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

In the Matter of the Accusation Against:	)	
Thomas McNeese Keller, M.D.	)	**Case No. 800-2017-030083**
Physician's and Surgeon's Certificate No. G 27288	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 25, 2019.

IT IS SO ORDERED November 18, 2019

MEDICAL BOARD OF CALIFORNIA

By: Christine J. Lally
Christine J. Lally
Interim Executive Director

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
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State Bar No. 111898
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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: **THOMAS MCNEESE KELLER, M.D.** **751 Church Street** **Santa Rosa, CA 95405** **Physician's and Surgeon's Certificate No. G 27288** Respondent.	Case No. 800-2017-030083 **STIPULATED SURRENDER OF LICENSE AND 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 Lawrence Mercer, Deputy Attorney General.

2. Thomas McNeese Keller, M.D. (Respondent) is represented in this proceeding by his attorneys, Brock D. Phillips and Pacific West Law Group, LLP, 503 San Pedro Cove, San Rafael, CA 94901.

3. On or about July 19, 1974, the Board issued Physician's and Surgeon's Certificate No. G 27288 to Thomas McNeese Keller, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-030083 and will expire on February 28, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030083 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 31, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-030083 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030083. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and 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.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-030083, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

RESERVATION

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

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and 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 Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 27288, issued to Respondent Thomas McNeese Keller, M.D., is surrendered and accepted by the Board.

1. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

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

3. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-030083 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

4. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2017-030083 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: October 26, 2019

Thomas McNeese Keller, MD

THOMAS MCNEESE KELLER, M.D.
Respondent

I have read and fully discussed with Respondent Thomas McNeese Keller, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

PACIFIC LAW GROUP, LLP

DATED: 11/3/2019

BROCK D. PHILLIPS
Attorney for Respondent

ENDORSEMENT

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

DATED: 11/4/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030083

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 3 2018
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **Thomas McNeese Keller, M.D.** **751 Church Street** **Santa Rosa, CA 95405** **Physician's and Surgeon's Certificate** **No. G 27288,** Respondent.	Case No. 800-2017-030083 **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 July 19, 1974, the Medical Board issued Physician's and Surgeon's Certificate Number G 27288 to Thomas McNeese Keller, 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 February 28, 2019, unless renewed. Pursuant to a stipulated decision, Respondent's certificate was revoked, effective December 19, 1990, but was reinstated on August 25, 1994, subject to the terms and conditions of a five-year probation. Said probation was

terminated by Order of the Board, effective June 13, 1997. Effective July 1, 2002, Respondent's certificate was subject to a public reprimand and, on February 19, 2003, a Public Letter of Reprimand issued.

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 2227 of the Code states:

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

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

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

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

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

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

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

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5. Section 2234 of the Code, states:

"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. . ."

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

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

7. 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."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Excessive Prescribing)

8. Respondent is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) and/or 725 in that Respondent prescribed excessively and/or inappropriately to Patients 1 through 5.[1] The circumstances are as follows:

Patient 1

9. On or about September 9, 2011, Patient 1, a 62 year old male, came under Respondent's care and treatment. Patient 1, a veteran being treated at the VA for a traumatic foot injury sustained in the Vietnam War, was referred to Respondent for treatment of chronic pain related to osteoarthritis of his shoulder and spine. Respondent prescribed methadone[2], 5 mg, BID, Neurontin[3], 200 mg, BID, Vicodin[4], 10/500 mg PRN, and Ambien[5], 10 mg, HS. The rationale for prescribing a sedating combination of drugs all at once and on the first patient encounter is not documented. Although the patient reported consuming four beers daily, an informed consent discussion advising the patient of the risks or recommending cessation, especially in light of the patient's neuropathy, is not documented beyond a general statement in the patient's medication agreement to make healthy lifestyle choices. Respondent did not order an EKG to evaluate for QT prolongation before starting the patient on methadone.

10. On September 22, 2011, the patient returned and reported that he was pleased with the relief provided by methadone. Respondent doubled the dosage of methadone at that time. At the next visit, on October 21, 2011, Respondent also increased the dosage of Neurontin and added

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[1] Patient's names are redacted to protect privacy.

[2] Methadone hydrochloride is a controlled substance and an opioid indicated for the treatment of pain severe enough to require around-the-clock long-term opioid management and for which alternative treatments have failed. Methadone exposes users to the risks of opioid addiction, misuse and abuse, which can lead to overdose and death.

[3] Neurontin (gabapentin) is an anticonvulsant that is used to treat nerve pain.

[4] Vicodin (hydrocodone bitartrate/acetaminophen) is a controlled substance used to control moderate to severe pain. Vicodin has a high potential for abuse.

[5] Ambien (zolpidem) is a controlled substance and a hypnotic used to treat insomnia. Ambien can cause dependence and, when taken in combination with opioids, can cause over-sedation and respiratory arrest.

a muscle relaxant, Soma[6], but did not chart a rationale for the increases in the patient's medications.

11. On December 22, 2011, the patient reported that his pain medications had made him dizzy and that he had not taken any for two weeks; however, Respondent continued to prescribe.

12. On March 12, 2012, the patient reported having run out of methadone, at which time MS Contin[7], 15 mg, QID, is substituted. Neither the reason for the change when the patient had only run out of his medication is explained, nor is Respondent's rationale for four daily doses of a 12-hour pain medication documented. On September 3, 2012, the patient returned and asked to be placed back on the medications he had been taking in March, 2012. Respondent placed him on Opana[8], 10 mg, BID. On September 24, 2012, the patient reported that Opana was not effective. Respondent increased the dosage to four times daily. The patient returned again on October 17th, 2012, stating that the Opana made him lethargic-- at which time Respondent began him on Kadian[9], an extended release pain reliever, 10 mg, BID. The dosage was increased to 20 mg, BID at the next visit and then increased again, to 30 mg, BID, a month later. On January 29, 2013, Respondent documented that he had increased the patient's dosage to Kadian, 20 mg, BID, and Kadian, 30 mg, BID. A rationale for these increases in medication is not documented by Respondent, other than to state the patient is "doing well" with Kadian.

13. In March, 2014, Respondent replaced the patient's Vicodin with Norco[10], 5/325, QID, a short-acting narcotic, and increased the dosage to 10/325 mg, QID, in June 2014. In September

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[6] Soma (carisoprodol) is a controlled substance and a muscle relaxer with pain relieving properties. When taken in combination with opioids, Soma increases the effects of the opioid and for that reason it has a high potential for misuse and abuse.

[7] MS Contin (morphine sulfate) is a controlled substance and a potent opioid intended for the management of pain severe enough to require daily, around-the-clock, long-term opioid management and for which alternative treatment options are inadequate. Morphine sulfate tablets expose patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death.

[8] Opana (oxymorphone) is a controlled substance and an opioid agonist used for around-the-clock, long-term opioid management. Opana exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death

[9] Kadian (morphine sulfate) is a controlled substance which has an extended release and therefore is a greater risk for overdose and death due to the larger amount of morphine present.

[10] Norco is a trade name for hydrocodone bitartrate and acetaminophen, a controlled substance and an opiate medication with the potential for habituation and use.

2014, Respondent added another short-acting opioid, Percocet[11], 10/325 mg, QID. Respondent did not chart an explanation for prescribing two short-acting opioid medications. In 2016, towards the end of the patient's treatment under his care, Respondent added oxycodone[12], a long-acting opioid, so that the patient was prescribed a total of 360 tablets/month of short- and long-acting opioid medications, resulting in a very high morphine equivalency without a documented justification.

14. On August 31, 2016, Patient 1 was seen by a nurse practitioner at the VA, who expressed concern about the large quantity of rapid-acting narcotics that the patient was receiving each month from Respondent. The patient was weaned from his narcotic medications and he transferred his care for osteoarthritis back to the VA.

Patient 2

15. Patient 2, a 61 year old male, came under Respondent's care for pain management related to cervical spondylosis on December 13, 2016. The patient reported that he was not currently taking any narcotics, but was taking Cymbalta[13], 60 mg, BID, and applying a 4% lidocaine gel. At the first and only patient encounter, Respondent prescribed Percocet, 10/325 mg, #90 (two tablets TID), Restoril[14], 30 mg, #15, and Soma, 350 mg, #45. Respondent also provided the patient with prescriptions for an additional two-month supply of Percocet at a higher dosage (2 tablets QID). Respondent did not document a rationale for providing a large supply of opioid medications at the initial visit or for prescribing a dosage that exceeded a standard starting dose for an opioid naïve patient. Respondent did not document a discussion with the patient about the risks of combining opioids, benzodiazepines and muscle relaxants. After the initial visit, Respondent was contacted by staff at the VA where Patient 2 was receiving care. The staff advised that Patient 2 had an opioid abuse disorder for which he had completed an opioid taper

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[11] Percocet is a trade name for oxycodone and acetaminophen, a narcotic analgesic with multiple actions similar to those of morphine with a high potential for dependence and abuse.

[12] Oxycodone is a narcotic analgesic with multiple actions similar to those of morphine. Oxycodone is a controlled substance and is available in combination with other drugs or alone. It can produce drug dependence and, therefore has the potential for being abused.

[13] Cymbalta (duloxetine hydrochloride) is approved for treatment of chronic musculoskeletal pain, which can be caused by conditions such as osteoarthritis or fibromyalgia.

[14] Restoril (temazepam) is a controlled substance and a benzodiazepine used for the short-term management of insomnia.

and nearly completed a benzodiazepine taper. On December 27, 2016, Respondent advised the patient that he would no longer prescribe for him. On December 28, 2016, and January 30, 2017, Patient 2 filled the additional prescriptions that Respondent had given to him at his office visit.

Patient 3

16. Beginning on October 11, 2013, Patient 3, a 32 year old female, came under Respondent's care and treatment for chronic flank pain secondary to chronic kidney stones, albeit the kidney stones were non-obstructing. At the time of her initial visit, the patient was taking Vicodin 5/500 mg, QID, and Tylenol, 500 mg, QID. Respondent prescribed methadone, 5 mg, BID, and Norco, 10/325 mg, QID, with the plan to eliminate Norco from the regimen if methadone was tolerated. Respondent did not order a baseline EKG before prescribing methadone.

17. Patient 3 returned on October 25, 2013, complaining of a migraine headache. Respondent did not perform a neurological work up, but prescribed Fiorinal[15]. The patient reported that methadone was sedating and, on subsequent visits stated that she was not taking methadone, but was taking Norco and Tylenol and applying a lidocaine gel. In June 2014, the patient was tried on Percocet, 10/325 mg, BID, but she complained that it was too strong and desired to go back to Norco. In August 2014, the patient tested positive for alcohol on urinalysis, but Respondent did not chart a discussion of the risks of alcohol consumption in combination with opioid medications. The patient reported taking a methadone tablet with good relief and this medication was resumed at a higher dose (10 mg) in October, 2014. Respondent noted that the patient was only taking methadone "prn" (as needed for pain), which is atypical prescribing of that long-acting opioid, especially since the patient was already taking short-acting medications for breakthrough pain. Respondent did not chart a rationale for this atypical prescribing.

18. In mid-2015, Respondent began increasing the dosage of the patient's Norco from QID to two tablets TID and then again, to two tablets QID. At about this time, the patient again tested positive for alcohol on urinalysis, but a discussion of the risk of possible interaction with

[15] Fiorinal (butalbital/aspirin/caffeine) are medications sometimes used to treat tension-type headaches

her opioid medications is not documented in Respondent's chart. By the end of 2015, the patient was taking Norco, 10/325 mg, 2 tablets TID and Percocet, 10/325 mg, HS, and methadone, 10 mg, BID.

19. In April, 2016, Patient 3 told Respondent that she would undergo a tubal ligation reversal in order to become pregnant. After that procedure was performed, Patient 3 stated that she planned to discontinue her pain medications during her pregnancy. However, on July 29, 2016, when she confirmed that she was pregnant, she relayed advice from her obstetrician that she could take low doses of Norco and even Percocet. Respondent did not document a consultation with Patient 3's obstetrician to develop a plan for opioids during pregnancy or later, breastfeeding, nor did he clarify what was meant by "low doses." Respondent did not document a discussion with the patient of the risks to her and her child of taking the medications or withdrawing from them. In fact, Respondent continued to prescribe Norco. 10/325 mg, QID, and Percocet 10/325 mg, BID, to Patient 3 during her pregnancy. Although the patient had again tested positive for alcohol, there was no discussion or plan for cessation. Respondent also added Tylenol/Codeine #3[16], BID, for those occasions when she ran out of her pain medications before it was time to refill her prescriptions, but did not chart a discussion why she was exceeding the prescribed dosage. As the patient's pregnancy progressed, Respondent twice increased her dosage of Norco at her request. After Patient 3 gave birth, Respondent continued to prescribe Norco and Percocet, but did not record a history regarding whether the patient was breastfeeding.

Patient 4

20. Patient 4, a 58 year old female, came under Respondent's care beginning on June 13, 2018. Patient 4's chief complaints were osteoarthritis of the hands, knees, neck and back. Due to a phobia regarding taking oral medication, Patient 4 was receiving an oral solution of oxycodone, 15 cc, every three hours. Patient 4 was clearly habituated and likely addicted to the oral oxycodone -- a fact that Respondent recognized early on -- but Respondent did not utilize the CURES reporting system to detect abuse until after he had already discharged the patient. Had he utilized CURES, he would have discovered that the patient was obtaining opioids from another

[16] Tylenol/Codeine combination used to treat mild to moderate pain.

physician during several months that she was under Respondent's care. Although Respondent counseled the patient to try an alternative opioid in the form of fentanyl[17] patches, he allowed her make the decision to remain on the high dose, oral opioid based, albeit these decisions were based on explanations (such as the need to care for a relative in Oregon) that did not make medical sense. He did not offer non-pharmacologic pain management techniques. Although he prescribed non-opioid medications at her first visit, including Voltaren and lidocaine patches, these were not pursued. After 14 months of the patient's resistance to Respondent's repeated recommendations for a change in her medications, Respondent terminated his care of her.

Patient 5

21. Patient 5, a 79 year old male, came under Respondent's care on October 18, 2016, for chronic back and neck pain. The patient had a history significant for prior surgeries on his back and neck, obesity, diabetes mellitus and compromised cardiac status. At the initial evaluation, Respondent stated that the patient was stable on Percocet, 10/325 mg, QID, and his plan was to maintain him on that dosage, with the addition of a 2% lidocaine gel.

22. Despite his plan to maintain the patient on Percocet, 10/325 mg, QID, at the next several visits Respondent significantly increased the patient's opioid medications, so that by February 28, 2017, the patient was taking Percocet, two tablets QID, and oxycodone IR, BID. The only documented rationale for the increased opioid medication was the patient's desire for increases in his medication. When the patient reported that his medications were causing nausea, Respondent added Zofran, 8 mg, BID, to counteract the nausea but did not alter his treatment plan. On July 12, 2017, the patient returned, again complaining of the nausea related to oxycodone, and stated that he wanted to be on Percocet only. Despite this request, Respondent renewed all of his medications, including the oxycodone IR, BID, in July and again in September, 2017.

[17] Fentanyl is a potent synthetic opioid analgesic. It is a controlled substance with a high potential for habituation and abuse. The basis for Respondent's determination that this would be a safer alternative is not documented.

23. In November, 2017, Respondent raised for the first time the high doses of opioid medications that he was prescribing to Patient 5, which he for the first time advised the patient was in excess of CDC and Medical Board prescribing guidelines and stated that a taper would be necessary. The patient expressed willingness to reduce his medications; however, rather than taper the patient's medications, Respondent discontinued the oxycodone IR entirely. In December, 2017, the patient returned stating that his pain was not tolerable on the medications prescribed, at which time Respondent told the patient that his only option was to be referred to another physician for placement of an intrathecal pump. When the patient refused the referral, Respondent terminated the patient from his practice.

Patients 1 through 5

24. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to disciplinary action based on his gross negligence and/or repeated negligent acts and/or excessive prescribing as set forth above and including, but not limited to, the following:

A. Respondent failed to develop and/or document a treatment plan related to the patients' symptoms and functioning in that Respondent increased or changed medications when the patients were stable;

B. Respondent excessively prescribed opioids and other controlled substances;

C. Respondent prescribed inappropriate combinations of drugs, including combinations of short-acting opioids and combinations of opioids and benzodiazepines;

D. Respondent failed to order appropriate tests, including baseline EKGs for patient who were prescribed methadone;

E. Respondent failed to provide adequate informed consent regarding the risks posed by the quantities and combinations of opioids, benzodiazepines and other drugs he prescribed;

F. Respondent failed to obtain appropriate consultations, such as consultation with Patient 3's treating obstetrician.

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SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

25. Complainant incorporates the allegations of the First Cause for Disciplinary Action as though fully set out here. Respondent is guilty of unprofessional conduct and for the reasons set forth above, Respondent's certificate is subject to disciplinary action for violation of Section 2266 of the Code for failure to keep adequate and accurate medical records.

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 27288, issued to Thomas McNeese Keller, M.D.;

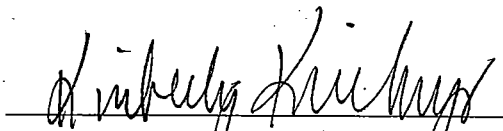
2. Revoking, suspending or denying approval of Thomas McNeese Keller, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Thomas McNeese Keller, 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:

December 31, 2018



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

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