

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

In the Matter of the Accusation)
Against:)
)
)
Norman Yuh Wei Chow)
)
Physician's and Surgeon's)
Certificate No. A 34003)
)
Respondent)
_____)

Case No. 800-2016-025337

DECISION

The attached Stipulated Surrender of License 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 January 21, 2020

IT IS SO ORDERED January 14, 2020

MEDICAL BOARD OF CALIFORNIA

By: _____

**Christine J. Lally
Interim Executive Director**



1 XAVIER BECERRA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 ROSEMARY F. LUZON
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8 *Attorneys for Complainant*

9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the Accusation Against:

Case No. 800-2016-025337

14 **Norman Yuh Wei Chow, M.D.**
15 **1440 South Stonecrest Place**
Diamond Bar, CA 91765

**STIPULATED SURRENDER OF
LICENSE AND DISCIPLINARY ORDER**

16 **Physician's and Surgeon's Certificate**
17 **No. A 34003,**

18 Respondent.

19
20 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
21 entitled proceedings that the following matters are true: .

22 **PARTIES**

23 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
24 of California (Board). She brought this action solely in her official capacity and is represented in
25 this matter by Xavier Becerra, Attorney General of the State of California, by Rosemary F.
26 Luzon, Deputy Attorney General.

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1 **CULPABILITY**

2 8. Respondent does not contest that, at an administrative hearing, Complainant could
3 establish a *prima facie* case with respect to all of the charges and allegations in Accusation No.
4 800-2016-025337, a true and correct copy of which is attached hereto as Exhibit A, and that he
5 has thereby subjected his Physician's and Surgeon's Certificate No. A 34003 to disciplinary
6 action. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. A 34003 for
7 the Board's formal acceptance.

8 9. Respondent agrees that his Physician's and Surgeon's Certificate No. A 34003 is
9 subject to discipline and he agrees to be bound by the Board's imposition of discipline as set
10 forth in the Disciplinary Order below.

11 10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's
12 and Surgeon's Certificate No. A 34003, or if an accusation or petition to revoke probation is ever
13 filed against him before the Medical Board of California, all of the charges and allegations
14 contained in Accusation No. 800-2016-025337 shall be deemed true, correct, and fully
15 admitted by Respondent for purposes of any such proceeding or any other licensing proceeding
16 involving Respondent in the State of California or elsewhere.

17 11. Respondent understands that, by signing this stipulation, he enables the Executive
18 Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his
19 Physician's and Surgeon's Certificate No. A 34003 without further notice to, or opportunity to be
20 heard by, Respondent.

21 **CONTINGENCY**

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

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

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

6 14. The parties agree that this Stipulated Surrender of License and Disciplinary Order
7 shall be null and void and not binding upon the parties unless approved and adopted by the
8 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full
9 force and effect. Respondent fully understands and agrees that in deciding whether or not to
10 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
11 Director and/or the Board may receive oral and written communications from its staff and/or the
12 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the
13 Executive Director, the Board, any member thereof, and/or any other person from future
14 participation in this or any other matter affecting or involving Respondent. In the event that the
15 Executive Director on behalf of the Board does not, in her discretion, approve and adopt this
16 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
17 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
18 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
19 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
20 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
21 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
22 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
23 of any matter or matters related hereto.

24 **ADDITIONAL PROVISIONS**

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

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ENDORSEMENT

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

DATED: 12/24/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

~~ROSEMARY F. LUZON
Deputy Attorney General
Attorneys for Complainant~~

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Exhibit A

Accusation No. 800-2016-025337

1 XAVIER BECERRA
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3 ROSEMARY F. LUZON
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8 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO *Aug. 15 20 19*
BY *[Signature]* ANALYST

9
10 BEFORE THE
MEDICAL BOARD OF CALIFORNIA
11 DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against:

Case No. 800-2016-025337

14 Norman Yuh Wei Chow, M.D.
15 1440 South Stonecrest Place
Diamond Bar, CA 91765.

ACCUSATION

16 Physician's and Surgeon's Certificate
17 No. A 34003,

18 Respondent.

19
20 Complainant alleges:

21 PARTIES

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

25 2. On or about June 21, 1979, the Board issued Physician's and Surgeon's Certificate
26 No. A 34003 to Norman Yuh Wei Chow, M.D. (Respondent). The Physician's and Surgeon's
27 Certificate was in full force and effect at all times relevant to the charges brought herein and will
28 expire on September 30, 2020, unless renewed.

JURISDICTION

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

4. Section 2220 of the Code states:

“Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .”

5. 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.

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6. 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.

"(d) Incompetence.

"..."

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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8. Section 2228.1 of the Code states:

“(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee’s probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board’s telephone number, and an explanation of how the patient can find further information on the licensee’s probation on the licensee’s profile page on the board’s online license information Internet Web site, to a patient or the patient’s guardian or health care surrogate before the patient’s first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

“(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

“... ”

“(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

“(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

“(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient’s guardian or health care surrogate, a separate, signed copy of that disclosure.

“... ”

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1 problems. Respondent noted that Patient A did not smoke or drink alcohol. Respondent's
2 diagnosis was high bilirubin and he ordered a hepatitis blood panel and refilled unspecified
3 medications. In an entirely separate section of Patient A's chart, referred to as the "Cumulative
4 Adult Patient Profile," Respondent documented his diagnosis for this visit. The diagnosis was
5 "cough – smoker[.]"

6 11. On or about November 13, 2013, Respondent saw Patient A again. Respondent did
7 not document any history or diagnoses in his consult notes. Patient A's vital signs were normal
8 and the physical exam was negative for any problems. Respondent noted the need for an
9 ultrasound and refilled unspecified medications.

10 12. On or about December 16, 2013, Respondent saw Patient A, who complained of an
11 intolerable cough and requested a refill of "Phenergan cod."² Respondent did not document any
12 diagnoses in his consult notes. Patient A's physical exam was normal and the plan was to refill
13 unspecified medications. In the "Cumulative Adult Patient Profile" section of Patient A's chart,
14 Respondent's diagnosis was "smoker's cough[.]"

15 13. On or about January 22, 2014, Patient A had a follow-up visit with Respondent for
16 complaints of a "smoker's cough," cold symptoms, and a sore throat, as well as to refill
17 prescriptions. According to Respondent's consult notes, Patient A did not smoke. Respondent's
18 diagnoses were irritable cough and elevated bilirubin. No history regarding Patient A's cough
19 was documented. In the "Cumulative Adult Patient Profile" section of Patient A's chart,
20 Respondent's diagnoses were irritable cough, elevated bilirubin, and negative hepatitis.

21 14. On or about February 26, 2014, Respondent saw Patient A for an irritable cough and
22 to refill prescriptions. Respondent's diagnosis was irritable cough, but he did not document any
23 history regarding Patient A's cough or any treatment plan other than to refill unspecified
24 medications. In the "Cumulative Adult Patient Profile" section of Patient A's chart, Respondent's
25 diagnosis was "cough[.]"

26
27 ² Phenergan-Codeine syrup, also known as Codeine Phosphate-Promethazine HCl
28 (codeine and promethazine), is a Schedule V controlled substance pursuant to Health and Safety
Code section 11058, subdivision (c), and a dangerous drug pursuant to Business and Professions
Code section 4022.

1 15. On or about March 19, 2014, Respondent saw Patient A for a sore throat and cough,
2 as well as to refill prescriptions. Respondent's diagnosis was pharyngitis. Respondent did not
3 document any treatment plan or history regarding Patient A's cough. In the "Cumulative Adult
4 Patient Profile" section of Patient A's chart, Respondent's diagnosis was pharyngitis.

5 16. On or about July 2, 2014, Respondent saw Patient A for an irritable cough and to
6 refill prescriptions. Respondent did not document any history regarding Patient A's cough and,
7 despite the notation in his consult notes that Patient A did not smoke, Respondent's diagnosis was
8 "smoker's cough." Respondent ordered a chest x-ray and refilled unspecified medications. In the
9 "Cumulative Adult Patient Profile" section of Patient A's chart, Respondent's diagnosis was
10 "cough[.]"

11 17. On or about July 23, 2014, Patient A followed up with Respondent regarding his x-
12 ray results and to refill prescriptions. Respondent noted that the chest x-ray was normal.
13 Respondent's diagnosis was irritable cough, but he did not document any treatment plan other
14 than to refill unspecified medications. No history regarding Patient A's cough was documented.
15 In the "Cumulative Adult Patient Profile" section of Patient A's chart, Respondent's diagnosis
16 was normal chest x-ray and irritable cough.

17 18. On or about August 13, 2014, and September 10, 2014, Respondent saw Patient A for
18 an irritable cough and to refill prescriptions. During both visits, Respondent's diagnosis was
19 irritable cough, but he did not document any treatment plan other than to refill unspecified
20 medications. No history regarding Patient A's cough was documented. During the September
21 10, 2014, visit, Respondent's diagnosis also included the notation "smoker," however, according
22 to Respondent's consult notes, Patient A did not smoke. In the "Cumulative Adult Patient
23 Profile" section of Patient A's chart, Respondent's diagnosis for both visits was "cough[.]"

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1 19. On or about October 15, 2014, Respondent saw Patient A for complaints of a cough,
2 especially at night, which was "non-productive." Patient A also sought to refill prescriptions.
3 Respondent's diagnosis was irritable cough, but he did not document any treatment plan other
4 than to refill unspecified medications and conduct a chest x-ray follow-up. No history regarding
5 Patient A's cough was documented. In the "Cumulative Adult Patient Profile" section of Patient
6 A's chart, Respondent's diagnosis was "cough – smoker[.]"

7 20. On or about November 5, 2014, Respondent saw Patient A for complaints of a cough
8 and runny nose, especially at night, and to refill prescriptions and follow up on x-ray results.
9 Respondent's diagnosis was irritable cough and allergy. Respondent ordered allergy testing and
10 refilled unspecified medications. No history regarding Patient A's cough or x-ray results was
11 documented. In the "Cumulative Adult Patient Profile" section of Patient A's chart,
12 Respondent's diagnosis was "allergic [illegible]" and "cough[.]"

13 21. On or about November 26, 2014, Respondent saw Patient A for complaints of an
14 irritable cough, especially at night when sleeping, which was "non-productive." Patient A also
15 sought to refill prescriptions. Respondent did not document any diagnosis or treatment plan other
16 than to refill unspecified medications. No history regarding Patient A's cough was documented.
17 In the "Cumulative Adult Patient Profile" section of Patient A's chart, Respondent's diagnosis
18 was "cough – smoker[.]"

19 22. On or about March 4, 2015, Respondent saw Patient A to follow up on x-ray results.
20 Respondent's diagnosis was "smoker's cough," even though Respondent's consult notes
21 continued to state that Patient A did not smoke. Respondent ordered an EKG. No history
22 regarding Patient A's cough or x-ray results was documented. In the "Cumulative Adult Patient
23 Profile" section of Patient A's chart, Respondent's diagnosis was "smoker's cough, pain in left
24 shoulder, [illegible], r/o cardiac pathology."

25 23. On or about March 18, 2015, Respondent saw Patient A to follow up on EKG results
26 and for complaints of chest pain. Patient A's EKG results and physical exam were normal.
27 Respondent's diagnoses were "smoker's cough" and "chest pain," and Respondent's treatment
28 plan was to refill unspecified medications and refer Patient A to cardiology for a stress test.

1 Respondent's consult notes did not mention anxiety or any other indication for prescribing
2 Xanax³ to Patient A. In the "Cumulative Adult Patient Profile" section of Patient A's chart,
3 Respondent's diagnoses were cough, chest pain, and anxiety.

4 24. On or about June 3, 2015, Respondent saw Patient A for complaints of pain in the left
5 ear. Respondent's consult notes did not mention anxiety or any other indication for prescribing
6 Xanax to Patient A. Respondent refilled unspecified medications. In the "Cumulative Adult
7 Patient Profile" section of Patient A's chart, Respondent's diagnoses were "smoker's cough,"
8 pain and tinnitus in the left ear, and anxiety.

9 25. According to the Controlled Substances Utilization and Evaluation System (CURES)
10 report for Patient A, between on or about November 6, 2013, and June 10, 2015, Patient A filled
11 approximately eleven (11) prescriptions of Phenergan-Codeine syrup and two (2) prescriptions of
12 Xanax, which Respondent prescribed. According to Patient A's medical records, specifically
13 Patient A's "Rx Therapeutic Record," Respondent prescribed Phenergan-Codeine syrup and
14 Xanax to Patient A on multiple occasions.

15 26. Between on or about November 6, 2013, and June 3, 2015, Respondent did not
16 document a complete history and progress of Patient A's cough.

17 27. Between on or about November 6, 2013, and June 3, 2015, Respondent prescribed
18 Phenergan-Codeine syrup to Patient A, despite the fact that Patient A had consistently normal
19 physical exams and did not exhibit respiratory distress.

20 28. Between on or about November 6, 2013, and June 3, 2015, Respondent prescribed
21 Phenergan-Codeine syrup to Patient A without documenting any discussions with Patient A
22 regarding safer alternative treatments.

23 29. Between on or about November 6, 2013, and June 3, 2015, Respondent did not refer
24 Patient A to a specialist, such as an allergist or pulmonologist, and he did not order pulmonary
25 function testing, despite the persistence of Patient A's cough and despite Patient A's repeated
26 requests for prescriptions of Phenergan-Codeine syrup.

27 ³ Xanax (alprazolam) is a Schedule IV controlled substance pursuant to Health and Safety
28 Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
Code section 4022.

1 30. Between on or about November 6, 2013, and June 3, 2015, Respondent did not have a
2 narcotic treatment agreement with Patient A.

3 31. Between on or about November 6, 2013, and June 3, 2015, Respondent did not
4 document Patient A's informed consent for narcotic treatment.

5 32. Between on or about November 6, 2013, and June 3, 2015, Respondent did not order
6 any urine drug screenings for Patient A.

7 33. Between on or about November 6, 2013, and June 3, 2015, Respondent did not
8 document any review of the CURES database, despite Patient A's repeated requests for
9 prescriptions of Phenergan-Codeine syrup and despite the lack of clear indication for the
10 medication.

11 34. On or about January 14, 2019, Respondent attended an interview as part of the
12 Board's investigation. At the interview, Respondent described codeine as a non-opiate, non-
13 addictive, and "not really severe."

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

16 (a) Respondent failed to keep a comprehensive history and progress of Patient A's
17 cough.

18 (b) Respondent failed to properly prescribe controlled substances to Patient A by:

19 (1) Prescribing Phenergan-Codeine syrup and Xanax to Patient A without
20 justifying the use of these medications in any substantial way;

21 (2) Prescribing Phenergan-Codeine syrup to Patient A, despite Patient A's
22 consistently normal physical exams and lack of respiratory distress;

23 (3) Prescribing Phenergan-Codeine syrup to Patient A without keeping a
24 comprehensive history and progress of Patient A's cough;

25 (4) Prescribing Phenergan-Codeine syrup to Patient A without documenting
26 any discussions with Patient A regarding safer alternative treatments;

27 (5) Prescribing Phenergan-Codeine syrup to Patient A without referring
28 Patient A to a specialist;

1 (6) Prescribing Phenergan-Codeine syrup to Patient A without ordering
2 pulmonary function testing;

3 (7) Prescribing Phenergan-Codeine syrup to Patient A without having a
4 narcotic treatment agreement;

5 (8) Prescribing Phenergan-Codeine syrup to Patient A without obtaining and
6 documenting Patient A's informed consent for narcotic treatment;

7 (9) Prescribing Phenergan-Codeine syrup to Patient A without ordering urine
8 drug screenings; and

9 (10) Prescribing Phenergan-Codeine syrup to Patient A without reviewing the
10 CURES database for Patient A's prescription history and patterns.

11 **Patient B**

12 36. On or about January 14, 2015, Respondent saw Patient B. According to
13 Respondent's consult notes, Patient B had a history of anxiety and mental illness, with a pending
14 psychiatric evaluation on March 3, 2015. Respondent noted that Patient B had back pain from the
15 neck down to the low back, as well as numbness in the mid back. However, the physical exam of
16 Patient B's back was marked as normal. Respondent's diagnoses included anxiety and back pain
17 due to scoliosis. Respondent ordered "scoliosis series" x-rays and refilled unspecified
18 medications. In an entirely separate section of Patient B's chart, referred to as the "Cumulative
19 Adult Patient Profile," Respondent noted an additional diagnosis of schizophrenia.

20 37. On or about February 11, 2015, Respondent saw Patient B for complaints of
21 "headache x 1 week" and to refill prescriptions. According to Respondent's consult notes, Patient
22 B's physical exam and vital signs were normal. Respondent did not document any further history
23 regarding Patient B's headache complaints or any diagnoses. Nor did he document any further
24 history of Patient B's anxiety, back pain, or scoliosis, including any prior x-ray results. His only
25 treatment plan was to refill unspecified medications. In the "Cumulative Adult Patient Profile"
26 section of Patient B's chart, Respondent noted his diagnoses for this visit, including anxiety, back
27 pain, schizophrenia, and migraine.

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1 38. On or about March 18, 2015, Patient B presented to Respondent for, *inter alia*, a
2 prescription refill. Respondent refilled unspecified medications.

3 39. On or about April 22, 2015, Respondent saw Patient B for a prescription refill and to
4 follow up on "results." Respondent documented a history of anxiety, back pain, depression, and
5 headaches, but he did not note any further history regarding these conditions or any diagnoses. In
6 the "Cumulative Adult Patient Profile" section of Patient B's chart, Respondent documented his
7 diagnoses for this visit, including anxiety, back pain, and schizophrenia. For this visit,
8 Respondent also completed a form entitled, "IEHP Dual Choice Annual Visit." In the assessment
9 and plan section of the form, Respondent noted that Patient B was taking Norco⁴ for chronic low
10 back pain, clonazepam⁵ for anxiety, and Imitrex for migraine headache. Respondent also noted
11 that Patient B had a drug dependency and a history of anxiety, schizophrenia, and depression with
12 a pending psychiatric follow-up. Respondent did not document any further history or details
13 regarding these conditions.

14 40. On or about June 17, 2015, Respondent saw Patient B for a prescription refill and
15 chiropractor referral. Respondent documented a history of anxiety, back pain, depression, and
16 headaches. Respondent's diagnoses were scoliosis and back pain. Respondent noted that
17 "scoliosis series" x-rays had been previously performed, but he did not document the x-ray results
18 or his assessment. Respondent did not note any further history regarding Patient B's scoliosis or
19 any other conditions. In the "Cumulative Adult Patient Profile" section of Patient B's chart,
20 Respondent documented his diagnoses for this visit, including anxiety, back pain (scoliosis), and
21 schizophrenia.

22 41. On or about July 22, 2015, September 16, 2015, October 21, 2015, November 18,
23 2015, and January 13, 2016, Respondent saw Patient B. According to Respondent's consult notes
24 for these visits, Respondent continued to note a history of anxiety, back pain, scoliosis,

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26 ⁴ Norco (hydrocodone and acetaminophen) 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.

27 ⁵ Clonazepam (Klonopin) is a Schedule IV controlled substance pursuant to Health and
28 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and
Professions Code section 4022.

1 depression, headaches, and schizophrenia. During the July 22, 2015, visit, Respondent described
2 Patient B's back pain, scoliosis, anxiety, mood disorder, and schizophrenia as "ongoing," but he
3 did not otherwise document any further history or details regarding these conditions. Respondent
4 continued to refill unspecified medications.

5 42. On or about April 6, 2016, Respondent saw Patient B for prescription refills and to
6 follow up on "results." According to Respondent's consult notes, no diagnoses were documented
7 and Respondent refilled unspecified medications. The treatment plan section referred to
8 "Physical Therapy LBP, DDD,"⁶ however, no further history or details were documented
9 regarding these conditions, including the results of any imaging tests. In the "Cumulative Adult
10 Patient Profile" section of Patient B's chart, Respondent documented his diagnoses for this visit,
11 including fatigue, anxiety, and chronic lower back pain.

12 43. On or about May 4, 2016, June 8, 2016, and July 7, 2016, Respondent saw Patient B.
13 Respondent continued to note a history of anxiety, back pain, and depression, but he did not
14 document any further history regarding these conditions and he continued to refill unspecified
15 medications. During the July 7, 2016, visit, Patient B had a normal physical exam and
16 Respondent did not document any diagnoses: In the treatment plan section, the words "pain
17 management" were also noted, however, nothing further was discussed. In the "Cumulative
18 Adult Patient Profile" section of Patient B's chart, Respondent documented his diagnoses for the
19 July 7, 2016, visit, including chronic lower back pain and anxiety.

20 44. On or about August 4, 2016, Respondent saw Patient B for a prescription refill, sore
21 throat, and sneezing. According to Respondent's consult notes, Respondent refilled unspecified
22 medications, but he did not document any diagnoses. Although Respondent continued to note a
23 history of anxiety, back pain, and depression, he did not document any further history or details
24 regarding these conditions. In the "Cumulative Adult Patient Profile" section of Patient B's chart,
25 Respondent documented his diagnoses for this visit, including, *inter alia*, chronic lower back pain
26 and anxiety.

27
28 ⁶ "LBP" and "DDD" appear to be shorthand for lower back pain and degenerative disk
disease.

1 45. According to the CURES report for Patient B, between on or about January 14, 2015,
2 and August 4, 2016, Patient B filled approximately seventeen (17) prescriptions of Norco and
3 fifteen (15) prescriptions of Klonopin, which Respondent prescribed.

4 46. Between on or about January 14, 2015, and August 4, 2016, Respondent documented
5 little to no history or treatment plan regarding Patient B's medical conditions, including anxiety,
6 back pain, scoliosis, depression, headaches, and schizophrenia.

7 47. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
8 document a comprehensive history of Patient B's back pain.

9 48. Between on or about January 14, 2015, and August 4, 2016, Respondent diagnosed
10 Patient B with scoliosis and degenerative disk disease, despite normal physical examinations and
11 the absence of imaging testing to corroborate these diagnoses.

12 49. Between on or about January 14, 2015, and August 4, 2016, Respondent did not have
13 any opioid treatment agreement with Patient B.

14 50. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
15 obtain or document Patient B's informed consent to use controlled substances, including Norco,
16 as part of the treatment plan.

17 51. Between on or about January 14, 2015, and August 4, 2016, Respondent did not order
18 any urine drug screenings for Patient B.

19 52. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
20 document that safer alternatives to Norco were tried first.

21 53. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
22 monitor Patient B's symptoms in order to, *inter alia*, assess Patient B's Norco dosages and make
23 adjustments thereto.

24 54. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
25 assess or document Patient B's baseline level of functioning or conduct any ongoing assessment
26 of Patient B's functionality and progress towards treatment goals.

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1 55. Between on or about January 14, 2015, and August 4, 2016, Respondent prescribed
2 Klonopin to Patient B without trying other treatments for anxiety and without insisting that
3 Patient B undergo regular psychiatric care.

4 56. Between on or about January 14, 2015, and August 4, 2016, Respondent did not make
5 any formal assessment of Patient B's anxiety, document any such assessments, or make any
6 referrals relating to Patient B's anxiety.

7 57. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
8 assess or document that safer alternative treatments to Klonopin were tried first.

9 58. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
10 assess or document Patient B's progress with anxiety or response to treatment.

11 59. Between on or about January 14, 2015, and August 4, 2016, Respondent did not
12 monitor Patient B for symptoms of schizophrenia.

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

15 (a) Respondent failed to appropriately document the history and plan of care
16 relating to Patient B's anxiety, back pain, scoliosis, depression, headaches, and
17 schizophrenia.

18 (b) Respondent failed to properly prescribe controlled substances to Patient B by:

19 (1) Prescribing Norco to Patient B without documenting a comprehensive
20 history of Patient B's back pain;

21 (2) Prescribing Norco to Patient B without corroborating the diagnoses of
22 scoliosis and degenerative disk disease, particularly in the face of normal physical
23 examinations;

24 (3) Prescribing Norco to Patient B without having an opioid treatment
25 agreement with Patient B;

26 (4) Prescribing Norco to Patient B without obtaining and documenting
27 Patient B's informed consent to use controlled substances as part of the treatment
28 plan;

- 1 (5) Prescribing Norco to Patient B without ordering urine drug screenings;
2 (6) Prescribing Norco to Patient B without documenting that safer
3 alternatives to Norco were tried first;
4 (7) Prescribing Norco to Patient B without monitoring Patient B's symptoms
5 in order to, *inter alia*, assess Patient B's dosages and make adjustments thereto;
6 (8) Prescribing Norco to Patient B without assessing or documenting any
7 baseline level of functioning and without conducting any ongoing assessment of
8 functionality and progress towards treatment goals; and
9 (9) Prescribing Klonopin to Patient B without trying other treatments for
10 anxiety and without insisting that Patient B undergo regular psychiatric care, given
11 Patient B's history of serious psychiatric diseases, which rendered Patient B a high-
12 risk patient.
13 (c) Respondent failed to appropriately evaluate and manage Patient B's anxiety
14 disorder by, *inter alia*, failing to formally assess Patient B's anxiety, document any
15 such assessments, or make any referrals; failing to assess or document that safer
16 alternative treatments to Klonopin were tried first; failing to assess or document
17 Patient B's progress with anxiety and response to treatment; and failing to monitor
18 Patient B for symptoms of schizophrenia.

19 **Patient C**

20 61. During a visit that took place on or about February 7, 2013, Patient C was diagnosed
21 with systemic lupus erythematosus, rheumatoid arthritis, and type 2 diabetes. The notes for this
22 visit described Patient C as "exhibiting drug-seeking behavior" and stated that she was referred to
23 pain management for chronic pain. In or around 2013, Patient C was referred to rheumatology
24 for a consultation regarding her rheumatoid arthritis and lupus, however, she did not show up at
25 the appointment on two occasions.

26 62. On or about June 28, 2013, Respondent saw Patient C. According to Respondent's
27 consult notes, Patient C had a history of diabetes, lupus, fibromyalgia, and CVA with right
28 hemiparesis and was "on pain med or other medication." Respondent did not document any

1 history or details regarding these conditions and he marked Patient C's physical exam as normal.
2 Respondent's only plan was to refill unspecified medications.

3 63. On or about July 19, 2013, Respondent saw Patient C to refill prescriptions.
4 According to Respondent's consult notes, Patient C admitted to "pain," however, no history or
5 details of the pain were documented. Patient C's physical exam was normal and Respondent's
6 plan was to refill unspecified medications and refer Patient C to pain management.

7 64. On or about August 16, 2013, Patient C reported to Respondent that she "had a mild
8 heart attack." No history or details of the heart attack were documented and no outside records
9 were referred to. Respondent did not document any diagnoses, and his plan was to refill
10 unspecified medications and "records release."

11 65. On or about September 20, 2013, Respondent saw Patient C. Respondent
12 documented Patient C's history of lupus and her report of "having pain all over[.]" needing pain
13 medication, and making frequent visits to the emergency room. However, no history or details of
14 Patient C's pain, lupus, or emergency visits were documented and no outside records were
15 referred to. Respondent's plan was to refill unspecified medications and refer Patient C to
16 rheumatology and pain management.

17 66. On or about October 11, 2013, Respondent saw Patient C for complaints of sore
18 throat, loss of voice, and cough, as well as to refill prescriptions. According to Respondent's
19 consult notes, Patient C stated that she did not want Percocet,⁷ but wanted Norco instead. Patient
20 C's physical exam was normal, except for throat and voice issues. Respondent's diagnoses were
21 systemic lupus erythematosus, rheumatoid arthritis, type 2 diabetes, laryngitis, and pharyngitis.
22 Respondent's plan was refill unspecified medications, order a urine drug screen, and refer Patient
23 C to rheumatology and pain management.

24 67. On or about November 8, 2013, December 6, 2013, February 5, 2014, March 5, 2014,
25 and April 2, 2014, Respondent continued to refill unspecified medications for Patient C. No
26 history or details of any of Patient C's medical conditions were documented. According to

27 ⁷ Percocet (oxycodone and acetaminophen) is a Schedule II controlled substance pursuant
28 to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to
Business and Professions Code section 4022.

1 Respondent's consult notes for a visit that took place on or about April 30, 2014, Respondent's
2 plan was to order a urine drug screen, but no history or details for the order were documented.

3 68. On or about May 28, 2014, Patient C was seen by another physician at Respondent's
4 clinic. According to the attending physician's consult notes, there was no supporting evidence in
5 Patient C's chart for any connective-tissue disorder, as well as no symptoms of an acute joint
6 problem or any deformities. The physician noted that Patient C could not give the name of the
7 rheumatologist she claimed to have seen and that she no-showed twice in 2013 at the
8 rheumatology office. In addition, the physician noted that Patient C was seen walking into the
9 clinic without assistance and, despite carrying a walker in front of her, she was not actually using
10 it to ambulate.

11 69. According to the CURES report for Patient C, between on or about June 28, 2013,
12 and April 30, 2014, Patient C filled approximately eleven (11) prescriptions of Endocet⁸ or
13 Percocet, nine (9) prescriptions of Fentanyl transdermal patch,⁹ two (2) prescriptions of Norco,
14 eight (8) prescriptions of Ambien,¹⁰ seven (7) prescriptions of Xanax (alprazolam), eight (8)
15 prescriptions of Soma,¹¹ and two (2) prescriptions of Klonopin (clonazepam), which Respondent
16 prescribed. According to Patient C's medical records, specifically Patient C's "Rx Therapeutic
17 Record," Respondent prescribed these medications to Patient C on multiple occasions.

18 70. Between on or about June 28, 2013, and April 30, 2014, Respondent did not ensure
19 that the painful medical conditions reported by Patient C, including lupus and rheumatoid
20 arthritis, were correct.

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22 ⁸ Endocet (oxycodone and acetaminophen) is a Schedule II controlled substance pursuant
23 to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to
Business and Professions Code section 4022.

24 ⁹ Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code
25 section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code
section 4022.

26 ¹⁰ Ambien (zolpidem tartrate) 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.

27 ¹¹ Soma (carisoprodol) is a Schedule IV controlled substance pursuant to Health and
28 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and
Professions Code section 4022.

1 71. Between on or about June 28, 2013, and April 30, 2014, Respondent prescribed pain
2 medications, benzodiazepines, and sedative muscle relaxers to Patient C, but Respondent did not
3 assess or document a comprehensive history of Patient C's painful medical conditions, her
4 activities and functional ability, or her therapy goals and progress.

5 72. Between on or about June 28, 2013, and April 30, 2014, Respondent prescribed high
6 dosages of opioids to Patient C concurrently with Xanax and Ambien, thereby placing Patient C
7 at high risk of adverse reactions, overdose, and death.

8 73. Between on or about June 28, 2013, and April 30, 2014, Respondent failed to obtain
9 Patient C's informed consent regarding the controlled substances prescribed by Respondent,
10 including warning Patient C of the dangers of taking high dosages of opioids concurrently with
11 benzodiazepines.

12 74. Between on or about June 28, 2013, and April 30, 2014, Respondent changed Patient
13 C's opioid medications from Percocet/Endocet to Norco on two separate occasions without any
14 clinical justification.

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

17 (a) Respondent failed to properly prescribe controlled substances to Patient C by:

18 (1) Prescribing pain medications to Patient C without ensuring that the
19 painful medical conditions reported by Patient C, including lupus and rheumatoid
20 arthritis, were correct;

21 (2) Prescribing pain medications, benzodiazepines, and sedative muscle
22 relaxers to Patient C without documenting a comprehensive history of Patient C's
23 painful medical conditions, her activities and functional ability, or her therapy goals
24 and progress;

25 (3) Prescribing high dosages of opioids to Patient C concurrently with Xanax
26 and Ambien, despite the high risk of adverse reactions, overdose, and death;

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- 1 (4) Failing to obtain Patient C's informed consent regarding the controlled
- 2 substances prescribed by Respondent and failing to warn Patient C of the dangers of
- 3 taking high dosages of opioids concurrently with benzodiazepines; and
- 4 (5) Changing Patient C's opioid medications without any clinical
- 5 justification.

6 **Patient D**

7 76. On or about May 30, 2012, Patient D underwent a spine x-ray revealing "an 8 degree

8 thoracic levoscoliosis, measured from the top of T6 to the top of T11."

9 77. On or about September 4, 2013, Respondent saw Patient D for a backache that

10 worsened with work. According to Respondent's consult notes, Patient D requested pain

11 medications. Respondent documented a history of scoliosis in the T-spine, significant backache,

12 and the use of Motrin with minimal efficacy. Patient D's physical exam was marked as normal

13 and Respondent's plan was to refer Patient D to orthopedics for scoliosis and backache.

14 78. On or about December 4, 2013, Respondent saw Patient D to refill prescriptions.

15 According to Respondent's consult notes, Respondent's diagnoses were scoliosis and back pain,

16 but no additional history or details regarding these medical conditions or any orthopedics

17 consultation were documented. Respondent did not document any treatment plan other than to

18 refill unspecified prescriptions.

19 79. On or about January 15, 2014, Respondent saw Patient D to refill prescriptions and

20 obtain another referral to orthopedics because Patient D "never made it to [the] [appointment]."

21 Respondent noted that Patient D complained of "backache [and] muscular spasm from scoliosis."

22 Other than noting "scoliosis," Respondent marked Patient D's physical exam as normal and the

23 plan was to refer Patient D to orthopedics and refill unspecified medications.

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1 80. On or about March 12, 2014, April 23, 2014, June 25, 2014, September 24, 2014, and
2 October 22, 2014, Respondent saw Patient D to refill prescriptions. According to Respondent's
3 consult notes for these visits, Respondent's diagnoses were scoliosis and back pain, but no
4 additional history or details regarding these medical conditions or any orthopedics consultation
5 were documented. Respondent marked Patient D's physical exam as normal. Other than refilling
6 unspecified prescriptions and ordering an orthopedics evaluation at the June 25, 2014, visit, no
7 other treatment plan was documented.

8 81. On or about January 7, 2015, and March 4, 2015, Respondent saw Patient D to refill
9 prescriptions. According to Respondent's consult notes for the January 7, 2015, visit, Patient D
10 never did an orthopedics consultation. For both visits, Respondent's diagnoses were scoliosis and
11 back pain, but no additional history or details regarding these medical conditions were
12 documented. Respondent marked Patient D's physical exam as normal. Respondent did not
13 document any treatment plan other than to refill unspecified prescriptions and order another
14 orthopedics evaluation.

15 82. On or about May 6, 2015, and June 3, 2015, Respondent saw Patient D to refill
16 prescriptions. According to Respondent's consult notes, Respondent's diagnoses were scoliosis
17 and back pain, but no additional history regarding these medical conditions was documented.
18 Respondent marked Patient D's physical exam as normal. Respondent did not document any
19 treatment plan other than to refill unspecified prescriptions.

20 83. On or about August 5, 2015, Respondent saw Patient D to refill prescriptions.
21 Respondent noted that Patient D had "no complaints." Respondent's diagnoses were scoliosis
22 and back pain, but no additional history or details regarding these medical conditions were
23 documented. Respondent marked Patient D's physical exam as normal. Respondent did not
24 document any treatment plan other than to refill unspecified prescriptions.

25 84. Between on or about September 30, 2015, and September 29, 2016, Respondent saw
26 Patient D on approximately ten (10) occasions to refill prescriptions. During a visit that took
27 place on or about February 3, 2016, Respondent ordered another orthopedics evaluation.
28 According to Respondent's consult notes for these visits, Respondent's diagnoses were scoliosis

1 and back pain, but no additional history or details regarding these medical conditions were
2 documented. Respondent marked Patient D's physical exam as normal. Respondent did not
3 document any treatment plan other than to refill unspecified prescriptions.

4 85. According to the CURES report for Patient D, between on or about September 4,
5 2013, and September 29, 2016, Patient D filled approximately twenty-six (26) prescriptions of
6 Tylenol-Codeine #3,¹² which Respondent prescribed. According to Patient D's medical records,
7 specifically Patient D's "Rx Therapeutic Record," Respondent prescribed Tylenol-Codeine #3 to
8 Patient D on multiple occasions.

9 86. Between on or about September 4, 2013, and September 29, 2016, Respondent lacked
10 appropriate clinical justification for prescribing multiple daily doses of Tylenol-Codeine #3 to
11 Patient D.

12 87. Between on or about September 4, 2013, and September 29, 2016, Respondent did
13 not assess or document a comprehensive history of Patient D's back pain, including any details of
14 the back pain.

15 88. Between on or about September 4, 2013, and September 29, 2016, Respondent did
16 not assess or document Patient D's functional ability or his progress with treatment, including any
17 adverse side effects of such treatment.

18 89. Between on or about September 4, 2013, and September 29, 2016, Respondent did
19 not assess or document any plans to de-escalate therapy with Tylenol-Codeine #3.

20 90. Between on or about September 4, 2013, and September 29, 2016, despite multiple
21 referrals for an orthopedics evaluation, Respondent did not insist that Patient D complete an
22 evaluation as a prerequisite for treatment with controlled substances.

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

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27 ¹² Tylenol-Codeine #3 (acetaminophen and codeine) is a Schedule III controlled substance
28 pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug
pursuant to Business and Professions Code section 4022.

1 (a) Respondent failed to properly prescribe controlled substances to Patient D by:

2 (1) Prescribing multiple daily doses of Tylenol-Codeine #3 to Patient D
3 without appropriate clinical justification;

4 (2) Failing to assess or document a comprehensive history of Patient D's
5 back pain, including any details of the back pain;

6 (3) Failing to assess or document Patient D's functional ability or his
7 progress with treatment, including any adverse side effects of such treatment;

8 (4) Failing to assess or document any plans to de-escalate therapy with
9 Tylenol-Codeine #3; and

10 (5) Failing to insist that Patient D complete an orthopedics evaluation as a
11 prerequisite for continuing treatment with Tylenol-Codeine #3.

12 **SECOND CAUSE FOR DISCIPLINE**

13 **(Repeated Negligent Acts)**

14 92. Respondent has subjected his Physician's and Surgeon's Certificate No. A 34003 to
15 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of
16 the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B,
17 C, D, and E, as more particularly alleged hereinafter:

18 **Patient A**

19 93. Paragraphs 10 through 35, above, are hereby incorporated by reference and re-alleged
20 as if fully set forth herein.

21 **Patient B**

22 94. Paragraphs 36 through 60, above, are hereby incorporated by reference and re-alleged
23 as if fully set forth herein.

24 **Patient C**

25 95. Paragraphs 61 through 75, above, are hereby incorporated by reference and re-alleged
26 as if fully set forth herein.

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1 **Patient D**

2 96. Paragraphs 76 through 91, above, are hereby incorporated by reference and re-alleged
3 as if fully set forth herein.

4 **Patient E**

5 97. On or about March 18, 2015, Respondent saw Patient E for pain in the right lower leg
6 and third finger. According to Respondent's consult notes, Patient E's physical exam was normal
7 and the plan was to order an x-ray of the spine and right hand.

8 98. On or about April 1, 2015, Respondent saw Patient E to follow up on the x-ray
9 results. Respondent noted that the spine x-ray showed degenerative changes. He also noted pain
10 in the left leg. Patient E's physical exam was marked normal. Respondent's diagnosis was
11 chronic low back pain and left leg radiculopathy. The plan was to refer Patient E for an
12 orthopedic evaluation and physical therapy. No medication prescriptions are reflected in
13 Respondent's consult notes for this visit.

14 99. On or about June 10, 2015, Respondent saw Patient E to follow up on her chronic low
15 back pain, which Respondent noted went down her left leg. Patient E's physical exam was
16 normal and the plan was to refill unspecified medications and order blood work.

17 100. Between on or about August 12, 2015, and December 29, 2016, Respondent saw
18 Patient E on a near-monthly basis. According to Respondent's consult notes for these visits,
19 Respondent continued to refill unspecified medications for Patient E.

20 101. According to the CURES report for Patient E, between on or about April 1, 2015, and
21 December 29, 2016, Patient E filled approximately fourteen (14) prescriptions of Tylenol-
22 Codeine #4,¹³ which Respondent prescribed. According to Patient E's medical records,
23 specifically Patient E's "Rx Therapeutic Record," Respondent prescribed Tylenol-Codeine #4 to
24 Patient E on multiple occasions.

25 102. Between on or about April 1, 2015, and December 29, 2016, Respondent did not
26 document a comprehensive history and progress of Patient E's degenerative disc disease.

27 ¹³ Tylenol-Codeine #4 (acetaminophen and codeine) is a Schedule III controlled substance
28 pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug
pursuant to Business and Professions Code section 4022.

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 34003, issued to Respondent Norman Yuh Wei Chow, M.D.;

2. Revoking, suspending or denying approval of Respondent Norman Yuh Wei Chow, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Norman Yuh Wei Chow, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Norman Yuh Wei Chow, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and

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

DATED: August 15, 2019


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

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