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

In the Matter of the Accusation Against:	)	
Blaise Philip Vinc DeSouza, M.D.	)	**Case No. 800-2016-020340**
Physician's and Surgeon's Certificate No. A 37917	)	
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 December 12, 2019.

IT IS SO ORDERED December 5, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Christine J. Lally

Christine J. Lally
Interim Executive Director

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
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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: **BLAISE PHILIP VINC DESOUZA, M.D.** **P.O. Box 1040** **Foresthill, CA 95631-1040** **Physician's and Surgeon's Certificate No. A 37917** Respondent.	Case No. 800-2016-020340 **STIPULATED SURRENDER OF LICENSE AND ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Surrender and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

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 Sarah J. Jacobs, Deputy Attorney General.

2. Blaise Philip Vinc DeSouza, M.D. (Respondent) is represented in this proceeding by attorney Dominique A. Pollara, whose address is: 3600 American River Drive, Suite 160 Sacramento, CA 95864.

3. On or about January 11, 1982, the Board issued Physician's and Surgeon's Certificate No. A 37917 to Blaise Philip Vinc DeSouza, 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. 800-2016-020340 and will expire on October 31, 2019, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-020340 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 May 16, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-020340 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. 800-2016-020340. 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.

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CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2016-020340, 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 prima facie factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. A 37917, all of the charges and allegations contained in Accusation No. 800-2016-020340 shall be deemed true, correct and fully admitted by Respondent for purposes of that reinstatement proceeding or any other licensing proceeding involving Respondent in the State of California.

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.

CONTINGENCY

11. 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.

12. 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.

13. 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. A 37917, issued to Respondent Blaise Philip Vinc DeSouza, M.D., is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-020340 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2016-020340 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.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Dominique A. Pollara. 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: 10/1/2019

BLAISE PHILIP VINC DESOUZA, M.D.
Respondent

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

DATED: 10/15/19

DOMINIQUE A. POLLARA
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: 10-24-2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

SARAH J. JACOBS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2016-020340

XAVIER BECERRA
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO May 16 2019
BY _____ ANALYST

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

In the Matter of the Accusation Against: **Blaise Philip Vinc DeSouza, M.D.** P.O. Box 1040 Foresthill, CA 95631-1040 **Physician's and Surgeon's Certificate No. A 37917,** Respondent.	Case No. 800-2016-020340 **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 January 11, 1982, the Medical Board issued Physician's and Surgeon's Certificate No. A 37917 to Blaise Philip Vinc DeSouza, 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 October 31, 2019, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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5. Section 2234 of the Code, states:

"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:

". . .

"(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:

"(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."

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."

8. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

9. **Ativan,** the trade name for lorazepam, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures.

10. **Diazepam,** known by the trade name Valium, is a medicine of the benzodiazepine class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon

abrupt discontinuance. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

11. **Dilaudid** is a trade name for hydromorphone hydrochloride. It is a dangerous drug as defined in Business and Professions Code section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b). It is primarily used as a pain reliever. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

12. **Fentanyl** (Actiq, Fentora, and Duragesic) is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication ordinarily used to treat patients with severe pain, especially after surgery. When properly prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant patients, severe enough to require daily, continuous, long term opioid treatment, and for which alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. The FDA has issued several black box warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS

depressants. Fentanyl comes in several forms, including as an injection, intrathecal administration (an injection around the spinal canal), a transdermal patch that is placed on the skin, or as a lozenge that is sucked like a cough drop (Actiq).

13. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCP's) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, HCP's are used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

14. **Methadone hydrochloride** is a synthetic narcotic pain reliever with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by Health and Safety Code section 11055(c). Methadone can produce drug dependence of the morphine type and, therefore, has the potential for abuse. Psychological and physical dependence can develop with repeated administration, and it should be prescribed and administered with the same degree of caution as with morphine.

15. **MS Contin** (morphine sulfate), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and

indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified MS Contin, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for MS Contin which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of MS Contin with benzodiazepines or other central nervous system (CNS) depressants.

16. **Oxycodone** (Percocet), an opioid analgesic, 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. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

17. **Soma**, a trade name for carisoprodol tablets, is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined by Health and Safety Code section 11057. It can be habit forming and its side effects may impair thinking or reactions; it can increase dizziness and drowsiness.

18. **Zolpidem** (Ambien), a Schedule IV controlled substance, is a sedative primarily used to treat insomnia. It is an addictive substance and users should avoid alcohol as serious interactions may occur.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, and D, as more particularly alleged hereinafter:

PATIENT A

20. Respondent first started treating Patient A,[1] a then 41-year-old male, on or about October 9, 2014, for a rash due to poison oak, musculoskeletal pain, carpal tunnel syndrome on the right side, and pain in his right limb due to overuse from congenital absence of his left forearm.[2] Respondent indicated that he conducted Phalen's test to assess for carpal tunnel syndrome.[3] It is noted that Patient A suffered from anxiety and depression. Respondent started the patient on hydrocodone, 10/325 mg, three times daily (#180), in conjunction with a controlled substance contract. Respondent indicated that he checked CURES, but does not provide a discussion as to why he increased the dosage from the patient's previous prescription for hydrocodone by another physician. Despite the patient complaining of a skin rash, Respondent did not document a history of skin rash or note the location in the physical exam.

21. On or about November 7, 2014, Patient A is seen by Respondent, but the note was largely an exact copy from the previous office visit. On or about December 8, 2014, the patient presented with high blood pressure, extremity pain, and rash. The medical note again appeared to be a duplicate from the previous office visit. On or about February 6, 2015, the patient was scheduled for carpal tunnel surgery, and reported pain in his knees, right upper extremity with numbness, and numbness of his right hand. However, Respondent stated no paresthesia[4] in the CNS section of the note. On or about March 6, 2015, Respondent indicated that the patient was recovering from carpal tunnel surgery, but continued to have pain due to an absence of his left upper extremity. On or about May 7, 2015, Respondent mistakenly identified Patient A's atrophic limb on his right side, which recurred numerous times in subsequent notes.

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[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

[2] Throughout subsequent office visits, Respondent incorrectly noted in the medical record that Patient A had a congenital absence of his right forearm.

[3] Phalen's test is generally conducted by applying force between a patient's two hands, yet Patient A only had one hand.

[4] Paresthesia, or "pins and needles," is an abnormal skin sensation (e.g., a tingling, pricking, chilling, burning, or numb sensation on the skin) with no apparent physical cause.

22. On or about July 7, 2015, the patient presents with high blood pressure and a cough. Respondent noted the correct atrophied left limb in the assessment section, but the subjective section is duplicated from the previous notes referencing the atrophied limb on the right limb. On or about May 17, 2016, Respondent indicated that Patient A stopped his medication and lost a significant amount of swelling, however, it is noted that the patient is to "continue on his narcotics as prescribed." On or about June 17, 2016, it was noted that Patient A had lost over 30 pounds and had a significant decrease in blood pressure. There was no change to his treatment plan.

23. On or about August 22, 2016, Respondent noted that the patient was experiencing severe anxiety due to his wife's new diagnosis of breast cancer. However, it was also noted that the "patient's mental and emotional functioning are clinically normal." There was no mental health examination conducted to determine mental health status. It was documented that the patient still had high blood pressure even though it was also noted that patient's blood pressure had improved. It was documented that the patient's pain was adequately controlled and he had chronic lymphatic insufficiency. On or about December 22, 2016, Respondent indicated that the patient was being treated for musculoskeletal pain of the right upper extremity and had congenital atrophy of the right upper extremity. While it was noted that the patient had chronic lymphatic insufficiency, Respondent did not note a disease of the lymphatics under the ROS-Lymphatics section.

24. Between approximately October 9, 2014, and July 13, 2018, Patient A was seen by Respondent approximately 44 times. During this period, the patient is prescribed 8,613 tablets of hydrocodone, 10 mg, 630 tablets of lorazepam, 1 mg, and 1,150 tablets of Soma, 30 mg. Patient A's average morphine equivalent dose (MED) is 60, which is a moderate dose. Many of the medical notes were largely duplicates of previous notes, including exact misspellings and syntax errors. Respondent did not classify the patient's risks and benefits, provide a sufficient treatment plan, or appropriately modify treatment due to likely reported side effects during the patient's long-term opioid use. Absent from the record was a discussion regarding the risks of combining

opioids with other prescribed respiratory depressants, a risk-benefit discussion regarding medications, as well as efforts to ensure adequate compliance monitoring.

25. Respondent committed gross negligence in his care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to undertake or document risk assessment for continued prescribing and long-term use of opioids, such as various screening and monitoring tools, and he failed to adequately evaluate the potential risks of combining opiate therapy with other respiratory depressants such as benzodiazepines (lorazepam) and barbiturates (Soma);

(b) Respondent failed to properly modify treatment after reported side effects of narcotics, benzodiazepines and barbiturate use, and Respondent failed to adequately evaluate the patient's progress toward functional goals and positive changes in pain status;

(c) Respondent failed to implement a comprehensive treatment plan with objectives and measurable goals for controlled substances, as well as an exit strategy for discontinuing opioid therapy;

(d) Respondent failed to undertake or document appropriate compliance monitoring of controlled substances, such as urine drug testing or pill counting; and

(e) Respondent failed to document clear, detailed and accurate medical records, including a history of present illness for various complaints made by the patient, the rationale for a diagnosis, and a discussion with the patient regarding the risks, benefits, and side effects of starting or discontinuing medication; Respondent largely duplicated the same review of systems notes for each office visit, including the same physical exam findings and inaccuracies within notes.

PATIENT B

26. On or about August 22, 2011, Respondent began treating Patient B,[5] a then-57-year old male, primarily for treatment of chronic musculoskeletal pain COPD, chronic pain, and anxiety. Patient B also had a personal history of methamphetamine use, pain, and addiction issues. According to CURES, Respondent prescribed the patient fentanyl 100 mcg per hour (#15), lorazepam, 1 mg (#30), and hydrocodone, 7.5 mg (#90). On or about February 12, 2012, a consultant note was sent to Respondent indicating that Patient B has lost his driver's license due to a DUI, and that he was medication noncompliant, smelled of THC, appeared medicated, and had been in and out of jail. An emergency room report from August 2011 indicated that the patient had been seen in the ER three times with multiple requests for narcotics or anti-anxiety medication. Respondent's initial medical note for the patient occurred on or about June 6, 2013. Respondent was not prescribing controlled substances to patient at this time as the patient was on criminal drug probation.

27. On or about February 17, 2014, the patient is seen for episodic chest pain, COPD, and hypogonadism. The patient indicated that he had abstained from drugs and alcohol for approximately two years and he was taking methadone. On or about April 29, 2014, Respondent began prescribing hydrocodone, 5/300 mg, every four hours, lorazepam, 1mg, every eight hours, and methadone, 10 mg, every four hours, to Patient B on a regular basis. Respondent noted that he was taking over patient care of Patient B, who had previously been under the care of a pain management specialist. Absent from the note was any indication that Respondent initiated tools to assess this high-risk patient for concerns of use, misuse, or diversion of medication. On or about May 15, 2014, the patient's pain had reportedly worsened and he was still without a pain management specialist. On or about May 29, 2014, Respondent noted that there were no red flags regarding opioid use, but did not indicate how this was determined.

28. On or about June 30, 2014, Respondent noted "...chronic complex patient with severe social problems including chronic pain, hands are shaking due to withdrawal from pot."

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[5] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

However, there was no discussion regarding this finding, and it was conflictingly noted that the patient was stable. Further, the CNS section listed the patient as normal rather than reflecting the tremor. While the note indicated the patient had worsened, much of the note was largely duplicated from previous notes. On or about December 22, 2014, Respondent started the patient on Percocet, 10/325 mg, in addition to the regular methadone prescription. Hydrocodone had been discontinued at this time. On or about January 22, 2015, Respondent documented that the patient had left-sided weakness that was almost resolved, however, there was no mention of this in the plan, CNS, or Physical-exam Neurological notes.

29. On or about February 20, 2015, the patient indicated that he was still smoking marijuana, yet it was noted that he is a former drug user. Percocet is continued for pain secondary to skin infection, in addition to methadone and lorazepam. On or about March 19, 2015, Respondent noted that he discussed the limitations of chronic pain treatment with the patient, including the pros and cons, and attempts to wean him off controlled substances. However, there exists no prior documentation of attempts to wean the patient off controlled substances. On or about May 15, 2015, the patient reported abrasions sustained to his nose and face from a lamp falling on his face. There lacked any discussion of the patient receiving hydromorphone from another physician at this visit.

30. On or about May 15, 2015, the patient filled three different prescriptions for methadone prescribed by Respondent at two different pharmacies. On or about May 27, 2015, Patient B filled two different prescriptions for lorazepam prescribed by Respondent at two different pharmacies. On or about June 8, 2015, Patient B requested an early refill of methadone because he was reportedly going out of town for the week. He filled two prescriptions for methadone at two different pharmacies the same day. According to CURES, the patient received 540 tablets of methadone on or about May 15, 2015, which was a 3-month supply, and just approximately three weeks later received 360 tablets of methadone.[6] Therefore, the patient received a 5-month supply of methadone within approximately three weeks. This is in addition to 180 tablets of lorazepam and 20 tablets of Percocet filled during the same period.

[6] Patient B's intended dosage of methadone, 10 mg, was 180 tablets every 30 days.

31. On or about August 6, 2015, Respondent noted that he reviewed CURES for Patient B and confirmed the patient was only receiving medication from him. That same day, the patient filled two separate prescriptions for 180 tablets of methadone, 10 mg, from two different pharmacies. On or about September 3, 2015, the patient reported dizziness and memory problems, although there was no follow-up discussion by Respondent. On or about October 29, 2015, the patient again received an early refill for methadone after having just filled his monthly prescription on or about October 6, 2015.

32. On or about May 18, 2016, Patient B was required to undergo a drug screening by another provider. The results were negative for both opiates and benzodiazepines, even though the patient had recently filled prescriptions for methadone and lorazepam. The results indicated misuse or diversion by the patient. Respondent admitted that he had reviewed the test results. Approximately one week later, Patient B signed a pain contract. However, there lacked any discussion by Respondent regarding inconsistencies in the drug screening result at this visit or in future office visits. In fact, Respondent noted on or about June 27, 2016, that the patient was medication and pain contract compliant.

33. On or about August 17, 2018, Respondent noted that he reviewed CURES for the patient, whose skin had been itching as a side effect from narcotics. Respondent ordered a drug urine screening for the patient, which tested positive for benzodiazepines, methadone, and alcohol. One week later, Respondent discharged the patient from his practice for violating the controlled substances contract by consuming alcohol.

34. Throughout the duration of Respondent's care of Patient B, he displayed extensive and recurring disconcerting signs and symptoms related to use, misuse and diversion of long-term controlled substance therapy. The patient demonstrated numerous instances of drug-seeking behavior and aberrant drug use, including utilizing multiple pharmacies to fill multiple prescriptions, continually requesting early refills, negative test results for opiates and benzodiazepines, and being on criminal drug probation.

35. Between approximately September 22, 2011, and August 17, 2018, the patient was seen a minimum of 70 times by Respondent. During this period, the patient was provided with

10,080 tablets of methadone, 10 mg, 90 tablets of hydrocodone, 7.5 mg, 30 tablets of hydrocodone, 5 mg, 15 fentanyl patches, 100 mcg/hour, 44 tablets of hydromorphone, 4 mg, 56 tablets of oxycodone, 325/10 mg, 450 tablets of diazepam, 5 mg, and 3630 tablets of lorazepam, 1.0 mg. Patient B's average dose during this period was approximately 160 MED's.

36. Many of the medical notes were largely duplicates of previous notes. Respondent did not classify the patient's risks and benefits, provide a sufficient treatment plan, or appropriately modify treatment due to likely reported side effects or aberrant drug behavior during the patient's long-term opioid use. Absent from the record was a discussion regarding the risks of combining opioids with other prescribed respiratory depressants, a risk-benefit discussion regarding medications, as well as efforts to ensure adequate compliance monitoring.

37. Respondent committed gross negligence in his care and treatment of Patient B which included, but was not limited to, the following:

(a) Respondent failed to document clear, detailed and accurate medical records, including a history of present illness for various complaints made by the patient, the rationale for a diagnosis, and a discussion with the patient regarding the risks, benefits, and side effects of starting or discontinuing medication; Respondent largely duplicated the same review of systems notes for each office visit, including the same physical exam findings.

(b) Respondent failed to undertake or document risk assessment for continued prescribing and long-term use of opioids, such as classifying the patient's risk initially or during continued monitoring using various screening and monitoring tools when the patient revealed a substantial risk of controlled substance abuse, misuse or diversion; Respondent failed to adequately evaluate the potential risks of combining opiate therapy with other respiratory depressants such as benzodiazepines (lorazepam and diazepam);

(c) Respondent failed to properly modify treatment after concerning reports of likely side effects of narcotics and benzodiazepines use indicating aberrant drug behavior, such as reported falls, changes in mental status, memory loss, early refills, refills at multiple pharmacies with multiple prescriptions, and inconsistent results on urine drug screening;

(d) Respondent failed to implement a comprehensive treatment plan with objectives and measurable goals for controlled substances, a well as an exit strategy for discontinuing opioid therapy; and

(e) Respondent failed to undertake or document appropriate compliance monitoring of controlled substances, such as urine drug testing or pill counting, despite evidence that the patient was misusing or diverting medication.

PATIENT C

38. On or about August 25, 2015, Respondent began treating Patient C, a then-55-year old male, primarily for treatment of chronic pain, and pain of the neck, mid-back, and lumbar region. The patient's MRI also showed moderate canal narrowing and mild ventral cord compression and myelopathy. The patient had just been terminated by a pain clinic, yet the reason was unclear whether it was due to noncompliance or another factor. It was noted that Patient C was a poor historian due to being under the influence of narcotics, as exhibited by his slurred speech and drowsiness. Respondent noted that he did not feel comfortable prescribing large quantities of narcotics to the patient. It was noted that the patient was depressed and in withdrawal from narcotics. Respondent agreed to take over Patient C's pain management and prescribed diazepam, 10 mg (#60), methadone, 10 mg (#60), and morphine, 10 mg (#30). Respondent reported that he reviewed CURES and the patient signed a pain contract.

39. On or about October 21, 2015, Respondent noted that the patient was "very much" under the influence of narcotics, tended to ramble, and was at times delusional. On or about November 20, 2015, Respondent noted that the patient was awake, alert, and not impaired due to

narcotics, yet conflictingly documented in the ROS section that the patient was very much under the influence of narcotics. On or about December 17, 2015, Respondent again noted that the patient has slurred speech and was impaired due to narcotics. In the abdominal examination section, Respondent noted that Patient C had no scars, despite just having abdominal surgery. On or about February 22, 2016, the patient indicated that morphine was no longer covered by his insurance, so Respondent removed morphine and increased methadone from 60 to 90 tablets monthly. On or about April 7, 2016, Respondent again conflictingly noted that the patient was not intoxicated, but also that he had slurred speech and was under the influence of narcotics. On or about May 6, 2016, it was noted that Respondent counseled the patient regarding gallstones causing some of his discomfort even though the patient had his gall bladder previously removed.

40. On or about May 19, 2016, Patient C reported that he fell and injured his wrist. On or about July 19, 2016, Respondent indicated that he checked CURES, but made no reference to the patient recently changing pharmacies. On or about August 31, 2016, the patient filled an early refill for methadone. On or about May 4, 2017, it was noted that the patient's pain had been masked for a number of months due to large doses of narcotics for chronic pain, as well as urinary symptoms and obstruction. On or about June 8, 2017, Patient C was seen at urgent care for a fall sustained at his home where he hit his right eye on a table. He also complained of wrist pain due to multiple spider bites. The urgent care physician noted that the patient had delusions regarding the source of his injury. Later that month, Respondent noted that the patient had wrist pain secondary to spider bites, but there was no further discussion of this issue.

41. On or about March 8, 2018, the patient was seen at urgent care for a possible infection and reported that one year ago spiders walked on him, crawled up his nose, and bit him. The urgent care physician documented potential delusional thinking. During Patient C's next visit with Respondent on or about April 5, 2018, there was no discussion regarding spiders or the urgent care visit. On or about May 3, 2018, Respondent noted that the patient complained of spider bites and that he was delusional about spiders crawling up his forearms. However, this impression was not documented in the psychiatric section of the note. On or about July 18, 2018,

the patient reported to another provider that he was bitten in the nose by a brown recluse spider, and was diagnosed with a deviated septum.

42. On or about August 21, 2018, Patient C is seen by a cardiologist, who noted that the patient had an inability to focus on his thoughts and was dwelling on the notion that his EKG was abnormal due to a history of spider bites. The patient believed that 10 spiders had crawled up his nose, and that he had a swollen leg because his wife "opened a letter from Saddam and let the dust out." It was noted that the patient had tangential thought with possible paranoid ideas and delusions.

43. Between approximately August 25, 2015, and July 2, 2018, the patient was seen approximately 48 times by Respondent. During this period, the patient was provided with 2,700 tablets of methadone, 10 mg, 180 tablets of morphine, 10 mg, and 1320 tablets of diazepam, 10 mg. Patient C's average dose during this time was approximately 100 MED's.

44. Throughout the duration of Respondent's care of Patient C, he displayed significant and repeated concerning signs and symptoms related to long-term controlled substance therapy. The patient exhibited slurred speech, drowsiness, and memory issues. He was a poor historian, tended to ramble, and changed pharmacies. Most importantly, he demonstrated delusional thoughts and paranoid ideas. The patient believed his health problems were caused by spider bites, and that his leg had swollen because of "dust" from a letter sent by "Saddam."

45. The patient was concurrently being treated by Respondent for both anxiety and pain, which may increase the patient's risk for abuse, misuse or addiction. Respondent had prescribed large quantities of benzodiazepines to the patient to treat his mental illness. Many of the medical notes were largely duplicates of previous notes. Respondent did not classify the patient's risks and benefits, provide a sufficient treatment plan, or appropriately modify treatment due to likely reported side effects or aberrant drug behavior during the patient's long-term opioid use. Absent from the record was a discussion regarding the risks of combining opioids with other prescribed respiratory depressants, a risk-benefit discussion regarding medications, as well as efforts to ensure adequate compliance monitoring.

46. Respondent committed gross negligence in his care and treatment of Patient C which included, but was not limited to, the following:

(a) Respondent failed to undertake or document risk assessment for continued prescribing and long-term use of opioids, such as various screening and monitoring tools, especially when the patient demonstrated significant risk of controlled substance misuse; Respondent failed to adequately evaluate the potential risks of combining opiate therapy with other respiratory depressants such as benzodiazepines (diazepam);

(b) Respondent failed to properly modify treatment after reported side effects of long-term narcotics and benzodiazepine use, including aberrant drug behavior and deeply concerning warning signs and symptoms, and Respondent failed to adequately evaluate the patient's progress toward functional goals and positive changes in pain status;

(c) Respondent failed to implement a comprehensive treatment plan with objectives and measurable goals for controlled substances, a well as an exit strategy for discontinuing opioid therapy;

(d) Respondent failed to undertake or document appropriate compliance monitoring of controlled substances, such as urine drug testing or pill counting; and

(e) Respondent failed to document clear, detailed and accurate medical records, including a history of present illness for various complaints made by the patient, the rationale for a diagnosis, and a discussion with the patient regarding the risks, benefits, and side effects of starting or discontinuing medication; Respondent largely duplicated the same review of systems notes for each office visit, including the same physical exam findings and inconsistencies within notes.

PATIENT D

47. On or about June 2, 2012, Respondent began treating Patient D, a then-59-year old male, primarily for treatment of chronic pain stemming from an injury sustained in a car accident 30 years prior. According to CURES, Respondent began prescribing morphine sulfate, 100 mg, three times daily, morphine sulfate, 60 mg, three times daily, morphine sulfate, 30 mg, three times daily, and Zolpidem 10 mg, once daily. On or about September 4, 2012, the patient reported his pain was 2 out of a possible 10 in severity, yet the same prescriptions for large quantities of narcotics continued. In fact, Respondent increased the number of tablets of morphine sulfate, 30 mg, from 90 to 100 at that time. On or about September 17, 2013, the patient's pain level remained at 2/10 and he entered into a pain contract. Approximately one year later, the patient's pain had worsened due to degenerative joint disease. On or about February 23, 2015, the patient was still being prescribed high quantities of morphine sulfate by Respondent. The patient reported his pain level was 9/10 in his back when not medicated and 2/10 when on medication.

48. On or about March 23, 2015, Respondent noted that the patient was still on "massive doses of morphine," and Respondent recommended tapering of the patient's medication to check its efficacy, as well as avoid tolerance. Respondent failed to include any information regarding methods of tapering or objectives. Approximately one month later, Respondent indicated that the patient was still on large doses of morphine after he tried to taper, but was unsuccessful. On or about May 22, 2015, the patient submitted for a urine test, which was negative for illicit drugs and positive for the prescribed opiates. On or about July 23, 2015 and August 21, 2015, Respondent noted confusion as to which pharmacy to send medication.

49. On or about February 16, 2016, Respondent requested that the patient bring in his medication bottle to monitor his use. Notes dated on or about April 14, 2016, and May 13, 2016, are exact duplicates from previous notes, including syntax errors. On or about January 6, 2017, Respondent conducted a pill count of Patient D's medication. On or about April 7, 2017, the patient was advised by Respondent to taper off his mediation and prescribed Narcan.[7] On or

[7] Narcan is a drug used to treat opioid overdose.

about November 2, 2017, the patient was still on very high doses of morphine despite Respondent's previous note to taper opiates. There was a note to order Narcan at this office visit, as well on or about December 1, 2017, and July 24, 2018, but there was no evidence it was actually ordered for these office visits. On or about March 1, 2018, Patient D was again advised to taper his medication, yet Respondent continued to prescribe the same dosage. On or about April 27, 2018, the patient was diagnosed with Hepatitis C and Respondent conducted a pill count. On or about August 21, 2018, Respondent discontinued the 60 mg dose of morphine. This was Patient D's last appointment with Respondent.

50. Between approximately June 4, 2012, and August 21, 2018, Patient D was seen approximately 58 times by Respondent. During this period, the patient was provided with 6,800 tablets of morphine sulfate, 30 mg, 6,120 tablets of morphine sulfate, 60 mg, 6,720 tablets of morphine sulfate, 100 mg, and 2040 tablets of Zolpidem, 10 mg. Patient D's average dose during this time was approximately 580 MED's, which is considered a high dose.[8]

51. The patient was concurrently being treated by Respondent for both anxiety and pain, which may increase the patient's risk for abuse, misuse or addiction. Respondent had prescribed Zolpidem, a sedative-hypnotic, known to cause respiratory depression, and has an increased risk of respiratory depression when combined with opiates such as morphine. Many of the medical notes were largely duplicates of previous notes. Respondent did not classify the patient's risks and benefits, provide a sufficient treatment plan, or appropriately modify treatment due to likely reported side effects or aberrant drug behavior during the patient's long-term opioid use. Absent from the record was a discussion regarding the risks of combing opioids with other prescribed respiratory depressants, a risk-benefit discussion regarding medications, as well as efforts to ensure adequate compliance monitoring.

52. Respondent committed gross negligence in his care and treatment of Patient D which included, but was not limited to, the following:

(a) Respondent failed to undertake or document risk assessment for continued prescribing and long-term use of opioids, such as various

[8] A dose greater than 200 mg MED per day is considered a high dose.

screening and monitoring tools, and he failed to adequately evaluate the potential risks of combining opiate therapy with other respiratory depressants such as sedatives/hypnotics (Zolpidem);

(b) Respondent failed to properly modify treatment after reported side effects of narcotics and sedative/hypnotic use, including aberrant drug behavior, and Respondent failed to adequately evaluate the patient's progress toward functional goals and positive changes in pain status;

(c) Respondent failed to implement a comprehensive treatment plan with objectives and measurable goals for controlled substances, a well as an exit strategy for discontinuing opioid therapy;

(d) Respondent failed to undertake or document appropriate compliance monitoring of controlled substances;

(e) Respondent failed to document clear, detailed and accurate medical records, including a history of present illness for various complaints made by the patient, the rationale for a diagnosis, and a discussion with the patient regarding the risks, benefits, and side effects of starting or discontinuing medication; Respondent largely duplicated the same review of systems notes for each office visit, including the same physical exam findings and syntax errors within notes.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

53. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, and D, as more particularly alleged herein.

PATIENT A

54. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but were not limited to, the following:

(a) Paragraphs 20 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT B

55. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but were not limited to, the following:

(a) Paragraphs 26 through 37, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to adequately provide informed consent to Patient B.

PATIENT C

56. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but were not limited to, the following:

(a) Paragraphs 38 through 46, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT D

57. Respondent committed repeated negligent acts in his care and treatment of Patient D which included, but were not limited to, the following:

(a) Paragraphs 47 through 52, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to adequately provide informed consent to Patient D.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

58. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs or treatment to Patient B, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 26 through 37, 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 Records)

59. Respondent is further subject to disciplinary action under sections 2227 and 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 patients A, B, C, and D, as more particularly alleged in paragraphs 20 through 52, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

60. To determine the degree of discipline, if any, to be imposed on Respondent Blaise Philip Vinc DeSouza, M.D., Complainant alleges that on or about July 5, 1999, in a prior disciplinary action entitled *In the Matter of the Disciplinary Proceeding Against Blaise Philip DeSouza, M.D.*, before the Medical Board of California, in Case No. 02-1998-92430, Respondent's license was placed on probation for a period of five (5) years for engaging in unprofessional conduct, including entering into a sexual relationship with a patient, abusing alcohol, and self-administering Xanax and Prozac without a valid prescription. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 37917, issued to Blaise Philip Vinc DeSouza, M.D.;

2. Revoking, suspending or denying approval of Blaise Philip Vinc DeSouza, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Blaise Philip Vinc DeSouza, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: May 16, 2019

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

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