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

In the Matter of the Accusation Against:	)	
John Edwin Parsons Jr., M.D.	)	**Case No. 800-2015-018605**
Physician's and Surgeon's Certificate No. G 78940	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 27, 2019.

IT IS SO ORDERED: October 30, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
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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: **JOHN EDWIN PARSONS, JR., M.D.** **1123 S. Imperial Ave.** **El Centro, CA 92243** **Physician's and Surgeon's Certificate No. G 78940** Respondent.	Case No. 800-2015-018605 OAH No. 2019080183 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Ryan J. Yates, Deputy Attorney General.

2. Respondent John Edwin Parsons, Jr., M.D. (Respondent) is represented in this proceeding by attorney Chris A. Yturralde Esq., whose address is: 3755 Avocado Boulevard, #434, La Mesa, CA 91941.

3. On or about May 25, 1994, the Board issued Physician's and Surgeon's Certificate No. G 78940 to John Edwin Parsons, Jr., M.D. (Respondent). The Physicians and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-018605, and will expire on September 30, 2019, unless renewed.

JURISDICTION

Accusation No. 800-2015-018605 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 13, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2015-018605 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-018605. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement 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 the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

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CULPABILITY

Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2015-018605 and that he has thereby subjected his license to disciplinary action.

9. Respondent further agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges contained in Accusation No. 800-2015-018605 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 agrees that his Physician's and Surgeon's Certificate No. G 78940 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

11. Respondent agrees the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 78940 issued to Respondent John Edwin Parsons, Jr., M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

2. PATIENT DISCLOSURE. Before a patient's first visit following the effective date of this order and while the respondent is on probation, Respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes the Respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on the respondent by the board, the board's telephone number, and an explanation of how the patient can find further information on the respondent's probation on the respondent's profile page on the board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent

shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct treatment relationship with the patient.

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

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

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

medicine. Respondent shall comply with the program's recommendations.

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

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

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

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

5. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours per year, for each year of probation. The educational program(s) or course(s)

shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category 1 certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME, of which forty (40) hours were in satisfaction of this condition.

6. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

7. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16; California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall

provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and billing, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (60) calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart

review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's place of residence. If Respondent engages in the practice of medicine at a patient's place of residence, Respondent shall maintain an office, where those patients' records are kept and made available to Respondent's practice monitor, as well as Board staff.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

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

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model

Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Chris A. Yturralde Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9-13-19

John Edwin Parsons, Jr. MD

JOHN EDWIN PARSONS, JR., M.D.
Respondent

I have read and fully discussed with Respondent John Edwin Parsons, Jr., M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/18/19

CHRIS A. YTURRALDE ESQ.
Attorney for Respondent

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ENDORSEMENT

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

DATED: 9/18/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

RYAN J. YATES
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-018605

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 13, 2018
BY: ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2015-018605
John Edwin Parsons, Jr., M.D. **1123 S. Imperial Ave.** **El Centro, CA 92243** **Physician's and Surgeon's Certificate No. G 78940,** Respondent.	**A C C U S A T I O N**

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 (Board).

2. On or about May 25, 1994, the Medical Board issued Physician's and Surgeon's Certificate Number G 78940 to John Edwin Parsons, Jr., M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2019, unless renewed.

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 unless otherwise indicated.

4. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

5. 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."

6. Section 725 of the Code 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."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (b), of the Code, in that respondent committed gross negligence in his care and treatment of patients A, B, C, D, and E.[1]

8. On or around November 15, 2015, the Medical Board of California (MBC) received a complaint against Respondent from the California Department of Health Care Services (DHCS). The complaint alleged various issues found during a focused review of Respondent's prescribing practices at Ampla Health in Oroville, CA, including substandard office visit documentation, substandard management of chronic pain, and quality of care issues. Controlled Substance Utilization Review and Evaluation System (CURES) reports were obtained on Respondent's prescribing. In Respondent's care and treatment of patients A, B, C, D, and E departures from the standard of care were identified as follows:

Patient A

9. Patient A is a male born in 1966 with history of hypertriglyceridemia, lumbar spinal stenosis with prior back surgery and failed back syndrome, anxiety, depression, chronic nausea, reported attention deficit disorder, and abdominal hernias with resulting surgeries. Patient A began seeing Respondent in December 2012 and saw him approximately every 2-3 months until December 2015, mostly for medication refills of Controlled Substances for chronic back pain. Respondent regularly prescribed non-controlled substances including numerous antibiotics, such as Phenergan for nausea, ProAir (albuterol) inhaler, and back braces and a TENS unit for back pain. Patient A also saw a psychiatrist who prescribed Xanax and Effexor although it is not clear how long he saw the other physician.

10. Patient A's "History of Present Illness" notations from April 2013 onward typically mention only "lumbar pain" with no discussion regarding the location of the pain, quality, provoking or palliating factors, radiation of the pain, pain level, or effect on patient A's function.

[1] The patients are referred to by letters in order to preserve their privacy. Their identity will be disclosed in the discovery provided to the respondent.

Patient A's vital signs were significant for a body mass index of 34-35 indicating obesity. Examination of Patient A is repeated verbatim at many visits and was noted as "palpable tenderness of the lumbar and thoracic spine, has difficulty forward flexing at the waist. Patient's lungs were clear, heart examination normal, abdomen significant for scarring" and mentation noted as "alert and oriented x 3, ambulatory."

11. On March 22, 2013, Respondent saw patient A for a visit noting that Patient A had a history of severe spine pain with history of spine surgery and was seeing a specialist who ordered a computed tomography (CT) scan of the spine. Patient A had failed two prior drug screenings in November of 2012 ordered by the Respondent's colleagues which were positive for methamphetamines. Patient A reported 10/10 on a pain scale, had anxiety and depression, and he was seeing a psychiatrist for these issues. Patient A reported nausea from his medications, requesting a transcutaneous electrical nerve stimulation (TENS) unit for his pain and the Respondent noted he was having difficulty finding a pain specialist who would see patient A. Respondent's note stated "...taking everything into consideration, I am going to attempt to reverse my decision for no-narcotics based on his positive drug screen with methamphetamines and I am going to attempt to give him a second chance. This is a controversial decision....I told the patient that he has to be able to pass future drug screens and he cannot be found to be habitually using methamphetamines....The patient has significant mental health issues and easily becomes very anxious and very depressed." Respondent further noted patient A had marked tenderness of his lumbar spine and was ambulatory. Respondent refilled Methadone[2] 10mg two tablets up to four times a day, maximum eight per day #240, oxycodone[3] IR 30 mg two tablets up to four times a day, maximum of eight per day #240. Respondent ordered a CT scan per the request of the surgeon and stated he would arrange for a TENS unit.

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[2] Methadone 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.

[3] Oxycodone, brand name OxyContin, 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.

12. Patient A was previously seen in January of 2013 and it was also noted at that time that he had a positive urine toxicology screening in November of 2012 but the Respondent agreed to continue to prescribe pain medications until the patient could be seen at a pain clinic. Patient A was also prescribed Ambien[4] at that visit. Patient A had previously had both physical therapy and epidural injections, neither of which were helpful for his pain. Respondent did order back brace and a TENS unit per patient A's request and also referred the patient to physical therapy again in October 2014.

13. The CURES report shows Respondent was prescribing patient A the following controlled substances on a regular basis: methadone 10 mg #240 per month December 2012 through August 2013, then #120 per month until January 2016; oxycodone 30 mg #240 per month December 2012 through August 2013, following this #180 per month until January 2016; Oxycontin[5] 80 mg, #90 per month, September 2013 through January 2016; Alprazolam (Xanax)[6] 2 mg #90 per month-prescribed by other physicians from 2011 through 2015, then by the Respondent beginning in March 2015, #60 per month.

14. Patient A had two controlled substance agreements on file signed by other providers within Ampla Health dated March 2011 and November 2012. There is a notation on March 17, 2015 in the chart that patient A filled out an agreement that date with Respondent but there is no agreement on file. There are two unsigned versions in the medical record.

15. Patient A consulted with a number of surgeons over the time period reviewed, although the patient A did not have any further interventions or surgeries from 2013 through 2015. At least two surgeons saw patient A and did not feel that he was a candidate for further

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[4] Zolpidem, brand name Ambien, 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.

[5] Oxycodone, brand name OxyContin, 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.

[6] Alprazolam is a benzodiazepine. Alprazolam affects chemicals in the brain that may be unbalanced in people with anxiety. Alprazolam is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam 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.

surgery and should be managed medically. Patient A was initially on Methadone and Oxycodone when Respondent began seeing him.

16. In October of 2013, the Respondent added Oxycontin (long-acting oxycodone) in addition to the Methadone and oxycodone in hopes of eventually discontinuing the Methadone, which was never done. Respondent discussed the case with a Tele-health pain specialist who recommended urine toxicology screenings. Patient A was referred to the Chico pain clinic in February 2013 although it appears he never went. Respondent let the patient know about a pain clinic in January of 2015 but made no official referral and again the patient A was not seen elsewhere for pain management. Respondent again recommended referral in May 2015 and September 2015 but the patient declined.

17. Patient A had five urine toxicology screenings during between November 2012 and September 2015.

18. On November 1, 2012, patient A had a toxicology screening ordered by a Nurse Practitioner. Patient A tested positive for oxycodone, marijuana, hydrocodone[7], amphetamine[8] and methamphetamine and negative for Xanax (alprazolam). Patient A's urine contained Methadone metabolites but not Methadone (indicating Methadone at either very low doses or taken a few days prior). Respondent noted "Failed testing. No more narcotics letter."

19. On November 28, 2012, patient A had a toxicology screening ordered by another Physician at Ampla. Patient A tested positive for opiates, morphine[9], oxycodone, Methadone, alprazolam, amphetamines and methamphetamine. At the time patient A was being prescribed Kadian[10] and Oxycodone.

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[7] Norco (acetaminophen and hydrocodone) is used to relieve moderate to severe pain. Norco (hydrocodone) 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.

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

[9] Morphine 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.

[10] Morphine sulfate (Kadian) is an analgesic opiate agonist used for relief of moderate to severe acute and chronic pain. Morphine is a dangerous drug as defined in section 4022, a

20. On December 12, 2013, patient A had a toxicology screening ordered by Respondent which was positive for morphine, hydrocodone, hydromorphone[11], norhydrocodone[12], oxycodone, oxymorphone[13] and noroxycodone[14] and negative for Methadone, benzodiazepines and amphetamines. Respondent made a handwritten notation to discuss it with Patient A the next visit. Patient A was next seen by the Respondent on January 10, 2014, and the urine toxicology results were not noted or discussed at that visit. Patient A was being prescribed Methadone, oxycodone and OxyContin at the time by the Respondent, as well as Xanax by the patient's psychiatrist.

21. On June 4, 2014, patient A had a toxicology screening ordered by Respondent which was negative for oxycodone, Oxycontin, Norco and Methadone, all of which Patient A was reportedly prescribed and positive for oxymorphone (a metabolite of oxycodone). The sample was negative for benzodiazepines and methamphetamine. No notations are made on the results but Respondent discussed this at the visit on July 2, 2014, and noted that patient A ran out four days prior to the test, although it should have been detectable for up to two weeks. Respondent continued to prescribe the same medication regimen including Oxycontin, oxycodone and Methadone at the same dosage and amounts. Respondent noted patient A would need some serial drug screens for the next several visits. Patient A's next drug screen was not ordered until September of 2015, approximately 14 months later.

22. On September 3, 2015, patient A had a toxicology screening ordered by Respondent which was positive for Methadone, alprazolam, oxymorphone, noroxycodone, and negative for OxyContin and oxycodone. Patient A was being prescribed oxycodone, OxyContin, Methadone and Xanax (alprazolam) at the time. This was not addressed by the Respondent.

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schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055(b)(1), and a Schedule II controlled substance as defined by section 1308.12(b)(1) of Title 21 of the Code of Federal Regulations.

[11] Hydromorphone, brand name Dilaudid, 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.

[12] Norhydrocodone is the major metabolite of the opioid analgesic hydrocodone.

[13] Oxymorphone 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.

[14] Noroxycodone is the major metabolite of the opioid analgesic oxycodone.

23. On December 19, 2012, patient A had an magnetic resonance imaging (MRI) ordered by Respondent with stable post-surgical changes and very mild canal stenosis at L3-4 and right neural foraminal stenosis at L4-5 and L5-S1. Patient A had a nerve conduction study performed on July 20, 2012, which was normal.

24. Respondent repeatedly states in patient A's medical notes that the controlled substance dosages were high and it is a goal to bring them down yet continued to prescribe the same dosages and amounts of opiates for three years.

25. On December 12, 2013, July 2, 2014, September 2, 2014, and October 1, 2014, patient A reported losing half a bottle of oxycodone down the sink.

26. On September 2, 2014, patient A reported withdrawal symptoms when he ran out of medications early.

27. On December 15, 2015, the patient had his last visit with Respondent. Respondent's chart notes indicate that patient A "is going to be referred to Oroville Pain Institute. I [Respondent] feel compelled to continue his current med doses at this time - he cannot tolerate decreasing the pain med doses at this time. Patient again states half his oxycodone bottle spilled into a sink and was damaged. The patient is in such a distressed mental state I am not going to argue with him out of fear he might harm himself." Respondent prescribed an extra two week bridging script of #90 oxycodone; and gave double script for oxycodone 6/day #180 and Methadone #120. Respondent referred patient A to tele-health psychiatry and prescribed Xanax (alprazolam) #60 plus 1 refill.

28. Over the three years of care, Respondent never addressed the possibility patient A having a substance abuse addiction or opiate dependence disorder and never considered the possibility that patient A was diverting his medications, even though patient A had a number of inconsistent urine toxicology results. No Electrocardiography (EKG) was ever performed and no mention was ever made regarding smoking cessation or vaccinations during the course of care.

29. Respondent committed gross negligence in his care and treatment of patient A, which included, but are not limited to, the following:

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(a) Paragraphs 9 through 28, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by prescribing two long-acting medications at a time, prescribing extremely high doses of opiates without good medical justification or informed consent, and without standard monitoring with CURES reports or more routine urine toxicology studies in a patient with known mental health issues and substance use; and

(c) Respondent departed from the standard of care by not addressing the patient's illicit substance use, not screening for or identifying Opiate Use Disorder, and continuing to prescribe high-dose high-risk narcotics even in light of inconsistent toxicology results.

Patient B

30. Patient B is a female born in 1971 with uncontrolled insulin-dependent diabetes, chronic back pain, carpal tunnel syndrome, asthma, bipolar disorder, anxiety, obesity, severe hypertension and a history of alcoholism. The Respondent saw the patient every two to three months from January 2013 through July of 2015 for treatment of her chronic pain issues, as well as her diabetes and hypertension. Respondent typically wrote prescriptions enough for two months at each visit.

31. The CURES report shows Respondent was prescribing patient B the following controlled substances on a regular basis: Oxycontin 80 mg #90 per month beginning January 2013, increased to #180/month in March 2013, stopped in October of 2013; Oxycodone 30 mg #180 per month beginning in November 2013, decreased to #90/month in March of 2014, stopped November 2014 when Hydromorphone was started; Hydromorphone (Dilaudid) 8mg #120 per month November 2014 through July 2015; Methadone (Dolophine)10 mg #180 per month January 2013, then increased to #240 per month in April 2013, increased to #270 in February 2014 and continued until September, 2015; Lorazepam (Ativan)[15] 2mg #30 January 2013,

[15] Lorazepam (generic name for Ativan) is a benzodiazepine used in the treatment of anxiety, insomnia, and status epilepticus. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance as defined by Health and Safety Code section 11057(d), and a Schedule IV controlled substance as defined by section 1308.14(c) of Title 21 of the Code of

increased to #60 per month November 2013; Clonazepam (Klonopin)[16] 1mg January 2014 #60 through July 2014; and Tramadol (Ultram)[17] 50 mg #150 per month starting in October 2, 2014, increased to #180 per month in November 2014 and continued until January 2016. Respondent prescribed the pain medications as above for chronic lumbar pain and bilateral carpal tunnel syndrome.

32. On December 20, 2012, patient B had an MRI of her lumbar spine which revealed mild degenerative changes in the lumbar spine and mild right neuroforaminal narrowing at 14-5. Respondent recommended that patient B see Dr. W, a pain interventionist, in the fall of 2014, however the patient canceled the referral. Patient B was also referred to physical therapy in 2014 as well as tele-psychiatry for her anxiety and depression, although it is unclear if these referrals were ever carried out. Respondent noted at the visit on February 21, 2013, that the MRI does not explain very well the degree of narcotic medication that she needs, yet Respondent continued to prescribe her relatively high dose opiates.

33. Patient B's physical examinations were repeated verbatim at the visits on October 29, 2014, January 19, 2015, March 13, 2015 and July 8, 2015 other than the vital signs which varied slightly. Most included no musculoskeletal examination whatsoever. A different template was used and repeated verbatim on July 10, 2013, September 4, 2013, October 1, 2013, October 28, 2013, November 25, 2013, December 17, 2013, January 5, 2014, February 9, 2014, march 14, 2014, June 10, 2014 and September 3, 2014. These noted only palpable tenderness of the lumbar spine with no assessment of the range of motion of the spine, any radicular symptoms or neurologic examination and over the three years of care, patient B's hands or wrists were never examined in regards to her carpal tunnel syndrome.

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Federal Regulations.

[16] Clonazepam 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.

[17] Tramadol is a narcotic-like pain reliever. Tramadol is used to treat moderate to severe pain.

34. In patient B's medical chart there is one Controlled Substance Agreement on file signed and dated on May 19, 2011, by another provider. There are no CURES reports included or mentioned in the medical record.

35. In April 2013, Respondent increased patient B's Methadone dosage from 20 mg three times a day to 20 mg four times a day for no reason other than patient B requested an increase.

36. On November 25, 2013, Patient B had a toxicology screening ordered by Respondent which was positive for oxycodone and Methadone and negative for benzodiazepines. Patient B was prescribed oxycodone, Methadone and lorazepam at the time.

37. In January 2014, Respondent began to prescribe clonazepam in addition to lorazepam with no explanation. This was continued until July of 2014.

38. On June 10, 2014, patient B had a toxicology screening ordered by Respondent which was positive for opiates oxycodone and oxymorphone and negative for the expected noroxycodone (an oxycodone metabolite), Methadone, and benzodiazepines. Patient B was prescribed Methadone, oxycodone, lorazepam and clonazepam at the time. The discrepancy was never addressed by Respondent. At the visit, patient B reported she was so tired and was standing in kitchen and fell backwards hitting her head and buttocks.

39. At the visit in September 2014, patient B reportedly lost all three of her Controlled Substance medications and needed an early refill. Patient B was informed of pain contract policy of no replacements and was given a second chance by Respondent. The Respondent provided early refills of all three medications.

40. On September 9, 2014, patient B had one EKG performed and patient B had a corrected QT interval of 469 ms (normal <450 ms) and some minor other changes. Respondent referred patient B to a cardiologist although it is unclear if she ever saw one. Patient B had one set of laboratory studies performed on September 26, 2013 significant for elevated triglycerides of 438, low HDL 37, elevated total cholesterol 206, Glycohemoglobin 13.4%, random glucose 385, normal renal and kidney function, and no anemia or evidence of infectious diseases including HIV, syphilis, and hepatitis. There is no documentation that these results were ever reviewed with patient B. Over the course of the over two years of care, patient B never had a pelvic examination,

referral to an eye doctor, neurologic evaluation for neuropathy, or microalbumin level ordered by Respondent.

41. At the visit on October 29, 2014, Respondent started prescribing Tramadol in addition to patient B's other narcotic pain medications. There is no documented reason in the chart notes. Respondent continued to prescribe Tramadol until the end of 2015.

42. In November of 2014, patient B requested a change from oxycodone to hydromorphone (Dilaudid) and Respondent complied with her request with no medical reason or documentation.

43. On July 8, 2015, patient B had a toxicology screening ordered by Respondent which was negative for opiates (including hydromorphone and tramadol which were being prescribed), and positive for Methadone, lorazepam and amphetamines including methamphetamine. At this point patient B was sent a letter from the administration that she would receive no more narcotics from Ampla health.

44. On September 4, 2015, Respondent wrote prescriptions for Methadone, Tramadol and Dilaudid (hydromorphone) and per the CURES report patient B continued to fill Tramadol and Lorazepam from Respondent until January 1, 2016, and December 27, 2014 respectively.

45. Respondent prescribed patient B multiple courses of anti-fungal medications for vaginal itch on April 17, 2013, January 15, 2014, February 9, 2014, March 14, 2014, and May 8, 2014, without ever examining the patient's genitalia. Respondent prescribed patient B multiple courses of antibiotics for sinusitis and bronchitis although at most of these visits the physical examination was normal or noted only mild sinus tenderness without fever. These included azithromycin for bronchitis on January 29, 2013, Levaquin for severe sinusitis on March 6, 2013, even though no sinus examination was performed, Levaquin for bronchitis on October 28, 2013, Cipro for possible bacterial sinusitis on December 17, 2013, Levaquin for cough with yellow phlegm on January 5, 2014, Cipro for sinusitis on March 14, 2014, Levaquin on March 13, 2015 for chronic bronchitis although the lung examination was normal.

46. Respondent committed gross negligence in his care and treatment of patient B, which included, but are not limited to, the following:

(a) Paragraphs 30 through 46, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by prescribing high doses of opiates without good medical justification or indication, nor informed consent, and without standard monitoring with CURES reports or appropriate management of urine toxicology findings in a patient with a known substance abuse history.

Patient C

47. Patient C is a male born in 1959 and presented with coronary artery disease, hypertension, asthma, and was seen regularly by the Respondent for chronic back and knee pain related to a prior fall and knee surgeries. Patient C saw an orthopedic surgeon Dr. B. in Redding, CA, as well as a cardiologist. He eventually had a repeat right knee replacement in November 2015 which went well. In November of 2015 he was referred to a pain clinic because he was taking an excess of opiates. Patient C had intermittent issues with edema. Patient C was on Methadone, oxycodone and MS Contin[18] for knee and spine pain when the Respondent began seeing him in December 2012. Respondent did not have a pain agreement on file with patient C.

48. The CURES report shows Respondent was prescribing patient C the following controlled substances on a regular basis: MS Contin (Morphine) 100mg #90 per month December 2012, increased to #120 per month in July 2013, decreased to #60 per month in October 2013, last filled October 16, 2015; Oxycodone 30mg #90 per month December 2012, increased to #120 per month in July 2013, increased to #150 per month in July 2015 through November 2015; Methadone 10mg #270 per month December 2012, increased to #360 per month in May, 2013 through November 2015; Valium (diazepam)[19] 10mg #30 per month March 2013 through

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[18] Morphine sulfate (generic name for MS Contin) is an analgesic opiate agonist used for relief of moderate to severe acute and chronic pain. Morphine is a dangerous drug as defined in section 4022, a schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055(b)(1), and a Schedule II controlled substance as defined by section 1308.12(b)(1) of Title 21 of the Code of Federal Regulations.

[19] Diazepam (Valium) is a benzodiazepine used in the treatment of anxiety, muscle spasms, and seizures. It is a dangerous drug as defined in section 4022, a schedule IV controlled substance as defined by Health and Safety Code section 11057(d), and a Schedule IV controlled substance as defined by section 1308.14(c) of Title 21 of the Code of Federal Regulations.

October 2015; Androgel (testosterone)[20]; and Phentermine[21] #30 per month intermittently for weight loss from February 2014 through April 2015.

49. The CURES report shows Respondent was prescribing patient C the following non-controlled substances on a regular basis: Nexium (esomeprazole)[22]; Lasix (furosemide)[23] a diuretic usually prescribed for heart failure and edema; Lopressor (metoprolol tartrate)[24] for blood pressure, heart disease, and potassium replacement; Advair and ProAir[25] inhalers for breathing problems; and nitroglycerin for heart disease. Patient C completed a few physical therapy visits for his knee pain in early 2015.

50. Most of patient C's History of Present Illness sections of his medical records state he only "comes to clinic today to continue the following medications". Patient C's Physical examination portion in his medical record is often repeated verbatim from visit to visit.

51. In patient C's medical records there are two pain management agreements on file that are initialed but not dated or signed.

52. In patient C's medical records there was only one urine toxicology test performed on July 8, 2015, ordered by the Respondent which was positive for oxycodone, morphine, and Methadone, as well as codeine, nordiazepam[26], temazepam[27] and oxazepam[28]. There is a

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[20] Androgel is used to treat conditions in men that result from a lack of natural testosterone.

[21] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant.

[22] Nexium (esomeprazole magnesium) is a proton pump inhibitor (PPI) that blocks acid production in the stomach and is used to treat stomach and duodenal ulcers, gastroesophageal reflux disease (GERD), and Zollinger-Ellison syndrome.

[23] Lasix (furosemide) is used to reduce extra fluid in the body (edema) caused by conditions such as heart failure, liver disease, and kidney disease.

[24] Lopressor (metoprolol tartrate) is a prescription drug used to treat high blood pressure, angina, abnormal rhythms of the heart, and some neurological issues.

[25] Albuterol (Advair and ProAir) is used to prevent and treat wheezing and shortness of breath caused by breathing problems (such as asthma, chronic obstructive pulmonary disease).

[26] Nordiazepam is the major metabolite of the benzodiazepine diazepam.

[27] Temazepam is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. Temazepam is used to treat insomnia.

[28] Oxazepam is a short-to-intermediate-acting benzodiazepine. Oxazepam is used for the treatment of anxiety and insomnia and in the control of symptoms of alcohol withdrawal syndrome. It is a metabolite of diazepam, prazepam, and temazepam, and has moderate amnesic, anxiolytic, anticonvulsant, hypnotic, sedative, and skeletal muscle relaxant properties compared to other benzodiazepines.

handwritten notation written by Respondent indicating he was going to discuss the results with patient C on the next visit.

53. On December 4, 2013, patient C was given a lab order for serum testing for morphine and oxycodone quantitative measurements, and another on September 11, 2014 for serum Methadone measurement. These lab orders were never performed. No CURES reports were obtained or referenced during the time period that the Respondent was seeing patient C.

54. In March of 2013, the Respondent began to prescribe Valium because patient C wanted to add diazepam at bedtime for muscle spasms in his leg. Respondent did not conduct an examination of patient C's legs or back. Respondent does not mention any existing muscle spasm. Respondent did not document that he counseled patient C regarding the added risks of benzodiazepines in combination with high-dose opiates.

55. On May 10, 2013, Patient C's chart note stated that the patient needed Ameritox urine screening and CURES review yet these were never done. At this visit, the Methadone was increased from 30 mg three times daily to 40mg four times a day reportedly because of continued pain. Respondent did not provide any other medical justification for the increase and the following visits made no notation of any improvement or change in function related to the increased dose.

56. On September 10, 2013, Respondent increased patient C's oxycodone from #90 to 120 per month in anticipation of starting physical therapy. Respondent noted that on patient C's next visit he would discuss patient C giving up the oxycodone again and that he needed Ameritox and CURES review. Respondent did not follow up with patient C as planned.

57. In May of 2014, patient C had a consultation with a tele-medicine pain specialist. The specialist felt that the patient C was taking too much pain medication and recommended that Respondent begin to wean down patient C's Methadone, especially given his cardiac history. The specialist also recommended a sleep study, adding tizanidine[29] at night to replace Valium and to complete urine toxicology screenings at every visit. Respondent encouraged patient C to decrease

[29] Tizanidine is used to treat muscle spasms caused by certain (such as multiple sclerosis, spinal cord injury). It works by helping to relax the muscles.

the Methadone to 30mg three times a day yet continued to prescribe the higher dose and patient C never weaned down. Patient C also did not have a urine toxicology screening again for another year and continued to receive Valium regularly. No sleep study was ever performed on patient C and he continued to receive the same doses of pain medications and Valium over the next 18 months. Only one urine toxicology screening was ever performed on patient C which was in June of 2015.

58. On December 31, 2013, patient C reported medications were stolen and that a police report was made. Patient C requested refills a week early.

59. On September 1, 2015, patient C reported a stolen prescription of Methadone. No police report was noted or requested. Per the CURES report, patient C filled Methadone prescriptions on August 8, #360, September 1, 2015, #84 and September 10, 2015, #360. At that visit patient C also reported falling down a set of stairs.

60. In October of 2013 patient C was hospitalized after a fall and the admission summary noted that patient C stated he often falls about every two weeks when catching his right foot on the carpet at home. The emergency room physician advised patient C to stop his Methadone or oxycodone given his concern regarding the high doses and frequent falls. The emergency room physician noted in the hospital summary that he was concerned that patient C's high-dose narcotics may be contributing also to his falls. This notation was coped to the Respondent and included in the patient's medical chart.

61. For most of 2014 patient C repeatedly postponed his knee surgeries. Patient C continued to take high doses of opiate narcotics which were never changed by Respondent even after the pain specialist's recommendations. Respondent noted in patient C's medical record that he could not decrease the doses because patient C did not want to decrease the dosage at that time. Respondent did not provide medical justification or note change in patient C's medical condition or function. Respondent repeatedly put in his notes "refer to tele-medicine pain" yet never complied with any of their recommendations.

62. Patient C's medical records do not show that laboratory studies nor orthopedic or other consultations were provided. There is only one mention of laboratory studies in the chart

notations on June 17, 2015, where Respondent notes low iron, normal blood sugar, normal BUN/creatinine (kidney function), normal CBC, urinalysis normal and Vitamin D was low at 23. Patient C had two EKGs on file on March 10, 2015, and June 17, 2015. Patient C's corrected QT intervals[30] were normal and the EKGs revealed only some old QRS[31] changes.

63. Respondent also prescribed Androgel repeatedly throughout his treatment of patient C although he never discussed this in the notes. There is no indication for this nor any documentation of the associated side effects, risks or efficacy to patient C. Respondent also prescribed phentermine on a number of occasions for weight loss again without any real mention of discussion of the medication's purpose, risks or side effects other than a mention that his cardiologist cleared patient C to use the medication. Respondent did not discuss vaccines or any cholesterol or prostate examination or testing with patient C.

64. Respondent committed gross negligence in his care and treatment of patient C, which included, but are not limited to, the following:

(a) Paragraphs 47 through 63, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by prescribing two long-acting opioid medications at a time, prescribed extremely high doses of opiates without good medical justification or informed consent, and without standard monitoring with CURES reports or routine urine toxicology studies even after clear guidance from a pain specialist.

Patient D

65. Patient D is a female born in 1953 with a history of fatty liver, hiatal hernia, recurrent blood clots on chronic blood thinners, chronic back and neck pain with sciatica, anxiety, depression and bowel issues. Patient D saw the Respondent regularly from August of 2013

[30] A QT interval is a measure of the time between the start of the Q wave and the end of the T wave in the heart's electrical cycle. The QT interval represents electrical depolarization and repolarization of the ventricles. A lengthened QT interval is a marker for the potential of ventricular tachyarrhythmias like torsades de pointes and a risk factor for sudden death.

[31] The QRS complex is a name for the combination of three of the graphical deflections seen on a typical electrocardiogram (EKG or ECG). It is usually the central and most visually obvious part of the tracing.

through February 2016. Patient D is a non-smoker, was not working because of her pain issues and denied alcohol use. She had gastric bypass surgery in 1978.

66. Most of patient D's History of Present Illness sections report only that the patient is being seen for medication refills. Patient D's medical records never mention symptoms of thyroid disease, anxiety or depression, or occasional mentions of diarrhea. Patient D had a body mass index (BMI) of 32-34 (obese) and normal blood pressures. Most of patient D's physical examinations are copied verbatim from visit-to-visit. The only musculoskeletal examinations are statements such as palpable tenderness of the lumbar spine. No neurologic examination, thyroid examination or comments on patient D's affect are included in the two and a half years she was treated by the Respondent. Patient D's diagnoses related to her pain typically included chronic severe lumbago, cervicalgia and for her benzodiazepines, the diagnosis of anxiety was used.

67. Patient D's CURES report and pharmacy records reveals Respondent was prescribing the patient the following controlled substances on a regular basis: Phentermine #30 per month August 2013 until July 2015 to prevent obesity; Norco (hydrocodone bitartrate-acetaminophen) 10-325 #90 per month August 2013, increased to #180 per month in October 2014, prescribed regularly until January 2016; Fentanyl[32] 100mcg/hr #20 per month, August 2013 until July 2014 when it was decreased to #10 per month; prescribed regularly until January 2016; Soma (carisoprodol[33]) 350mg #90 per month August 2013 until October 2014; Diazepam (Valium) 10mg #60 per month August 2013 until December 2015; and Temazepam (Restoril) 30mg #30 per month October 2013 until March 2015.

68. Patient D's CURES report and pharmacy records reveals Respondent was prescribing patient D the following non-controlled substances on a regular basis: Gabapentin (Neurontin) and pregabalin (Lyrica) for pain; Duloxetine (Cymbalta) for depression; Levetiracetam (Keppra) for epilepsy; Levothyroxine thyroid supplementation 175 mcg per day;

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[32] Fentanyl, brand name Duragesic, 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.

[33] Soma is the brand name for Carisoprodol, a Schedule IV controlled substances pursuant to 21 C.F.R. § 1308, and a dangerous drug pursuant to Business and Professions Code section 4022.

Cyclobenzaprine (Flexeril) a muscle relaxant, beginning in 2015; Warfarin (Coumadin) a blood thinner to prevent blood clots, monitored at a separate Coumadin clinic; Diphenoxylate/Atropine (Lomotil) for diarrhea; Ondansetron (Zofran) for nausea; Omeprazole and Nexium (esomeprazole) for gastritis; Trazodone for sleep for a short time; and Pramipexole (Mirapex) for restless legs.

69. In patient D's medical records there is one controlled substance agreement on file dated 2005 with another provider. In patient D's medical records there are a few notations stating patient C was aware of the risks of her high dose fentanyl and she assumed the risks.

70. On August 1, 2013, Patient D had a toxicology screening ordered by Respondent. At the time, patient D was prescribed Fentanyl, Soma, Vicoden and Diazepam and per CURES report was filling these. Patient D's was negative for Vicoden and Diazepam and positive for Fentanyl and Soma. The result of patient D's test is initialed by Respondent. Respondent considered this a pass as it did not contain any illicit substances.

71. On December 2, 2013 a serum Fentanyl test was performed patient D which was positive for Fentanyl and the metabolite norfentanyl.[34]

72. On June 10, 2014, patient D had a toxicology screening ordered by Respondent. Patient D was being prescribed Norco, Fentanyl, Phentermine, Soma, diazepam and temazepam at the time. Patient D's test was positive for Norco, Fentanyl, Soma, morphine, temazepam, amphetamines and metabolites of diazepam. Morphine was detected and not prescribed and is not a metabolite of any of her prescribed medications. Respondent's chart notations state that patient D passed her drug screen.

73. On August 7, 2015, patient D had a toxicology screening ordered by Respondent which was positive for fentanyl, hydrocodone, temazepam and diazepam metabolites and negative for amphetamines. There is a handwritten note from Respondent stating discuss next visit. At the time the Respondent was prescribing Norco, Phentermine, Diazepam, and Fentanyl. Per the CURES report, the last temazepam prescription was filled by patient D was filled in March 2015.

[34] Norfentanyl is a metabolite of fentanyl.

74. From August of 2013 through February 2016, no lumbar x-rays or MRIs, Pap smears, mammograms, hepatitis C testing, colon cancer screening or immunizations were ever ordered for or discussed with patient D.

75. Patient D saw Respondent approximately every two months, mostly for refills of medications. Over the course of Respondent's care from 2013 to 2016, no imaging studies were ever performed of the patient D's low back nor any referenced from previous providers, nor any referrals to physical therapy or any orthopedic or neurosurgeons.

76. On December 30, 2013, Respondent ordered a pain consult with Dr. P. Patient D claimed she lost the appointment and the consultation was ever completed. Patient D was seeing a psychiatry nurse practitioner who repeatedly recommended decreasing benzodiazepine use and in her notations states she discussed this with the Respondent. The psychiatry nurse practitioner recommended that Respondent refer patient D for psychotherapy to help with her anxiety, depression and insomnia.

77. Patient D was hospitalized in June 2014 for seizures and low magnesium levels. At the visit on July 10, 2014 following this hospitalization, patient D agreed to decrease her Fentanyl dose from 200 mcg/h to 100 mcg/hour. Following this, there was no reported change in patient D's pain levels or functioning, even though her opioid dose was cut by half. At discharge from the hospital, patient D was also advised to discontinue her Phentermine but she declined to do so.

78. Patient D's medication regimen changed little over the course of care. Her Norco was increased from 90 to 180 tablets per month in October 2014. This was not specifically discussed in patient D's chart notations but is around the time that her fentanyl dosing was cut in half. Patient D did stop Soma in October of 2014 and was eventually started on the muscle relaxant Flexeril (cyclobenzaprine) in 2015. Patient D was on two benzodiazepines diazepam and temazepam between October 2013 and March 2015 and diazepam alone during the other time periods reviewed. Other than the one-time decrease in the fentanyl dose, no other efforts were made to attempt to decrease Patient D medications or attempt other treatment modalities.

79. On May 6, 2015, patient D was seen by Respondent and reported withdrawal symptoms if she did not take her Fentanyl. Patient D also insisted Respondent prescribe

temazepam in addition to her diazepam. Respondent notified the patient of the risk of breathing problems and noted patient says she is not concerned about that and assumed the risk. Patient D also requested Phentermine that she had been taking for years to prevent obesity after having gastric bypass surgery.

80. Respondent committed gross negligence in his care and treatment of patient D, which included, but are not limited to, the following:

(a) Paragraphs 65 through 79, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by prescribing high doses of opiates without any objective evidence of pathology, without standard monitoring with CURES reports nor a documented Controlled Substances Agreement, and without considering safer alternatives or that the patient had an Opiate use disorder.

Patient E

81. Patient E is a female born in 1975 who saw the Respondent regularly from July 2012 through November 2015. Patient E had a number of health issues including chronic neck and back pain, migraines, obesity, bipolar illness, hypertension, reported narcolepsy, attention deficit disorder and sleep apnea with the use of a continuous positive airway pressure (CPAP) machine. Patient E was originally seen by a pain specialist at Feather River Clinic and was on Methadone, Norco and Soma for chronic neck pain. Patient E failed a drug screen there and they were no longer willing to prescribe her pain medications, so she presented to the Respondent for medication refills in 2012. Patient E reported at the first visit with the Respondent that the illicit drugs detected at Feather River were a one-time thing after going to a swingers' club. Patient E reported using medical marijuana and the Respondent notified patient E that if she continued this, she would need to bring in a copy of her medical marijuana card which she never did.

82. Patient E saw Respondent approximately every one to two months for refills of medications for pain, narcolepsy and attention deficit hyperactivity disorder (ADHD). Respondent's notes alternate between cervical and lumbar pain as the diagnosis and indication for pain medications. Most of Patient E's History of Present Illness sections report only "here to

continue medications" or "follow up L-spine pain..." with little or no other reports of the patient E's symptoms, function, response to medications, or side effects. In Patient E's medical record there is no mention of spasms, mood changes, mania symptoms or symptoms related to concentration or attention. Most of the physical examinations are scant and include vital signs with BMI of 35 indicating obesity and occasional elevations in blood pressure of up to 190/100. The only musculoskeletal examinations are repeated verbatim from visit-to-visit and state tenderness on palpation of lumbar spine and occasional notation of tenderness over the cervical spine. The only evaluation of the range of motion was performed at the initial visit on July 10, 2012, when Respondent notes patient E's forward flexion at the waist is limited to about 40 degrees. There is no evaluation of the patient E's affect or mental status other than Respondent noting she is alert and "oriented x 3". No neurological examination was ever given to patient E.

83. Respondent repeatedly discussed ordering an MRI of patient E's cervical spine and referring the patient to an interventionist pain specialist. Neither of these were ever completed.

84. Respondent refilled the medication Provigil (modafinil) regularly for narcolepsy. In patient E's medical records there is no discussion of this other than the patient self-report of the diagnosis and the report that she needed the medication to stay awake. There is no indication of a sleep study or sleep specialist evaluation ever being requested or reviewed by the Respondent. Respondent refilled patient E's prescription for amphetamine salts (Adderall) on a regular basis for ADHD. None of patient E's History of Present Illness sections ever comment on symptoms of decreased attention or concentration and no attention deficit symptoms scales are included nor referenced. Respondent treated Patient E for depression and bipolar disorder. In patient E's chart notes Respondent never discusses the patient's symptoms and there was no discussion regarding patient E's symptoms of mania. Respondent ordered tele-health psychiatry evaluations on a number of occasions but it appears this was never performed.

85. Patient E's CURES report and pharmacy records reveals Respondent was prescribing patient E the following controlled substances on a regular basis: Methadone 10mg #270 per month beginning July 2012 and prescribed until December 2015; Amphetamine salts (Adderall) for Attention Deficit disorder 30mg #120-150 per month beginning July 2012 and prescribed until

December 2015; Soma (carisoprodol) 350mg #30 per month, beginning July 2012, increased to #60 per month in September 2013, prescribed until October, 2014; Modafinil (Provigil)[35] 200mg #60 per month beginning August, 2012, decreased to #30 per month in June 2015 and continued until September 2015; and Hydrocodone-acetaminophen 10-500 #120 per month beginning September 2013 until December 2015. No CURES reports were included or referenced in the medical record. One Controlled Substance agreement is included but it is not dated or signed.

86. Patient E's CURES report and pharmacy records reveals Respondent was prescribing the patient the following non-controlled substances on a regular basis: Ibuprofen 600 alternating with Naproxen[36] 500 mg for back pain; Topamax (topiramate)[37] and Nadolol[38] for migraine prophylaxis and blood pressure control; Sumatriptan[39] for migraine treatment; Promethazine[40] 25 mg up to 4 times a day #120 at a time for nausea; Chantix for smoking cessation; of note there is no documentation regarding the potential psychiatric side effects when this was started on August 20, 2014; Abilify 2mg for bipolar disorder; Paroxetine (Paxil)[41] and Pristiq off and on for depression; Baclofen[42] prescribed in October 2014 when he stopped prescribing Soma; the patient stopped this after two months.

87. On August 8, 2012, patient E had a toxicology screening ordered by another provider while she was prescribed Methadone, Adderall, Soma, and Modafinil. The test was negative for Soma, Norco (hydrocodone), and amphetamine salts and positive for Methadone. There is no

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[35] Modafinil (Provigil) is a medication to treat sleepiness due to narcolepsy, shift work sleep disorder, or obstructive sleep apnea.

[36] Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) of the propionic acid class that relieves pain, fever, swelling, and stiffness.

[37] Topamax is the brand name of topiramate, an anticonvulsant drug used to prevent seizures and reduce the frequency of migraines.

[38] Nadolol is a non-selective beta blocker used in the treatment of high blood pressure and chest pain.

[39] Sumatriptan is a medication used for the treatment of migraine headaches. It is a synthetic drug belonging to the triptan class.

[40] Promethazine is used to treat several conditions, including allergies, motion sickness, nausea and vomiting, anxiety before surgery, and pain after surgery.

[41] Paxil (paroxetine) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be unbalanced in people with depression, anxiety, or other disorders.

[42] Baclofen acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or spinal cord diseases. It also relieves pain and improves muscle movement.

review or discussion of the results at the following visit. However, at the next visit on November 2, 2012, the Respondent noted that patient E had Ameritox[43] done in August of 2012 and she passed that Ameritox screen. However, patient E was being prescribed Soma and Adderall yet these were not detected.

88. On February 3, 2012, an MRI of patient E's lumbar spine was performed which revealed multilevel degenerative disc problems and neuroforaminal narrowing with mild to moderate spinal stenosis at L4-5.

89. Respondent ordered labs for patient E in January 2013 and December 2014 but they were never done.

90. On October 23, 2013, Respondent ordered a lumbar spine X-ray which was never performed. Respondent ordered physical therapy but patient E declined because she had it in the past and it worsened her pain.

91. On May 20, 2014, patient E had a toxicology screening ordered by Respondent. The test was positive for Soma, Methadone, norhydrocodone (a metabolite of hydrocodone indicating usage in the last 72 hours) and negative for amphetamine salts. At the time patient E was being prescribed Adderall which should have been detected; this was never addressed or discussed.

92. Patient E's arthritis panel on March 11, 2015, was significant for elevated C-reactive protein (CRP)[44] and sedimentation rate and this was never addressed by Respondent.

93. On May 8, 2015 patient E reported running out early of her medications and took her husband's Dilaudid. The Respondent decided to give her a second chance.

94. On November 30, 2015, patient E reportedly washed her Methadone script in the washer. Per CURES, she filled prescriptions for #270 Methadone on October 2, October 30, November 30 and December 29, 2015.

95. Respondent ordered a cervical spine MRI and sleep study repeatedly for patient E and these were never performed. Other than urine testing and one arthritis panel, no laboratory studies

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[43] Ameritox was a company that provided physicians with urine drug monitoring and reporting services.

[44] C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation.

were ever performed. No EKGs, Pap smears or immunizations were ever performed on patient E or discussed by Respondent.

96. Respondent committed gross negligence in his care and treatment of patient E, which included, but are not limited to, the following:

(a) Paragraphs 81 through 95, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care by prescribing high doses of opiates without insisting on safer alternatives or compliance with recommendations for specialist evaluations, without standard monitoring with CURES reports, routine drug testing, nor a documented controlled substances agreement, and without considering safer alternatives or that the patient had an Opiate use disorder.

97. Respondent's conduct, as described above, constitutes gross negligence in the practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to discipline Respondent's license.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

98. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated acts of negligence in his care and treatment of patients A, B, C, D, and E.

Patient A

99. Paragraphs 9 through 28 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

100. Respondent committed acts of repeated negligence in his care and treatment of patient A, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by not offering adequate medical justification for prescribing Methadone, especially in conjunction with another long-acting narcotic. Also, Respondent did not monitor the patient's EKG nor take into consideration

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the potential for QT prolongation with the patient's other medications represents a lack of knowledge; and

(b) Respondent departed from the standard of care by not adequately assessing the patient's anxiety symptoms, not offering safer alternatives to benzodiazepines, and prescribing relatively large quantities of benzodiazepines to a patient on high-dose opiates with a history of depression, potential suicidality and known substance abuse issues and inconsistent toxicology screenings without any informed consent regarding the risks of the medications.

Patient B

101. Paragraphs 30 through 46 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

102. Respondent committed acts of repeated negligence in his care and treatment of patient B, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by not adequately assessing the patient's anxiety symptoms, not offering safer alternatives to benzodiazepines, and prescribing relatively large quantities of benzodiazepines to a patient on high-dose opiates with a history of alcoholism and inconsistent toxicology screenings without any informed consent regarding the risks of the medications; and

(b) Respondent departed from the standard of care by failing to keep timely, legible and accurate medical records. Respondent's documentation for this patient is sparse and often not accurate; and

(c) Respondent departed from the standard of care in his management of the patient's diabetes which did not include standard monitoring of glycohemoglobin, creatinine or microalbumin, nor appropriate use of medications to optimize the patient's cholesterol or sugar, representing a lack of knowledge; and

(d) Respondent departed from the standard of care by repeatedly prescribing antimicrobial agents without a thorough physical examination and clear medical indications for antibiotics.

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Patient C

103. Paragraphs 47 through 63 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

104. Respondent committed acts of repeated negligence in his care and treatment of patient C, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to screen for or identify Opiate Use Disorder. Respondent's failure also shows lack of knowledge; and

(b) Respondent departed from the standard of care by prescribing benzodiazepines in a patient taking high dose narcotics without counseling the patient regarding specific risks of the medications nor considering safer alternatives, even after specific recommendations from the pain specialist; and

(c) Respondent departed from the standard of care prescribing second-line Methadone in conjunction with another long-acting opioid without medical justification and did not seem aware of nor counsel or screen the patient for cardiac effects of Methadone until after almost three years of care; and

(d) Respondent departed from the standard of care by prescribing the controlled substance Androgel without a clear indication, any chart documentation regarding indication, efficacy or side effects and without appropriate monitoring.

Patient D

105. Paragraphs 65 through 79 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

106. Respondent committed acts of repeated negligence in his care and treatment of patient D, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by prescribing high doses of opiates without any objective evidence of pathology, without standard monitoring with CURES reports nor a documented controlled substances agreement, and without considering safer alternatives or that the patient had an Opiate use disorder; and

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(b) Respondent departed from the standard of care by failing to screen the patient for or identify Opiate Use Disorder; and

(c) Respondent departed from the standard of care by failing to properly document justification for the benzodiazepines, not offering safer alternatives, not attempting to decrease the benzodiazepine use when other medications were added, and not monitoring CURES reports or address the fact that benzodiazepines were not detected in the 2013 toxicology screening; and

(d) Respondent departed from the standard of care by prescribing the high-risk medication Soma for over 18 months to a patient with no clear indication for such and without appropriate consideration of safer alternatives; and

(e) Respondent departed from the standard of care by failing to appropriately interpret or take into account the results of aberrant urine drug testing represent a lack of knowledge; and

(f) Respondent departed from the standard of care by failing to address preventative measure in the he regularly treated for over three years; and

(g) Respondent departed from the standard of care by failing to appropriately manage or monitor the patient's thyroid disease.

Patient E

107. Paragraphs 81 through 95 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

108. Respondent committed acts of repeated negligence in his care and treatment of patient E, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by failing to offer adequate medical justification for prescribing Methadone, not monitoring the patient's EKG or taking into consideration the potential for QT prolongation with the patient's other medications represents a Lack of Knowledge; and

(b) Respondent departed from the standard of care by failing to appropriately treat the patient's spine pain with safer alternatives and modalities, or insist on definitive evaluation

and treatment by more qualified specialists and did not perform adequate physical examination in regards to the patient's pain; and

(c) Respondent departed from the standard of care by failing to screen the patient for or identify Opiate Use Disorder; and

(d) Respondent departed from the standard of care by prescribing the high-risk medication Soma for over two years to a patient with no clear indication for such and without appropriate consideration of safer alternatives; and

(e) Respondent departed from the standard of care by not appropriately assessing or evaluating the patient's mental health symptoms, not asking about suicidal ideation or mania, prescribing medications that may have worsened her symptoms without adequately discussing potential risks and side effects, not insisting on appropriate consultation with mental health providers and not prescribing appropriate dosages of Abilify, all of which constitute a lack of knowledge; and

(f) Respondent departed from the standard of care by his lack of adequate history taking in relation to the complaints of attention, nor review of the DSM criteria or monitoring of stimulant therapy; and

(g) Respondent departed from the standard of care by prescribing modafanil without a definitive diagnosis, and without considering safer alternatives and in conjunction with other high-risk medications.

109. Respondent's conduct, as described above, constitutes repeated acts of negligence in the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to discipline Respondent's license.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

110. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent excessively overprescribed in his care and treatment of patients A, B, C, D, and E, as more particularly alleged in paragraphs 9 through 95 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

111. Respondent is subject to disciplinary action under section 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of patient B as more particularly alleged in paragraphs 30 through 46 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

112. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (d), of the Code, in that respondent was incompetent in his care and treatment of patients A, B, C, D, and E, as more particularly alleged in paragraphs 9 through 95 above, which are hereby incorporated by reference and realleged 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 Number G 78940, issued to John Edwin Parsons, Jr., M.D.;

2. Revoking, suspending or denying approval of John Edwin Parsons, Jr., M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Edwin Parsons, Jr., M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED:
November 13, 2018

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

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