a notation that patient T.C. had a well healed gunshot wound in the right flank and a gunshot wound to the right ankle that was tender to the touch. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document a description of patient T.C.'s anxiety complaint. Respondent did not order any diagnostic testing and did not document a treatment plan.

(3) On or about May 12, 2012, respondent prescribed oxycodone[1] 30 mg, quantity 90 and alprazolam[2] 2 mg, quantity 60 to patient T.C.

(4) On or about June 14, 2012, patient T.C. presented to respondent for a follow up appointment. Respondent noted the patient was without complaint and that there were no new physical findings. Respondent documented that patient T.C. had no limitations with respect to daily activities.

(5) On or about June 14, 2012, respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not note why he increased the prescription for oxycodone or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(6) On or about August 15, 2012, patient T.C. presented to respondent for a follow up appointment. Respondent documented that there were no problems and described objective findings as "noncontributory." Respondent diagnosed lumbar strain. Respondent

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[1] Oxycodone is a Schedule II controlled substance from the opiates class pursuant to Health and Safety Code section 11055, subdivision (b), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision (b)(1)(xiii), and a dangerous drug pursuant to Business and Professions Code section 4022.

[2] Alprazolam is a schedule IV controlled substance from the benzodiazepine class, pursuant to pursuant to Title 21 of the Code of Federal Regulations, section 1308.14, subdivision (c)(1) and Health and Safety Code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022.

prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a lumbar strain would require 120 mg of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(7) On or about September 13, 2012, patient T.C. presented to respondent for a follow up appointment. Respondent documented that there were no new physical findings. Respondent diagnosed lumbar strain. Respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a lumbar strain would require 120 mg of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(8) On or about October 12, 2012, respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient T.C. There is no clinical note that corresponds with that prescription.

(9) On or about November 14, 2012, respondent prescribed oxycodone 30 mg, quantity 150 and alprazolam 2 mg, quantity 60 to patient T.C. There is no clinical note that corresponds with that prescription or that explains why the oxycodone prescription was increased from 120 to 150 tablets.

(10) On or about December 19, 2012, patient T.C. presented to respondent for a follow up appointment. Respondent noted no new physical findings and no subjective complaints. Respondent changed his diagnosis to herniated disc at L4-5. Respondent prescribed oxycodone 30 mg, quantity 150 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a herniated disc would require 120 mg of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(11) On or about January 23, 2013, patient T.C. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no physical examination is documented. Respondent changed his diagnosis back to lumbar strain. Respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient T.C.

Respondent did not document why a patient with a lumbar strain or herniated disc would require 120 mg of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(12) On or about February 21, 2013, patient T.C. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no new physical findings. Respondent changed his diagnosis back to herniated disc at L4-5. Respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a lumbar strain or herniated disc would require 150 mg of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(13) On or about March 20, 2013, patient T.C. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no new physical findings. Respondent prescribed oxycodone 30 mg, quantity 150 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a lumbar strain or herniated disc would require 120 mg, of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(14) On or about June 14, 2013, patient T.C. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no new physical findings. Respondent prescribed oxycodone 30 mg, quantity 90 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a lumbar strain or herniated disc would require oxycodone or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(15) On or about June 27, 2013, patient T.C. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no new physical findings. Respondent prescribed oxycodone 30 mg, quantity 150 and alprazolam 2 mg, quantity 60 to patient T.C. Respondent did not document why a patient with a lumbar strain or herniated disc would require 120 mg of oxycodone per day or whether patient T.C. was benefitting from the alprazolam in the treatment of his anxiety.

(16) On or about January 29, 2014, respondent prescribed carisoprodol[3] 350 mg, quantity 90 and hydrocodone/APAP[4] 10/325, quantity 150 to patient T.C. There is no clinical note that corresponds with this prescription.

(17) Respondent committed gross negligence in his care and treatment of patient T.C., in that:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient T.C.;

(B) Respondent prescribed controlled substances to patient T.C. without a medical indication; and

(C) Respondent failed to properly monitor patient T.C.'s use of controlled substances.

(b) Patient E.D.

(1) Respondent treated patient E.D. from on or about May 24, 2012, to on or about May 8, 2013.

(2) On or about May 24, 2012, patient E.D. presented to respondent with back pain from an automobile accident in October 2011. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document a history of previous pain treatment or a substance abuse history. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent did not obtain informed consent from patient E.D. prior to prescribing controlled substances. Respondent prescribed amoxicillin[5] 500 mg, quantity 60, oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient E.D.

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[3] Carisoprodol is a muscle relaxant with a known potentiating effect on narcotics. In December, 2011, the Federal Drug Administration listed carisoprodol as a Schedule IV controlled substance. (76 Fed.Reg. 77330 (Dec. 12, 2011).)

[4] Hydrocodone/APAP is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Amoxicillin is an antibiotic used to treat bacterial infections.

(3) On or about February 13, 2013, patient E.D. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no new physical findings. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document a history of previous pain treatment or a substance abuse history. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent did not obtain informed consent from patient E.D. Respondent prescribed amoxicillin 500 mg, quantity 60, oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient E.D.

(4) On or about May 8, 2013, patient E.D. presented to respondent for a follow up appointment. Respondent noted no subjective complaints and no new physical findings. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document a history of previous pain treatment or a substance abuse history. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent did not obtain informed consent from patient E.D. Respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60 to patient E.D.

(5) Respondent committed gross negligence in his care and treatment of patient E.D., which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient E.D.;

(B) Respondent prescribed controlled substances to patient E.D. without a medical indication; and

(C) Respondent failed to properly monitor patient E.D.'s use of controlled substances, and

(D) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient E.D.

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(c) **Patient "DeAndre Dotson"**

(1) On or about August 1, 2013, and August 29, 2013, then-Medical Board Investigator Ray Ephraim conducted undercover operations at respondent's medical office. Then-Medical Board Investigator Ray Ephraim posing as patient "DeAndre Dotson" saw respondent as a patient on or about August 1, 2013, and August 29, 2013. The interactions between patient "DeAndre Dotson" and respondent were video and audio recorded.

(2) On or about August 1, 2013, patient "DeAndre Dotson" presented to respondent and requested a prescription for OxyContin.[6] Respondent asked patient "DeAndre Dotson" why he was requesting OxyContin. Patient "DeAndre Dotson" informed respondent that he had "bad headaches." Respondent did not perform any physical examination or request any laboratory or diagnostic testing. Respondent did not document any previous pain treatment or substance abuse history. Respondent diagnosed lumbar strain despite patient "DeAndre Dotson" sole complaint of headaches. Patient "DeAndre Dotson" gave respondent $300.00 cash and respondent provided patient "DeAndre Dotson" with a prescription for oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and Keflex[7] 500 mg, quantity 60.

(3) On or about August 29, 2013, patient "DeAndre Dotson" presented to respondent's office and requested a prescription for OxyContin. Patient "DeAndre Dotson" gave respondent's receptionist $200.00 cash and in return received another prescription for oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and Keflex 500 mg, quantity 60 from respondent. On this visit, respondent did not have a face-to-face interaction with patient "DeAndre Dotson," and did not document this visit.

(4) Respondent committed gross negligence in his care and treatment of patient "DeAndre Dotson," which included, but was not limited to, the following:

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[6] OxyContin is a brand name for oxycodone, a Schedule II controlled substance from the opiates class pursuant to Health and Safety Code section 11055, subdivision (b), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision (b)(1)(xiii), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Keflex is an antibiotic used to treat bacterial infections.

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient "DeAndre Dotson;"

(B) Respondent prescribed controlled substances to patient "DeAndre Dotson" without a medical indication;

(C) Respondent failed to properly monitor patient "DeAndre Dotson's" use of controlled substances; and

(D) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient "DeAndre Dotson."

(d) Patient L.F.

(1) Respondent treated patient L.F. from on or about April 10, 2013, to on or about April 17, 2014.

(2) On or about April 10, 2013, patient L.F. presented to respondent with low back pain suffered in an automobile accident four (4) years prior to the visit. Respondent's note for this visit indicated that patient L.F. was "without complaint" and had "no new physical findings." Respondent's note for this visit does not contain a history concerning the nature and extent of patient L.F.'s pain, a history of previous pain treatment, a substance abuse history, a physical examination, diagnostic testing or a urine screen. Respondent also failed to document a proper diagnosis, adequate informed consent for the use of controlled substances or a treatment plan. Respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F.

(3) On or about May 15, 2013, patient L.F. presented to respondent for a follow up visit. Respondent's note for this visit indicated that patient L.F. was "without complaint" and had "no new physical findings." Respondent's note for this visit does not contain a history concerning the nature and extent of patient L.F.'s pain, a history of previous pain treatment, a substance abuse history, a physical examination, diagnostic testing or a urine screen. Respondent also failed to document a proper diagnosis, adequate informed consent or a treatment plan. Respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F.

(4) On or about June 5, 2013, respondent prescribed oxycodone 30 mg, quantity 150 to patient L.F. There is no associated clinic note for this prescription.

(5) On or about July 11, 2013, respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. Respondent noted a diagnosis of "neuralgia" on the prescription. There is no associated clinic note for this prescription.

(6) On or about August 29, 2013, respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(7) On or about September 25, 2013, respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(8) On or about October 30, 2013, respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(9) On or about December 4, 2013, respondent prescribed alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(10) On or about January 8, 2014, respondent prescribed alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(11) On or about February 1, 2014, respondent prescribed alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(12) On or about March 13, 2014, respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(13) On or about April 17, 2014, respondent prescribed oxycodone 30 mg, quantity 150, alprazolam 2 mg, quantity 60, and carisoprodol 350 mg, quantity 90 to patient L.F. There is no associated clinic note for this prescription.

(14) Respondent committed gross negligence in his care and treatment of patient L.F., which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient L.F.;

(B) Respondent prescribed controlled substances to patient L.F. without a medical indication;

(C) Respondent failed to properly monitor patient L.F.'s use of controlled substances; and

(D) Respondent failed to maintain adequate and accurate records in his care and treatment of patient L.F.

(e) Patient T.G.

(1) Respondent treated patient T.G. from on or about January 10, 2006, to on or about August 6, 2014.

(2) On or about January 10, 2006, patient T.G. presented to respondent with a history of chronic pain and tenderness in her low back, shoulders and upper back. Respondent did not document a history of previous pain treatment or a substance abuse history. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent did not obtain informed consent from patient T.G. Respondent plan was to continue patient T.G. on methadone.[8]

(3) On or about December 7, 2007, respondent documented a chart note dated "January 9, 2007 thru December 7, 2007." This note is the sole documentation of

[8] Methadone is a Schedule II controlled substance from the opiates class pursuant to and Health and Safety Code section 11055, subdivision (c), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision (c)(15), and a dangerous drug pursuant to Business and Professions Code section 4022.

respondent's treatment of T.G. during the 2007 calendar year. Respondent reiterated the history from his January 10, 2006, note. Respondent did not perform and/or document a physical examination. Respondent documented that patient T.G. was taking methadone 50 mg daily, Actiq[9] 800 µg one unit per day, and Xanax[10] 2 mg three times per day. Respondent did not document why patient T.G. was receiving Xanax.

(4) On or about November 4, 2008, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 150, Xanax 2 mg, quantity 90 and Actiq 800 µg, quantity 30. Respondent did not document why patient T.G. was receiving Xanax.

(5) On or about December 30, 2008, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 150, Xanax 2 mg, quantity 90 and Actiq 800 µg, quantity 30. Respondent did not document why patient T.G. was receiving Xanax.

(6) On or about January 27, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 150, Xanax 2 mg, quantity 90 and Actiq 800 µg, quantity 30. Respondent did not document why patient T.G. was receiving Xanax.

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[9] Actiq is a brand name for fentanyl, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Xanax is a brand name for alprazolam (a benzodiazepine), a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

(7) On or about March 3, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 150, Xanax 2 mg, quantity 90 and Actiq 800 µg, quantity 30. Respondent did not document why patient T.G. was receiving Xanax.

(8) On or about March 31, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was increased from 150 to 240 tablets.

(9) On or about April 28, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(10) On or about June 30, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why

the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(11) On or about July 27, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(12) On or about August 25, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(13) On or about September 22, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(14) On or about October 27, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to

that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(15) On or about November 24, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(16) On or about December 23, 2009, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(17) On or about January 19, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why

the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(18) On or about February 16, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(19) On or about March 16, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(20) On or about April 13, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(21) On or about May 11, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to

that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets.

(22) On or about June 8, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240, Xanax 2 mg, quantity 90, and Dilaudid[11] 8 mg, quantity 150. Respondent did not document why patient T.G. is receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was previously increased from 150 to 240 tablets. Respondent did not document why Dilaudid was added to patient T.G.'s prescribed medications.

(23) On or about July 2, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240 and Xanax 2 mg, quantity 90. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was increased from 240 to 270 tablets. Respondent did not document why Dilaudid was previously added to patient T.G.'s prescribed medications, or why it was discontinued at

[11] Dilaudid a brand name for hydromorphone, a Schedule II controlled substance from the opiates class pursuant to Health and Safety Code section 11055, subdivision (b), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision (b)(1)(vii), and a dangerous drug pursuant to Business and Professions Code section 4022.

this point.

(24) On or about July 6, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented a brief history identical to that documented in his previous notes. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 240, Xanax 2 mg, quantity 90, and Dilaudid 8 mg, quantity 150. Respondent did not document why patient T.G. was receiving Xanax. Respondent did not document why the previous Actiq prescription was discontinued or why the quantity of methadone was increased from 240 to 270 tablets. Respondent did not document why Dilaudid was added back to patient T.G.'s prescribed medications. Respondent did not document why he refilled prescriptions four (4) days after patient T.G. had previously received a thirty-day (30) supply of Methadone, Xanax and Dilaudid from respondent on or about July 2, 2010.

(25) On or about August 2, 2010, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination, a neurological exam, or a treatment plan. Respondent noted patient T.G. was receiving methadone 10 mg, quantity 270, but did not note patient T.G.'s other medications, including Xanax and Dilaudid.

(26) On or about August 3, 2010, respondent terminated his doctor-patient relationship with patient T.G. because he discovered she was receiving controlled substances from another physician.

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(27) On or about May 10, 2011, respondent resumed his care and treatment of patient T.G. Respondent did not document blood pressure, pulse or a neurological examination. Respondent did not document why he resumed treatment of patient T.G. after terminating her as a patient on or about August 3, 2010. Respondent prescribed methadone 10 mg, quantity 200, Xanax 2 mg, quantity 90, and Norco 10/325,[12] quantity 120. Respondent did not document why Norco was added to patient T.G.'s prescribed medications. Respondent did not document why patient T.G. was receiving Xanax.

(28) On or about June 7, 2011, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent altered patient T.G.'s methadone prescription to methadone 10 mg, quantity 270 (two tablets four times per day and one tablet at bedtime). Respondent did not document why he changed patient T.G.'s methadone dose. Respondent did not document why patient T.G. was receiving Xanax.

(29) On or about September 27, 2011, respondent prescribed methadone 10 mg, quantity 300, to patient T.G. There is no corresponding chart note for this prescription in respondent's medical chart for patient T.G.

(30) On or about December 14, 2011, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(31) On or about January 12, 2012, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G.

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[12] Norco (hydrocodone 10 mg / acetaminophen 325 mg) is a Schedule III controlled substance from the opiates class pursuant to Health and Safety Code section 11056, subdivision (e), and Title 21 of the Code of Federal Regulations, section 1308.13, subdivision (e)(1)(iv), and is a dangerous drug pursuant to Business and Professions Code section 4022.

There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(32) On or about February 9, 2012, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(33) On or about March 8, 2012, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(34) On or about March 15, 2012, patient T.G. presented to respondent. Respondent's note for this visit documented brief subjective complaints. Respondent did not perform and/or document objective findings, a physical examination, a neurological examination, or a treatment plan.

(35) On or about May 7, 2012, respondent prescribed methadone 10 mg, quantity 300 to patient T.G. There is no corresponding chart note for this prescription in respondent's medical chart for patient T.G.

(36) On or about May 30, 2012, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(37) On or about July 3, 2012, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

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(38) On or about August 1, 2012, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(39) On or about August 29, 2012, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief history and a brief assessment. Respondent did not perform and/or document a physical examination, a neurological examination, or a treatment plan. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

(40) On or about September 26, 2012, respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient T.G.

(41) On or about November 13, 2012, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination or a neurological examination. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

(42) On or about December 13, 2012, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination or a neurological examination. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

(43) On or about January 10, 2013, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and

subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination or a neurological examination. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

(44) On or about February 7, 2013, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination or a neurological examination. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

(45) On or about March 7, 2013, patient T.G. presented to respondent for prescription refills. Respondent's note for this visit documented brief objective and subjective complaints and a brief assessment. Respondent did not perform and/or document a physical examination or a neurological examination. Respondent prescribed methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. Respondent did not document why patient T.G. was receiving Xanax.

(46) Between on or about April 5, 2013, and August 6, 2014, respondent wrote approximately eighteen (18) prescriptions for methadone 10 mg, quantity 300, Xanax 2 mg, quantity 90, and Norco 10/325, quantity 120 to patient T.G. There are no corresponding chart notes for these prescription in respondent's medical chart for patient T.G.

(47) Respondent committed gross negligence in his care and treatment of patient T.G., which included, but was not limited to, the following:

(A) Respondent prescribed controlled substances to patient T.G. without a medical indication;

(B) Respondent failed to properly monitor patient T.G.'s use of controlled substances; and

(C) Respondent failed to maintain adequate and accurate records in his care and treatment of patient T.G.

(f) **Patient S.J.**

(1) Respondent treated patient S.J. from on or about April 25, 2013, to on or about September 5, 2013.

(2) On or about April 25, 2013, patient S.J. presented to respondent with low back pain, upper shoulder pain, and tingling in her arm, hand, hips and legs. Respondent noted current medications as metformin,[13] benazepril[14] and "Xanax/stress." Respondent noted previous MRI findings but did not maintain the MRI report in patient S.J.'s medical chart. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document prior efforts at pain treatment or sufficient informed consent. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent prescribed oxycodone 30 mg, quantity 150, and alprazolam 2 mg, quantity 60 to patient S.J. Respondent did not document why he prescribed a high dosage of oxycodone for an opiate naïve patient.

(3) On or about May 22, 2013, patient S.J. presented to respondent for a follow up visit. Respondent's note for this visit indicates that patient S.J. was "without complaint" and "no new physical findings." Respondent's note for this visit does not contain a history concerning the nature and extent of patient S.J.'s pain, a history or previous pain treatment, a substance abuse history, a physical examination, diagnostic testing or a urine screen. Respondent's note for this visit also failed to document a proper diagnosis, adequate informed consent or a treatment plan. Respondent prescribed oxycodone 30 mg, quantity 150, and alprazolam 2 mg, quantity 60 to patient S.J. Respondent did not document why he prescribed a high dosage of oxycodone for an opiate naïve patient.

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[13] Metformin is an oral antidiabetic drug in the biguanide class. It is the first-line drug of choice for the treatment of type 2 diabetes.

[14] Benazepril is a drug of the angiotensin-converting enzyme (ACE) inhibitor class used primarily in treatment of hypertension, congestive heart failure, and heart attacks, and also in preventing renal and retinal complications of diabetes.

(4) On or about July 1, 2013, respondent prescribed oxycodone 30 mg, quantity 120 and alprazolam 2 mg, quantity 60. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient S.J.

(5) On or about July 19, 2013, patient S.J. presented to respondent for a follow up visit. Respondent's note for this visit indicates that patient S.J. was "without complaint" and "no new physical findings." Respondent's note for this visit does not contain a history concerning the nature and extent of patient S.J.'s pain, a history or previous pain treatment, a substance abuse history, a physical examination, diagnostic testing or a urine screen. Respondent's note for this visit also failed to document an explanation why patient S.J.'s diagnosis was changed from disc degeneration-site unspecified to lumbar strain. Respondent failed to document an adequate informed consent or a treatment plan. Respondent prescribed alprazolam 2 mg, quantity 60 to patient S.J eighteen (18) days after he had previously prescribed patient S.J. a thirty (30) day supply of alprazolam on or about July 1, 2013.

(6) On or about September 13, 2013, patient S.J. presented to respondent for a follow up visit. Respondent's note for this visit indicated that patient S.J. was "without complaint" and had "no new physical findings." Respondent's note for this visit does not contain a history concerning the nature and extent of patient S.J.'s pain, a history or previous pain treatment, a substance abuse history, a physical examination, diagnostic testing or a urine screen. Respondent's note for this visit also failed to document an explanation why patient S.J.'s diagnosis was changed from lumbar strain to cervical disc disease without myelopathy. Respondent failed to document an adequate informed consent or a treatment plan. Respondent prescribed oxycodone 30 mg, quantity 150, and alprazolam 2 mg, quantity 60 to patient S.J. Respondent did not document why he prescribed a high dosage of oxycodone for an opiate naïve patient.

(7) On or about October 2, 2013, respondent prescribed oxycodone 30 mg, quantity 120, alprazolam 2 mg, quantity 60, and hydrocodone/APAP 10/325, quantity 150. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient

S.J.

(8) Respondent committed gross negligence in his care and treatment of patient S.J., which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient S.J.;

(B) Respondent prescribed controlled substances to patient S.J. without a medical indication;

(C) Respondent failed to properly monitor patient S.J.'s use of controlled substances; and

(D) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient S.J.

(g) Patient N.M.

(1) Respondent treated patient N.M. from on or about September 2, 2011, to on or about May 4, 2012.

(2) On or about September 2, 2011, respondent prescribed oxycodone 30 mg, quantity 240 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(3) On or about September 30, 2011, respondent prescribed oxycodone 30 mg, quantity 240 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(4) On or about October 25, 2011, respondent prescribed oxycodone 30 mg, quantity 240 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(5) On or about December 10, 2011, respondent prescribed oxycodone 30 mg, quantity 240 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(6) On or about December 13, 2011, respondent prescribed oxycodone 30 mg, quantity 240 to patient N.M. There is no corresponding chart note for this prescription in

respondent's medical chart for patient N.M.

(7) On or about January 9, 2012, respondent prescribed oxycodone 30 mg, quantity 240, and Morphine Sulfate[15] 15 mg, quantity 60 to patient N.M. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient N.M.

(8) On or about January 27, 2012, respondent prescribed Fentanyl[16] transdermal patch 75 mcg/hr, quantity 10 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(9) On or about February 4, 2012, respondent prescribed oxycodone 30 mg, quantity 240, and hydromorphone/HCL[17] 8 mg, quantity 20 to patient N.M. There is no corresponding chart note for these prescriptions in respondent's medical chart for patient N.M.

(10) On or about February 16, 2012, respondent prescribed oxycodone 30 mg, quantity 240 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(11) On or about March 8, 2012, respondent prescribed oxycodone 30 mg, quantity 120 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(12) On or about April 5, 2012, respondent prescribed oxycodone 30 mg, quantity 180 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

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[15] Morphine Sulfate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[16] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[17] Hydromorphone/HCL is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

(13) On or about May 4, 2012, respondent prescribed oxycodone 30 mg, quantity 180 to patient N.M. There is no corresponding chart note for this prescription in respondent's medical chart for patient N.M.

(14) Respondent committed gross negligence in his care and treatment of patient N.M., which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient N.M.;

(B) Respondent prescribed controlled substances to patient N.M. without a medical indication;

(C) Respondent failed to properly monitor patient N.M.'s use of controlled substances; and

(D) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient N.M.

(h) Patient V.S.

(1) Respondent treated patient V.S. for lower extremity pain due to reflex sympathetic dystrophy[18] (RSD) from on or about September 20, 2001, to on or about April 25, 2014.

(2) In or about November 2011, patient V.S. filled three prescriptions from respondent for Norco 10/325, quantity 720. During November 2011, patient V.S. received 1,680 tablets of Norco 10/325. Patient V.S. received an average of 46.8 tablets per day prior to filling his next prescription from respondent for Norco 10/325 on or about February 2, 2012.

(3) On or about April 25, 2012, respondent prescribed a three (3) month supply of four controlled substances to patient V.S. Specifically, respondent prescribed OxyContin 20 mg, quantity 270, OxyContin 10 mg, quantity 270, Norco 10/325, quantity 720, and

[18] Reflex sympathetic dystrophy (RSD), also known as complex regional pain syndrome, is a rare disorder of the sympathetic nervous system that is characterized by chronic, severe pain.

Soma[19] 350 mg, quantity 360 to patient V.S.

(4) On or about May 2, 2012, respondent again prescribed a three (3) month supply of four controlled substances to patient V.S. Specifically, respondent prescribed OxyContin 20 mg, quantity 270, OxyContin 10 mg, quantity 270, Norco 10/325, quantity 720 and Soma 350 mg, quantity 360 to patient V.S.

(5) On or about October 2, 2012, respondent ran a Controlled Substances Utilization Review and Evaluation System (CURES)[20] report for patient V.S. that indicated patient V.S. received seven (7) prescriptions for hydrocodone/APAP 7.5/750, quantity 100 between on or about October 2, 2011 and October 2, 2012, from another physician. Despite having this information, respondent wrote five (5) prescriptions for Norco 10/325 during the same period of time. Respondent did not document the overlapping prescriptions but instead documented that there was no suspicious activity on the part of patient V.S.

(6) On or about October 9, 2013, respondent prescribed a three (3) month supply of three controlled substances to patient V.S. Specifically, respondent prescribed OxyContin 20 mg, quantity 270, Oxycodone 20 mg, quantity 270, Norco 10/325, quantity 720 to patient V.S.

(7) On or about October 23, 2013, respondent again prescribed a three (3) month supply of three controlled substances to patient V.S. Specifically, respondent prescribed OxyContin 20 mg, quantity 270, Oxycodone 20 mg, quantity 270, Norco 10/325, quantity 720 to patient V.S.

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[19] Soma is a brand name for carisoprodol, a muscle relaxant with a known potentiating effect on narcotics. In December, 2011, the Federal Drug Administration listed carisoprodol as a Schedule IV controlled substance. (76 Fed.Reg. 77330 (Dec. 12, 2011).)

[20] The CURES is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) The history of controlled substances dispensed to a specific patient based on the data contained in the CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

(8) Despite respondent's long term prescriptions of OxyContin 20 mg, Oxycodone 20 mg, and Norco 10/325, to patient V.S., respondent failed to perform any laboratory testing to check liver function.

(9) Respondent committed gross negligence in his care and treatment of patient V.S. which included, but was not limited to, the following:

(A) Respondent failed to properly monitor patient V.S.'s use of controlled substances; and

(B) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient V.S.

(i) Patient L.S.

(1) Respondent treated patient L.S. from on or about September 5, 2012, to on or about April 24, 2014.

(2) On or about September 5, 2012, patient L.S. presented to respondent with back pain and numbness/weakness in his arm, hand, and leg. Respondent did not address patient L.S.'s complaint of numbness/weakness in his arm, hand, and leg. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document prior efforts at pain treatment or sufficient informed consent. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent prescribed oxycodone/acetaminophen 30 mg, quantity 120 to patient L.S.

(3) On or about September 6, 2012, respondent documented a follow-up visit with patient L.S. Respondent did not document why the patient presented a day after the initial examination. Respondent documented a diagnosis of lumbar strain. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document prior efforts at pain treatment or sufficient informed consent. Respondent did not order any diagnostic testing and did not document a treatment plan.

(4) On or about September 12, 2012, respondent documented a follow-up visit with patient L.S. Respondent documented a diagnosis of lumbar strain. Respondent did not perform and/or document vital signs, a basic physical examination, range of motion testing or neurological findings. Respondent did not document prior efforts at pain treatment or sufficient informed consent. Respondent did not order any diagnostic testing and did not document a treatment plan. Respondent prescribed oxycodone/acetaminophen 30 mg, quantity 120 to patient L.S.

(5) On or about October 9, 2012, respondent prescribed Percocet[21] 10/325, quantity 180 and Xanax 2 mg, quantity 60 to patient L.S. There is no associated chart note for this prescription and no explanation why patient L.S. was prescribed Xanax.

(6) On or about October 24, 2012, respondent prescribed oxycodone 30 mg, quantity 90 and Xanax 2 mg, quantity 60 to patient L.S. There is no associated chart note for these prescriptions and no explanation why patient L.S. was prescribed Xanax.

(7) On or about January 9, 2013, respondent prescribed Percocet 10/325, quantity 120, Keflex 500 mg, quantity 60, and Xanax 2 mg, quantity 60 to patient L.S. There is no associated chart note for these prescriptions and no explanation why patient L.S. was prescribed Xanax or Keflex.

(8) On or about March 28, 2013, respondent prescribed oxycodone 15 mg, quantity 90 and Xanax 2 mg, quantity 90 to patient L.S. There is no associated chart note for these prescriptions and no explanation why patient L.S. was prescribed Xanax.

(9) On or about May 2, 2013, respondent prescribed ampicillin[22] 500 mg, quantity 60, oxycodone 15 mg, quantity 150 and Xanax 2 mg, quantity 60 to patient L.S. There is no associated chart note for these prescriptions and no explanation why patient L.S. was prescribed Xanax or ampicillin.

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[21] Percocet is a brand named drug containing oxycodone, a Schedule II controlled substance from the opiates class pursuant to Health and Safety Code section 11055, subdivision (b), and Title 21 of the Code of Federal Regulations, section 1308.12, subdivision (b)(1)(xiii), and a dangerous drug pursuant to Business and Professions Code section 4022.

[22] Ampicillin is an antibiotic used to treat bacterial infections.

(10) On or about August 12, 2013, respondent prescribed oxycodone 15 mg, quantity 150 and Xanax 2 mg, quantity 60 to patient L.S. There is no associated chart note for these prescriptions and no explanation why patient L.S. was prescribed Xanax.

(11) On or about October 9, 2013, respondent prescribed Percocet 10/325, quantity 180, and Xanax 2 mg, quantity 90 to patient L.S. There is no associated chart note for these prescriptions and no explanation why patient L.S. was prescribed Xanax.

(12) On or about April 24, 2014, respondent prescribed oxycodone 30 mg, quantity 90 to patient L.S. There is no associated chart note for this prescription.

(13) Respondent committed gross negligence in his care and treatment of patient L.S., which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient L.S.;

(B) Respondent prescribed controlled substances to patient L.S. without a medical indication;

(C) Respondent failed to properly monitor patient L.S.'s use of controlled substances; and

(D) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient L.S.

(j) Patient "Tasha Thomas"

(1) On or about August 1, 2013, and August 29, 2013, then-Medical Board Investigator Tanya Meadows conducted undercover operations at respondent's medical office. Then-Medical Board Investigator Tanya Meadows posing as patient "Tasha Thomas" saw respondent as a patient on or August 1, 2013, and August 29, 2013. The interactions between patient "Tasha Thomas" and respondent were video and audio recorded.

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(2) On or about August 1, 2013, patient "Tasha Thomas" presented to respondent and requested a prescription for OxyContin. Respondent asked patient "Tasha Thomas" why she was requesting OxyContin. Patient "Tasha Thomas" informed respondent that she was in a car accident a long time ago and had pain in her back and leg. Respondent did not perform any physical examination or request any laboratory exams or diagnostic testing. Respondent did not document any previous pain treatment or substance abuse history. Respondent diagnosed "neuralgia." Patient "Tasha Thomas" gave respondent $300.00 cash and respondent provided patient "Tasha Thomas" with a prescription for gabapentin[23] 300 mg, quantity 60, oxycodone 30 mg, quantity 150, and alprazolam 2 mg, quantity 60.

(3) On or about August 29, 2013, patient "Tasha Thomas" presented to respondent's office and requested a prescription for OxyContin. Patient "Tasha Thomas" gave respondent's receptionist $200.00 cash and in return received another prescription for gabapentin 300 mg, quantity 60, oxycodone 30 mg, quantity 150, and alprazolam 2 mg, quantity 60 from respondent. On this visit, respondent did not have a face-to-face interaction with patient "Tasha Thomas," and respondent did not document this visit.

(4) Respondent committed gross negligence in his care and treatment of patient "Tasha Thomas" which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient "Tasha Thomas;"

(B) Respondent prescribed controlled substances to patient "Tasha Thomas" without a medical indication;

(C) Respondent failed to properly monitor patient "Tasha Thomas'" use of controlled substances; and

(D) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient "Tasha Thomas."

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[23] Gabapentin is a medication used as an anticonvulsant and analgesic. It was originally developed to treat epilepsy, and is currently also used to relieve neuropathic pain.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients T.C., E.D., M.D., "DeAndre Dotson," L.F., T.G., S.J., N.M., L.R., V.S., L.S. and "Tasha Thomas," as more particularly alleged hereinafter:

(a) Patient T.C.

(1) Paragraph 13(a), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(2) Respondent committed repeated negligent acts in his care and treatment of patient T.C., which included, but was not limited to, the following:

(A) Respondent failed to maintain adequate and accurate records in his care and treatment of patient T.C.

(b) Patient E.D.

(1) Paragraph 13(b), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(c) Patient "DeAndre Dotson"

(1) Paragraph 13(c), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(d) Patient L.F.

(1) Paragraph 13(d), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(e) Patient T.G.

(1) Paragraph 13(e), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(2) Respondent committed repeated negligent acts in his care and treatment of patient T.G., which included, but was not limited to, the following:

(A) Respondent failed to perform an appropriate examination prior to prescribing controlled substances to patient T.G.

(f) Patient S.J.

(1) Paragraph 13(f), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(g) Patient N.M.

(1) Paragraph 13(g), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(h) Patient V.S.

(1) Paragraph 13(h), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(i) Patient L.S.

(1) Paragraph 13(i), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(j) Patient "Tasha Thomas"

(1) Paragraph 13(j), above, is hereby realleged and incorporated by reference as if fully set forth herein.

(k) Patient M.D.

(1) Respondent treated patient M.D. from on or about February 7, 2003, to on or about August 14, 2014.

(2) On or about February 7, 2003, patient M.D. presented to respondent with neck, back and shoulder pain on referral from her chiropractor due to an industrial injury suffered during her employment at a school district.

(3) On May 16, 2011, respondent documented an office visit with patient M.D. Respondent documented that there were "no new significant physical findings per exam. Gait remains antalgic and ambulation aided by walker. Alert and oriented to person, place and time." In fact, on May 16, 2011, patient M.D. was subject to a sub rosa investigation conducted by RJN Investigations due to suspicions about the veracity of her Worker's

Compensation claim. The RJN investigation established that patient M.D. did not see respondent on May 16, 2011.

(4) On June 6, 2011, respondent documented an office visit with patient M.D. Respondent documented that "exam deferred due to current physical state. Alert and oriented to person, place and time. Gait remains antalgic and ambulation aided by walker." In fact, on June 6, 2011, patient M.D. was subject to a sub rosa investigation conducted by RJN Investigations due to suspicions about the veracity of her Worker's Compensation claim. The RJN investigation established that patient M.D. did not see respondent on June 6, 2011.

(5) Between on or about December 29, 2008, and December 29, 2011, respondent saw patient M.D. on approximately a monthly basis. Respondent's notes for these visits lack physical examinations apart from occasional notations of tenderness and muscle spasm. Respondent did not perform and/or document neurological testing or vital signs.

(6) Between on or about January 12, 2009, and July 20, 2011, respondent wrote forty-one (41) prescriptions for OxyContin to patient M.D. Respondent prescribed an average of 392 mg of OxyContin per day during this time with an average of twenty-three (23) days between prescriptions. Respondent's notes during this time frame indicated he was prescribing patient M.D. OxyContin every thirty (30) days with a daily dose of 320 mg of OxyContin. In reality, patient M.D. was receiving an average of 392 mg of OxyContin per day.

(7) Between on or about January 3, 2009, and August 5, 2011, respondent wrote seventy-five (75) prescriptions for Actiq to patient M.D. Respondent prescribed an average of 6.6 units of Actiq per day during this time with an average of thirteen (13) days between prescriptions. Respondent's notes during this time frame indicated he was prescribing patient M.D. 5.0 units of Actiq daily. In reality, patient M.D. was receiving an average of 6.6 units of Actiq per day.

(8) Between on or about January 12, 2009, and February 21, 2011, respondent wrote nineteen (19) prescriptions for hydrocodone/APAP 7.5/750 to patient M.D.

Respondent prescribed an average of 29 mg of hydrocodone/APAP per day during this time with an average of forty-two (42) days between prescriptions.

(9) Between on or about January 12, 2009, and July 16, 2011, respondent wrote forty (40) prescriptions for diazepam[24] to patient M.D. Respondent prescribed an average of 37 mg of diazepam per day during this time with an average of twenty-three (23) days between prescriptions. Respondent's notes during this time frame indicated he was prescribing patient M.D. diazepam every thirty (30) days with a daily dose of 30 mg of diazepam. In reality, patient M.D. was receiving an average of 37 mg of diazepam per day.

(10) Respondent committed repeated negligent acts in his care and treatment of patient M.D., which included, but was not limited to, the following:

(A) Respondent failed to properly monitor patient M.D.'s use of controlled substances; and

(B) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient M.D.

(l) Patient L.R.

(1) Respondent treated patient L.R. from on or about November 1, 2001, to on or about March 31, 2014.

(2) On or about November 1, 2001, patient L.R. presented to respondent with back pain due to an industrial injury. Respondent referred patient L.R. for a series of epidural injections.

(3) On or about April 15, 2004, respondent resumed his treatment of patient L.R. Respondent treated L.R. continuously through on or about March 31, 2014.

(4) Between on or about May 24, 2011, and March 31, 2014, respondent failed to document and/or perform an adequate physical examination of patient L.R. including documenting vital signs. Respondent further failed to adequately document the nature and

[24] Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

extent of patient L.R.'s pain.

(5) On or about February 14, 2013, patient L.R. reported angina and the onset of pain and numbness in her right hand. Respondent did not document this complaint in his chart note and did not take patient L.R.'s vital signs.

(6) Between on or about August 15, 2011 and March 31, 2014, respondent prescribed hydrocodone/APAP 10/325, quantity 240, twenty-eight (28) times to Patient L.R. Patient L.R. received an average of 75 mg of hydrocodone/APAP per day during this time period. Respondent did not order laboratory testing to check patient L.R.'s liver function during this time period. On several occasions during this time period respondent wrote prescriptions for early refills without explanation.

(7) Between on or about August 15, 2011, and March 31, 2014, respondent prescribed morphine sulfate 100 mg, quantity 180, twenty-two (22) times to patient L.R. Patient L.R. received an average of 517 mg of morphine per day. On several occasions during this time period respondent wrote prescriptions for early refills without explanation.

(8) Respondent committed repeated negligent acts in his care and treatment of patient L.R., which included, but was not limited to, the following:

(A) Respondent failed to properly monitor patient L.R.'s use of controlled substances; and

(B) Respondent failed to maintain adequate and accurate records regarding his care and treatment of patient L.R.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs or Controlled Substances Without an Appropriate Prior Examination and/or Medical Indication)

15. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed, dispensed, or furnished dangerous drugs as defined by Section 4022 of the Code, without an appropriate prior examination and/or medical indication, to patients T.C., E.D., M.D., "DeAndre Dotson," L.F., T.G., S.J., N.M., L.R., V.S., L.S. and "Tasha Thomas," as

more particularly alleged in paragraphs 13 and 14, above, which are hereby realleged and incorporated by reference as if fully stated herein.

FOURTH CAUSE FOR DISCIPLINE

(Violation of State Statute or Regulation Regulating Drugs)

16. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code, in that he has violated a federal or state statute or regulation regulating dangerous drugs or controlled substances, as more particularly alleged hereinafter:

(a) Paragraphs 13 through 15, above, are hereby realleged and incorporated herein by reference as if fully set forth herein.

(b) Respondent repeatedly prescribed dangerous drugs as defined by Business and Professions Code section 4022, to patients T.C., E.D., "DeAndre Dotson," L.F., T.G., S.J., N.M., L.R., V.S., L.S. and "Tasha Thomas" without an appropriate prior examination and a medical indication, in violation of Business and Professions Code section 2242.

(c) Respondent repeatedly prescribed controlled substances to patients T.C., E.D., M.D., "DeAndre Dotson," L.F., T.G., S.J., N.M., L.R., V.S., L.S. and "Tasha Thomas" in quantities and for periods of time in excess of what was reasonably necessary, in violation of Health and Safety Code section 11210.

(d) Respondent committed repeated acts of clearly excessive prescribing of drugs, as determined by the standard of the community of physicians, in violation of Business and Professions Code section 725.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing or Treatment)

17. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing drugs or treatment, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 13 through 16, above, which is hereby incorporated by reference and realleged as if

fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(False Representation on a Document Directly or Indirectly Related to the Practice of Medicine)

18. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2261, of the Code, in that he has knowingly made or signed a certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, as more particularly alleged in paragraphs 13(c), 13(j) and 14(k), above, which are hereby realleged and incorporated by reference as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption)

19. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of the Code, in that he has committed acts of dishonesty or corruption in his care and treatment of patients M.D., "DeAndre Dotson," and "Tasha Thomas," as more particularly alleged in paragraphs 13(c) and (j), 14(k), and 18 above, which are hereby realleged and incorporated by reference as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

20. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he has failed to maintain adequate and accurate records regarding his care and treatment of patients T.C., E.D., M.D., "DeAndre Dotson," L.F., T.G., S.J., N.M., L.R., V.S., L.S. and "Tasha Thomas," as more particularly alleged in paragraphs 13 and 14, above, which are hereby realleged and incorporated by reference as if fully set forth herein.

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NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

21. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breached the rules or ethical code of the medical profession, or conduct unbecoming a member in good standing of the medical profession, and which demonstrated an unfitness to practice medicine, as more particularly alleged in paragraphs 13 through 20, above, which are hereby realleged and incorporated herein by reference as if fully set forth herein.

TENTH CAUSE FOR DISCIPLINE

(Violation of the Medical Practice Act)

22. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43837 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that he has violated or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or conspired to violate a provision of the Medical Practice Act, as more particularly alleged in paragraphs 13, 14, 15, 16, 18, 19, 20, and 21, above, which are hereby realleged and incorporated herein by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate A 43837, issued to respondent Wendell Street, M.D.;

2. Revoking, suspending or denying approval of respondent Wendell Street, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Wendell Street, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: December 8, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant