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

In the Matter of the Accusation and Petition to Revoke Probation Against:	)	
Eric David Gordon, M.D.	)	Case No. 800-2018-039973
Physician's and Surgeon's Certificate No. G82342	)	
Respondent	)	

DECISION

The attached Proposed Decision 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 February 28, 2020.

IT IS SO ORDERED: January 31, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation and Petition to Revoke Probation against:

ERIC DAVID GORDON, M.D., Respondent

Case No. 800-2018-039973

OAH No. 2019061225

PROPOSED DECISION

Administrative Law Judge (ALJ) Tiffany L. King, Office of Administrative Hearings (OAH), State of California, heard this matter on October 9 through 11, and November 7 and 8, 2019, in Oakland, California.

Lynne K. Dombrowski, Deputy Attorney General, represented Kimberly Kirchmeyer (complainant), the former Executive Director, Medical Board of California (Board), Department of Consumer Affairs, State of California.

Marvin Firestone, Attorney at Law, represented Eric David Gordon, M.D. (respondent), who was present.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for written decision on November 8, 2019.

FACTUAL FINDINGS

1. The Board issued Physician's and Surgeon's Certificate Number G 82342 (license) to respondent on July 17, 1996. The license will expire on January 31, 2020, unless revoked or renewed.

2. On April 25, 2018, complainant, in her official capacity, made and served the Accusation and Petition to Revoke Probation against respondent. Complainant seeks to discipline respondent's license on the grounds of gross negligence, repeated negligent acts, prescribing without prior exam and medical indication, excessive prescribing, and failure to maintain adequate and accurate records. Additionally, complainant seeks to revoke respondent's probation based on allegations he violated Probation Condition 9, to obey all rules governing the practice of medicine.

3. Respondent timely filed a Notice of Defense pursuant to Government Code section 11505. The matter was set for an evidentiary hearing before an administrative law judge of the Office of Administrative Hearings pursuant to Government Code section 11500 et seq.

Respondent's Probation

4. In October 2015, in Case No. 12-2012-227503, an accusation was filed against respondent which alleged that he engaged in gross negligence, repeated negligent acts, prescribing without prior exam and medical indication and excessive prescribing with regard to his treatment and care for four patients. On October 6, 2016, respondent entered into a Stipulated Settlement and Disciplinary Order (Stipulated Settlement), pursuant to which respondent's license was revoked, the revocation stayed, and respondent was placed on probation for three years.

Additionally, respondent stipulated that if the Board "ever petitions for revocation of probation, all of the charges and allegations contained in the accusation . . . shall be deemed true, correct and fully admitted by [r]espondent for purposes of that proceeding or any other licensing proceeding . . ." On November 18, 2016, the Board adopted the Stipulated Settlement as its Decision and Order, effective December 16, 2016.

5. Respondent's probation included the following pertinent terms and conditions: prohibition against prescribing Schedule II controlled substances until successful completion of a course in prescribing practices; prohibition against issuance of medical marijuana recommendations; maintenance of a controlled substances log; completion of 40 hours of educational courses, including 20 hours in the area of chronic pain management; completion of courses in prescribing practices and medical record keeping; use of a practice monitor board-certified in pain medicine who will submit quarterly reports to the Board; and, compliance with the rules governing the practice of medicine in California.

6. Respondent successfully completed the educational courses prior to the start of his probationary term. As a result, his ability to prescribe Schedule II controlled substances was not restricted when he began probation.

7. On March 26, 2018, pursuant to the parties' stipulation, ALJ David Benjamin issued an Interim Suspension Order Restricting Medical Practice (Interim Order) against respondent. The Interim Order, which remains in full force and effect, prohibits respondent from prescribing, administering, or otherwise dispensing any controlled substances.

Respondent's Background

8. Respondent graduated from Queens College of the City University of New York in 1976, earning a bachelor of science in chemistry. He earned his medical doctorate from Albany Medical College in 1980. Thereafter, respondent completed residency training in family practice at St. Clare's Hospital in New York from 1980 to 1983. Respondent then practiced as an emergency room physician at Leonard Hospital for two years before joining the private medical group, Greenwich Family Practice. Respondent continued as a family medicine practitioner in New York until 1996. From 1996 to 1997, he served as the associate medical director of the Pain Clinic at Shealy Institute in Springfield, Missouri.

9. In 1997, respondent and his wife relocated to Santa Rosa, California, to be closer to their grandchildren. Upon becoming licensed in California, respondent worked in private practice specializing in family medicine and alternative medicine for Santa Rosa Medical Group and later, Heart to Heart Medical Center. Since 2003, respondent has operated his own practice, Gordon Medical Associates, specializing in family medicine and alternative medicine.

10. Respondent is licensed to practice medicine in California and Missouri, and was previously licensed in New York.[1] He has been board-certified in family practice since 1984. He also holds a certificate in osteopathic manipulation and a certificate of qualification in geriatrics.

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[1] In July 2017, respondent surrendered his New York medical license due, in part, to the 2015 Board accusation against his California license.

11. When he initially began practicing in California, respondent practiced in pain management for the first six months before shifting to functional medicine and treating atypical syndromes. He had specialized in Lyme disease since 1991, and it ultimately grew to 70 to 80 percent of his practice.

12. With few exceptions, respondent stopped accepting new chronic pain patients in 2005. The only chronic pain patients he continued to treat were long-term patients from 1995 to 2005, though most of his general patients also have pain as a component of their presenting issue. When he was placed on probation in 2016, respondent had approximately 30 patients whom he had been treating for chronic pain for at least 15 to 20 years. Today, respondent treats almost no patients for chronic pain. He does not prescribe medications, rather his patients receive prescriptions by outside doctors, or referrals to pain management or specialist for additional treatment.

Albert Y. Leung, M.D. - Practice Monitor

13. To comply with his probation, respondent retained a practice monitor selected through the Physician Enhancement Program (PEP) of the Physician Assessment and Clinical Education (PACE) program at the University of California, San Diego (UC San Diego), School of Medicine. PEP assigned Albert Y. Leung, M.D., to review and evaluate respondent's management and care of patients with chronic pain.

14. Dr. Leung is licensed to practice medicine in California, and board-certified in anesthesiology, with added qualification in pain management, and in pain medicine. Dr. Leung earned a bachelor of science in biochemistry from the University of California, Davis (UC Davis), in 1988, and a medical doctorate from the University of Pittsburgh, School of Medicine in 1993. He completed a three-year residency advanced

clinical track in anesthesiology at UC Davis, followed by a two-year combined clinical and research pain fellowship at UC San Diego. From 1999 to 2011, Dr. Leung taught in the Department of Anesthesiology at the UC San Diego, School of Medicine. From 2001 to 2006, he was also the Director of the Anesthesia Pain and Palliative Medicine Service for the Veteran Affairs San Diego Healthcare System (VA San Diego).

15. Since 2011, Dr. Leung has been a full professor at UC San Diego, School of Medicine, in the Department of Anesthesiology and associated with the Center for Pain Medicine. He has also served as the Director of the Center for Pain and Research at the VA San Diego since 2017. Both roles include a clinical component in which Dr. Leung evaluates, treats and manages chronic pain patients. Since 2015, he has been a senior faculty member on UC San Diego's Clinical Competence Committee for pain management. He has also published extensively on topics relating to chronic pain and pain management.

16. Dr. Leung has been a faculty mentor with PACE since 2007, and has mentored approximately 20 physicians during his tenure. In this role, he assists physicians who are the subject of Board discipline by monitoring and trying to improve their clinical proficiencies in order to facilitate their rehabilitation and full restoration of their license to practice. His responsibilities included providing a monthly review of patient charts submitted by the physician, conducting a site visit at the practice location every six months, and discussing his findings and recommendations with the physician.

17. As respondent's practice monitor, Dr. Leung was provided with and reviewed respondent's curriculum vitae, the Board's 2015 disciplinary documentation, and respondent's self-assessment regarding the Board's disciplinary actions. Additionally, every month, he was provided six to seven of respondent's redacted

patient chart notes, randomly selected, which documented a patient visit, procedure, or telephone call. Dr. Leung reviewed and comments on each chart note, including making findings as to its sufficiency and recommendations, then discusses them with respondent. Dr. Leung's comments are then compiled into a PEP audit report. Additionally, Dr. Leung prepared a quarterly report regarding his review. The report is then submitted to PEP, the Board, and respondent.

FIRST QUARTERLY REPORT – MARCH THROUGH MAY 2017

18. Dr. Leung's first quarterly report regarding respondent's pain management practice was dated July 20, 2017, and covered the period of March through May 2017. In his report, without identifying any specific patient or record, Dr. Leung opined that respondent's patient notes were below a satisfactory level overall and that he deemed some of respondent's practice patterns to be unsafe and below the standard of care. Specifically, Dr. Leung noted the following issues:

> 1) The notes were not in standard SOAP[2] format and most of the notes did not mention any chief complaints;
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> 2) Subjective findings were too broad without any specific and detailed information about individual pain complaints;
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> 3) Very little or no information was provided for patients' past pain therapy and current doses of analgesic and their side effects and efficacy;

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[2] SOAP is an acronym for subjective, objective, assessment, and plan, and is a method of documentation employed by physicians to enter notes in a patient's chart.

4) Likewise, the physical exam findings were too brief and non-specific for the presented clinical problems;

5) I found it very concerning the participant provided intravenous narcotics and sedatives such as Versed to his patients at an outpatient practice without proper training in conscious sedation and sounded [*sic*] clinical justification;

6) Equally concerning is his prescribing of narcotic medication to a patient who is currently using cannabis without adequate risk assessment and sound clinical justification;

7) Pain assessments were poorly supported by non-specific subjective and objective findings;

8) Patients with significant co-morbid psychological conditions are not being co-managed by mental health professionals.

19. Dr. Leung discussed these issues with respondent and made initial recommendations during a telephone call on July 19, 2017. In his report, he noted that respondent was "quite defensive," but overall understood that he needed to make modifications to his practice to meet the standard of care and minimize risks. Dr. Leung recommended respondent be continuously and closely monitored until the deficiencies were addressed.

20. In an email dated July 23, 2017, respondent thanked Dr. Leung for his "patience with my behavior on the phone," explaining that his emotions got the better

of him. Respondent also noted he was currently using a physician's assistant (PA) as a scribe, but that the PA "cannot read my mind," and he would work on improving his charting. In a post-script, respondent stated: "I know that my actions were light years from the standard of care and accept the need for the work you are attempting to do. It is the over the top legal verbiage that provokes me."

21. Dr. Leung responded by email on July 26, 2017. He noted that respondent's reaction to having a practice monitor was "in fact quite common among the PACE participants," and hoped respondent would see the program's benefits in the coming months. Dr. Leung also reiterated his role as a practice monitor was to "point out to you things that I see as problematic in your practice relating to pain management and help you come up with [a] solution to address these issues, minimize risks and improve your practice accordingly."

SITE VISIT – SEPTEMBER 28, 2017

22. Dr. Leung conducted a site visit at respondent's Santa Rosa office on September 28, 2017. Approximately one month before the site visit, Dr. Leung requested by email that respondent "prepare 6-8 volumes of patient record [*sic*] and all relevant regulatory documents for review." While respondent sought clarification of what was a "regulatory document," he did not state anything with respect to the request for six to eight patient longitudinal records.

23. Dr. Leung authored a report, dated October 4, 2017, in which he summarized his observations and assessments of respondent's practice during the site visit on September 28, 2017:

a. Respondent periodically infused narcotic (Fentanyl)[3], anxiolytics (Versed[4] and Xanax[5]), and ketamine[6] to his chronic pain patients; he also provided muscle injections to his patients using a local anesthetic or other polotherapeutic agents.

b. Respondent did not have any established policy relevant to patients' pre- and post-infusion evaluations as well as medical emergency handling.

c. All Schedule II controlled substances were locked in a drawer, but other medications were unlocked. Also, multi-dosing vials of medication were

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[3] Fentanyl is an opioid analgesic, primarily used for anesthesia and sedation. It is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (b)(1), and a dangerous drug as defined by Business and Professions Code section 4022.

[4] Versed, a brand name for midazolam, is a Schedule IV controlled substance as defined by Health and Safety Code section 11057, subdivision (d), and a dangerous drug as defined by Business and Professions Code section 4022.

[5] Xanax, a brand name for alprazolam, is a Schedule IV controlled substance as defined by Health and Safety Code section 11057, subdivision (d), and a dangerous drug as defined by Business and Professions Code section 4022.

[6] Ketamine is a short-acting anesthetic and a Schedule III controlled substance as defined in Health and Safety Code section 11056, and a dangerous drug as defined by Business and Professions Code section 4022.

unlabeled; in his office, respondent had open local anesthetic vials without a date of first usage.

d. Respondent's certification for Advanced Cardiac Life Support (ACLS) was expired. Some of the medications in the ACLS kits had expired. Additionally, the ACLS kits had only one size of ventilation mask and did not have any larynx scopes or endotracheal tubes.

e. Respondent lacked knowledge regarding conscious sedation and the requirements associated with his practice of outpatient IV infusions of narcotics and anxiolytics.

f. Respondent was unable to produce longitudinal patient records notwithstanding Dr. Leung had requested such records in advance. Respondent could not produce any chronic pain patient record with an initial evaluation performed after 2011, when his office adopted an electronic medical records (EMR) system.

24. Dr. Leung also observed respondent evaluate three chronic pain patients, including JP, a patient on a "very high narcotic regimen for many years." Dr. Leung assessed that respondent's evaluation of these patients' pain problems was too general and lacked specificity in formulating the diagnosis. He noted that respondent also failed to recognize that one patient's development of clonus[7] may be "a possible side effect from the long-term usage of high doses of opioids." He criticized respondent's overreliance on his physician assistant to take notes of the patient visit.

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[7] Clonus is a muscular spasm involving repeated, often rhythmic, contractions. (https://www.lexico.com/en/definition/clonus.)

Finally, Dr. Leung noted that respondent's "practice of IV infusion of medications without adequate resuscitation preparation and training, and policy to guide the staff in case of a medical emergency is very concerning," and that respondent seemed to be "confused" about the current definition of conscious sedation as well as the guidelines and requirements associated with it. To that end, Dr. Leung opined that "the practice of regular outpatient IV infusion of narcotic and anxiolytics are outside the boundary of the standard [of] care and should be stopped immediately."

25. During the site visit, Dr. Leung demonstrated to respondent the type of patient exam which should have been performed. Respondent was receptive to the demonstration. Dr. Leung also observed that respondent relied heavily on a PA scribe, which was problematic as some of the pertinent information can get lost in translation, or not adequately reflected by the PA in the chart note. When he spoke with the PA, she expressed to Dr. Leung that she had her own concerns and did not know what was required for charting pain assessments.

26. At the conclusion of the site visit, Dr. Leung discussed his concerns and recommendations with respondent, including that respondent participate in the clinical observation program of PACE's Phase II program. Respondent declined, citing financial reasons.

SECOND QUARTERLY REPORT – JUNE THROUGH AUGUST 2017

27. Dr. Leung authored and submitted a second quarterly report, dated October 5, 2017, and covering the period of June through August 2017. In this report, Dr. Leung noted that most of the issues discussed in the first quarterly report remained outstanding. Regarding documentation, he cited as an example a chart note for one patient's muscular injection, which he opined "was poorly documented in

terms of diagnosis, informed consent, procedural approach, the amount of medication and instrument used for the injection."

28. Dr. Leung noted that there was "no major improvement" in respondent's practice patterns in pain management, several of which were unsafe and did not meet the standard of care. He again recommended that respondent continue to be monitored closely until the noted deficiencies were addressed.

THIRD QUARTERLY REPORT – SEPTEMBER THROUGH NOVEMBER 2017

29. Dr. Leung's third quarterly report, dated January 18, 2018, covered the period of September through November 2017, and noted the following outstanding issues:

> 1) Descriptives in the subjective finding are still not well structured and at times very confusing;
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> 2) Some of the phone record actually has a physical exam description. The participant should consider conducting detailed proof reading before signing the note;
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> 3) Some procedure notes were bundled in with regular clinic visit notes without clear description of the informed consent process, the indication and the required details of the procedure;
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> 4) A majority of his patients carrying the diagnosis of 'Lyme Disease.' Some presented with ongoing neurological manifestation including seizure. There is a tendency for the participant to assume that all pain presentations are

manifestations of the disease, and thus ignoring any additional investigation or assessments[.] [It] is paramount that a more detailed workup or a neurology consult should be performed to ascertain other possible reversible causes;

5) Long term use of [intramuscular] Demerol[8] or other IV opioids for patients with headache and chronic pain were intermittently found in the recent cycles of review. This sort of practice without well justification can potentially impose a negative impact on the patient's pain management and inadvertently increase the practice risks;

6) Likewise, Precedex, an anesthesia sedation agent, mainly utilized in intraoperative and intensive care settings was being considered as an outpatient IV infusion regiment for a patient with anxiety and mood issues without clear justification and inputs form mental health professionals;

7) Physical exam findings are still too brief and non-specific for the presented clinical problems. Some of the follow-up notes did not have ANY documented exam findings;

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[8] Demerol, a brand name of meperidine hydrochloride, is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (c), and a dangerous drug as defined by Business and Professions Code section 4022.

8) Overall, pain assessments were poorly supported by non-specific subjective and objective findings.

30. While Dr. Leung recognized "some improvement" in respondent's overall chart documentation, he nevertheless found that some of respondent's practice patterns remained unsafe and did not meet the standard of care. Dr. Leung recommended that respondent continue to be monitored closely until "some of the major practice issues are adequately addressed."

Respondent's Testimony – Practice Monitor

31. When respondent was initially placed on probation, he knew the Board had to approve his practice monitor. He decided to go through the PACE PEP program because it was guaranteed the Board would approve whomever was assigned. Although his probation required that he have a practice monitor for the pain management side of his practice only, respondent opted to hire a second practice monitor from PACE, Philip J. Eulie, M.D., to evaluate and guide him on the family practice side as well.

32. Respondent submitted his patient chart notes and did not hear anything from PACE for several months. He first spoke with Dr. Leung in July 2017. Just prior to that discussion, respondent had surrendered his New York medical license because of the 2015 California Board action. This was particularly upsetting because it was his first medical license.

33. Dr. Leung focused a lot on documentation and the SOAP format. Although respondent was familiar with SOAP from his hospital days, the format did not work for respondent's chronic pain patients. Rather, respondent wrote chart notes for "an audience of one" – to keep himself on track. A typical follow up visit lasts 45

minutes to an hour, during which there is extensive discussion. Respondent does not type because it hurts his hands, so he got into the habit of writing things in phrases. His chart notes would get "skimpier" the longer he was treating the chronic pain patient because he knew them so well. Still, respondent acknowledged that his recordkeeping had gotten "sloppy" over the years. Respondent has since hired a scribe to write down what he says during patient visits.

34. Prior to probation, it was not respondent's practice to document every time he obtained informed consent, even though he fully discussed any procedure with the patient before doing anything. He began documenting informed consent after taking the recordkeeping course at PACE, but sometimes he still misses it. Prior to probation, patient JP was the only one of respondent's patients who was administered any IV opioid (Fentanyl) on a regular basis. During probation, the only patients who were administered opioids via injection were JP (IV Fentanyl) and ND (Versed intramuscularly). He also obtained a conscious sedation certificate upon Dr. Leung's recommendation, and renewed his ACLS certification. Since March 2018, due to the interim suspension order, respondent has not prescribed or administered any opioid medications.

35. When describing his relationship with Dr. Leung, respondent asserted that one "could not find two more opposite human beings." He felt Dr. Leung employed a rigid, linear approach, and had no interest in understanding his practice. When Dr. Leung interacted with respondent's patients during the site visit, he did not seem to pay any attention to them. Respondent tried to follow Dr. Leung's suggestions "with renewed vigor," but he was frustrated and the site visit had not been as comfortable as he had hoped. His communications with Dr. Leung were difficult. He did not receive the type of guidance he desired or expected.

36. Respondent's initial interaction with Dr. Eulie was similar to that of Dr. Leung. He felt misunderstood, and was insulted and embarrassed by the whole disciplinary process. However, Dr. Eulie continued to work collaboratively with him and saw significant improvement on the family practice side of his office.

Expert Witnesses

ALBERT LEUNG, M.D.

37. At hearing, complainant called Dr. Leung as an expert witness. Dr. Leung did not author an expert report, but relied on, and testified consistently with, his practice monitor reports and review of respondent's patient chart notes. At hearing, he testified about ten chronic pain patients treated by respondent in 2017, whose chart notes respondent submitted to the PEP Program.[9] With respect to charting, Dr. Leung testified that, while the SOAP format is not required, it works best for pain management. Each chart note should reflect the patient's chronic pain complaints and symptoms, as well as assessment and physical exam, even if there is no change since the last visit and regardless if the physician utilizes an EMR system or records chart notes by hand.

BERNARD R. WILCOSKY, JR., M.D.

38. Respondent called Bernard Wilcosky, M.D., as an expert witness. Dr. Wilcosky was a career military man who attended Duke University School of Medicine on a military scholarship program and received his medical degree in 1981. He initially

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[9] None of these ten patients are identified in the Accusation / Petition to Revoke Probation or any of Dr. Leung's quarterly reports or site visit report.

became interested in pain management based on his own combat injuries. Dr. Wilcosky completed his internship (rotating), residency (anesthesiology) and fellowship (cardiothoracic anesthesia) at the Letterman Army Medical Center in San Francisco. His duties during residency included setting up a pain clinic to provide pain management experience for anesthesiology residents, to meet new requirements by the American Board of Anesthesiology.

39. Dr. Wilcosky is board-certified in anesthesiology, with added qualification in pain management, and in pain medicine. He has held an advanced prescriber certificate from the American Academy of Pain Management since 2015. He is a Diplomate of the National Board of Medical Examiners. Dr. Wilcosky has been a treating physician throughout his career, and maintains privileges in pain management and anesthesiology at Sequoia Hospital (Sequoia) in Redwood City. For six years, he served as Sequoia's Chairman of Anesthesia and participated in its Clinical Competence Committee from 1990 to 1997. His current clinical practice is devoted to the treatment of chronic pain, predominately on an outpatient basis. He has treated patients with chronic pain problems for over 30 years.

40. Dr. Wilcosky reviewed the following documents: the Accusation; declaration of Dr. Leung; PEP chart audit tools for May 2017; email correspondence between Dr. Leung and respondent; respondent's office notes from August through October 2017; PEP cases for April 2017; PACE documents for 2017; PEP cases for July 2017; PEP blinded documents for February and March 2017; PEP audit for May 2017; Dr. Wilcosky's declaration from 2015 Board action; declaration of Neal Benowitz, M.D.,

from 2015 Board action.[10] Dr. Wilcosky prepared a written report, dated September 4, 2019, regarding the applicable standards of care and his findings regarding respondent's treatment and care of chronic pain patients, and his documentation thereof. He testified at hearing consistent with his report. Additionally, Dr. Wilcosky testified about the specific patient chart notes identified by Dr. Leung at hearing.

41. Dr. Wilcosky disagreed overall with Dr. Leung's assessment that respondent's practice patterns in pain management are "unsafe and do not meet the standard of care." Regarding respondent's non-adoption of the SOAP format, Dr. Wilcosky opined there is no required template for office notes. In any event, he noted that respondent's chart notes included all of the elements of a SOAP note, even if they were organized in a different manner. Concerning respondent's degree of documentation, Dr. Wilcosky noted that the records reviewed were for respondent's longstanding patients, and that "respondent's records conform to the level and quality that I am accustomed to seeing for followup [*sic*] visits in well-established patients." Dr. Wilcosky further found respondent's records to be replete with pertinent information regarding his patients' past pain therapy, current medications, and their side effects and efficacy.

42. Dr. Wilcosky opined that respondent's physical examinations were appropriate and within the standard of care for follow up visits, noting that such visits for established patients are more focused and a physical examination is not required unless "it materially impacts the decision-making." Moreover, respondent's use of IV

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[10] Dr. Benowitz did not testify at the hearing on the instant Accusation and Petition. As a result, his 2015 declaration was not admitted into evidence, nor was any testimony concerning his declaration or opinions therein permitted.

medications was specific to the patient's needs after failure of more conservative means, with the rational clearly indicated in the record.

43. Concerning the administration of IV narcotics and sedatives to patients on an outpatient basis, Dr. Wilcosky noted that respondent's use was specific to patient needs after more conservative means had failed, and that he clearly indicated the rationale in the record. Regarding the conscious sedation certification, it was unclear to Dr. Wilcosky whether the medications respondent administered were intended to or achieved a level of sedation. He noted that respondent "performed no painful procedures and medications were carefully titrated to avoid sedation." In any event, respondent obtained a conscious sedation certification at Dr. Leung's suggestion.

44. Concerning respondent's IV medication infusion practice, Dr. Wilcosky noted that respondent's practice "was very limited and included on those few patients whose special needs had been clearly established through laborious trial and error by respondent and previous treaters." Regarding anxiolytics and ketamine, "the doses were low" and provided in a monitored setting. All of the treatments were "well tolerated and successful." Regarding IV opioids (Fentanyl) administered to a single patient, respondent employed sound pharmacologic principles. Dr. Wilcosky opined, "[h]igh doses of opioids in selected patients with established tolerance does not violate the standard of care."

45. Dr. Wilcosky noted that "the role of cannabis and related substances in the treatment of pain remains ill defined," and the response to cannabis by pain patients is "highly individual." While opioids are effective in treating pain, it would be "inappropriate to treat anxiety and insomnia or both with opioids alone."

46. Dr. Wilcosky noted there is no uniform requirement to consult with mental health professionals for chronic pain patients, and that there is a "high incidence of depression in patients with chronic diseases, including pain." A lack of accessibility to mental health resources is a further limiting factor. As a result, patients derive "a great deal" of psychological support from their treating physicians."

47. Dr. Wilcosky disagreed that clonus was consistently observed as a result of opioid use. He further explained, the finding of one or two beats of clonus at the ankle is of "equivocal significance, at best."

48. Regarding respondent's knowledge and basic clinical skills in evaluating, examining and treating chronic pain patients, Dr. Wilcosky opined respondent had no deficiencies in his knowledge of the clinical use of opioids, benzodiazepines, or Ketamine, especially in light of respondent's background in palliative medicine.

WILLIAM G. BROSE, M.D.

49. Respondent also presented the expert testimony of William G. Brose, M.D. Dr. Brose is licensed to practice medicine in California, and is board-certified in anesthesiology, with added qualification in pain management, and in pain medicine. He is a qualified medical examiner in the workers' compensation system.

50. Dr. Brose attended medical school at Kansas University School of Medicine. He completed an internship in anesthesiology at Santa Clara Valley Medical Center and a residency in anesthesiology at Stanford University School of Medicine. Dr. Brose completed a one-year fellowship in obstetric anesthesia at Stanford, and the following year was a chief resident in anesthesia at Stanford. From 1988 to 1989, he served as a Physician Specialist at Stanford, and also completed a clinical research fellowship in chronic pain management in Flinders Medical Centre in South Australia.

51. Dr. Brose has held a number of academic positions at Stanford University School of Medicine since 1989 including: Director of the Standard Pain Management Service (1989-1996); Associate Professor of Anesthesia (1989-1995); Associate Professor of Anesthesia (1995-1997); Adjunct Associate Professor of Anesthesia (1997-2011); and, Adjunct Clinical Professor of Anesthesia (2011-present). He has also held numerous clinical positions over the years: President of Alpha Omega Pain Medicine Associates, Inc. (1998-2018); Chief Executive Officer (CEO) of HELP, Holdings, Inc. and HELP Pain Medical Network (2010-2018); and, CEO of American Health Medical Group (2014-2018).

52. Dr. Brose has been awarded two research grants, has published 25 articles in peer-reviewed journals, and has written seven book chapters. He has given numerous presentations to physicians on chronic pain and opioid treatment. Dr. Brose has provided expert testimony in civil court proceedings and administrative hearings before the Board. He has never served as an expert reviewer for the Board.

53. Dr. Brose reviewed the following documents: the Accusation; declaration of Dr. Leung; respondent's narcotic controlled drug account record from 2016 to 2018; redacted medical records from respondent; PEP chart audit tools for May 2018; PEP monitoring of redacted records; correspondence between respondent and Dr. Leung; and, respondent's curriculum vitae. Dr. Brose prepared a written report, dated September 5, 2019, regarding the applicable standards of care and his findings regarding respondent's treatment and care of chronic pain patients, and his documentation thereof. He testified at hearing consistent with his report. Additionally, Dr. Brose testified about the specific patient chart notes identified by Dr. Leung at hearing.

54. As a preliminary matter, Dr. Brose noted that, in his correspondence to respondent, Dr. Leung did not describe any deviations from the standard of care prior to his declaration which resulted in the current Accusation. Respondent also never received a personal and practice development plan from Dr. Leung, to establish specific goals for practice improvement. Dr. Leung's monthly reports lacked "any narrative direction with constructive criticism or detailed recommendations for remediation of the reported deficiencies."

55. Dr. Brose posited there are different documentation standards for hospitals versus outpatient clinics. The former offer broad services to payer groups and a deep set of services covering multiple specialties, requiring extensive documentation which is captured in templates created for each visit type. The latter rely on longitudinal relationship with patients, and the chart notes do not tend to document previous events or information from a prior visit. Dr. Brose opined that Dr. Leung's standard of care for documentation was a "rigid interpretation." He noted that respondent provided longitudinal care to his chronic pain patients, "dating back many years with multiple complicating medical conditions." He found that respondent's chart notes were within the standard of care. He explained that requiring him to document "the care of such complicated patients over a period of years in a single note would need to comprise many pages and as a consequence would be seen as both over burdensome and redundant for practical clinical use."

56. Regarding conscious sedation, Dr. Brose explained it is not considered conscious sedation if the doctor is not performing a procedure, but provides an analgesic or sedative to the patient because of relief needed at that time. In reviewing respondent's chart notes, Dr. Brose did not see any evidence that respondent had performed conscious sedation.

SPECIFIC PATIENT CHART NOTES

Patient JP

57. Patient JP was a 62-year old male chronic pain patient who met respondent for a follow-up visit on March 24, 2017. JP presented with persistent neck and lumbar pain due to a motor vehicle accident in October 2016. Prior to the accident, JP could "go all day" without pain medication and took it only at night to help with sleep. Following the accident, he required pain medication during the day as well. JP reported an exacerbation of pain after his recliner broke, and required more medication than usual. He took Toradol as needed every one to two weeks. He last took it two days before the visit, but JP did not feel any pain relief. JP was administered IV Fentanyl on March 22, 2017 after experiencing "extreme pain" the day before. His pain diminished and he was able to have a bowel movement again.

Respondent documented that he counseled JP about the risks of long-term use of IV Fentanyl. He also noted JP's testosterone level was low and respondent renewed his hormonal topical cream. Finally, he documented that meditation was helpful, and that nerve blocks were helpful but JP could no longer tolerate them. Respondent conducted and documented his physical exam of JP, noting the patient was tender to palpation at his shoulder and along the whole spine, and had severe trigger point pain in his left buttock. Respondent assessed JP as having "chronic persistent pain that has worsened in the aftermath of MVA in October 2016," cervicalgia, constipation unspecified, sprain of ligaments of lumbar spine, testicular hypofunction, and sciatica unspecified side. Respondent documented the following plan: referral to pain management specialists; IV Magnesium 3g in the bag with IV Fentanyl; and follow up appointment regarding neck pain.

58. Dr. Leung: Dr. Leung opined that respondent's treatment and care of JP, and documentation of the same, was below the standard of care. The chart note did not identify the main pain problem from the motor vehicle accident, and therefore lacked an adequate assessment of the underlying pain problem. Moreover, IV Fentanyl is not proper to address acute pain in a patient with chronic pain issue, and can be life-threatening. He explained that Fentanyl is a synthetic narcotic with very short durations. It is not considered an effective treatment in chronic pain patients because it can encourage medical-seeking or drug-seeking behavior. Dr. Leung is unaware of any pain management specialist who would use IV Fentanyl to treat acute pain in a chronic pain patient. He further opined that IV Fentanyl should only be administered in an inpatient, surgical setting.

59. Dr. Wilcosky: Dr. Wilcosky opined that respondent's treatment and care of JP, and documentation of the same, met the standard of care. Respondent had been treating JP for almost 20 years; his documentation of the March 24, 2017 visit was typical of an interval assessment of a patient well-known to the treating physician. It contained all the SOAP elements and was sufficient for respondent to assess JP presently and for future treatment. Dr. Wilcosky was not concerned with the administration of IV Fentanyl to JP on an outpatient basis, explaining that respondent had reached this regimen after a "laborious trial and error of different modalities," including back surgeries and a spinal cord stimulator. Although these prior treatments were not documented in the chart note, Dr. Wilcosky discussed them with respondent prior to his testifying at hearing. This was not unusual, as it was Dr. Wilcosky's practice to discuss a patient with the referring doctor and ask any questions. He was also unconcerned that the amount of IV Fentanyl administered was not charted in the note, explaining that respondent knew the dosage amount and it could be easily verified by medication administration records.

Dr. Wilcosky noted that JP was a "very complex" patient, who was "essentially at the end of his rope" and suicidal prior to receiving IV Fentanyl.[11] The IV Fentanyl was administered to JP under supervision and at appropriate intervals according to JP's complaint of pain. Nothing about JP caused Dr. Wilcosky's to be concerned about abuse, noting the evidence showed he had a consistent response to the medication. Dr. Wilcosky also was not concerned regarding the dosage amount, noting the amount was arrived at through trial and error and escalated in increments. He explained that patients like JP are "extremely desperate" and thankful for any small amount of pain relief, no matter the means.

60. Dr. Brose: Dr. Brose also opined that respondent's treatment and care of JP, and documentation of the same, met the standard of care. Respondent's chart note met the standards of the American Medical Association and included a description of the office visit, patient historical information, physical exam, assessment, and treatment plan for ongoing care. The use of IV Fentanyl to treat acute exacerbation of JP's neck pain was also within the standard of care, and Dr. Brose knows other pain specialists who have done the same. There was no evidence suggesting JP was drug-seeking. Dr. Brose was not concerned with the amount of IV Fentanyl administered, or that the chart note did not list the amount, noting if it was not in the chart, it would be in the prescription log. Additionally, the longitudinal record for JP would include the intensity, quality, character, and location of his pain complaint, especially if the chronic pain remained relatively stable over the course of treatments being considered.

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[11] JP's prior suicidal ideations were not charted in the note for March 24, 2017; Dr. Wilcosky learned about them from his discussions with respondent prior to hearing.

61. Respondent's Testimony: JP was one of respondent's first chronic pain patients in California. He was referred to respondent for alternative treatment for hepatitis-C; respondent also began treating him for hormonal replacement. JP was a plumber by trade. He injured his back in the late 1980s causing him to go on disability. He had multiple back surgeries which failed. From the late 1990s until approximately 2012, he had received an estimated 40 steroid epidural injections by other pain specialists. Respondent treated JP mostly for trigger point and osteopathic manipulation, and continued him on high dosages of morphine. Starting in 2007, JP had success with sublingual Fentanyl for pain relief, an expensive treatment which his insurance covered until 2010.

Thereafter, JP's back pain significantly increased, and had extended to his lower leg which was throbbing. Respondent prescribed Fentanyl lollipops, but they did not work. JP had suicidal ideations due to the pain. Eventually, respondent decided to try IV Fentanyl to ease JP's pain. Respondent titrated the amount of Fentanyl administered to JP, observing him to see the effect. JP was already taking 1400mg of morphine at that time, so he required a larger dose of Fentanyl than a normal person would tolerate. Eventually, JP reached 5,000 to 10,000 mcg of Fentanyl before his pain level began to decline. By this time, respondent no longer accepted JP's insurance and he provided JP these treatments every one to three months at a reduced cost or for free. Respondent never considered JP to be a drug-seeking patient.

JP was one of the patients at issue in the 2015 accusation against respondent. At that time, respondent prescribed IV Fentanyl for JP to self-administer in his home. Respondent believed his subsequent probation prohibited JP's home use of IV Fentanyl, but did not prohibit administration of the drug to JP in respondent's office.

After JP was rear-ended in a motor vehicle accident in October 2016, he had flaring neck pain that was severe. Respondent continued to prescribe IV Fentanyl which was administered to JP in respondent's office. When Dr. Leung spoke with respondent for the first time in July 2017, he had reviewed JP's chart note and was "shocked" at the dosage. Respondent explained JP's unique situation, but Dr. Leung "did not hear" him. Dr. Leung advised respondent to stop the treatments immediately. Respondent administered two to three additional treatments to JP that summer, but then stopped altogether in September 2017, even though he thought the treatments were crucial for JP. JP was the only patient whom respondent administered IV Fentanyl. JP left respondent's care sometime in 2017, after the Fentanyl treatments stopped. He subsequently passed away.

Patient ND

62. Patient ND was a 54-year-old chronic pain patient who saw respondent for a follow-up visit on April 14, 2017. Respondent noted that ND was in the emergency room the prior month for a respiratory infection, fever, and laryngitis. She had been taking prednisone to treat Crohn's disease, but had been off of the medication for three weeks. ND presented with back pain, stomach pain and cramps, though her severe abdominal pain was gone after prednisone. She also experienced muscle pain, stating her legs felt like "tree trunks." On the date of the visit, ND had a migraine, wore dark glasses, and felt very weak and anemic. Respondent noted ND was resistant to therapy and they discussed cognitive behavior therapy (CBT). Respondent also explained the need to taper her pain medications. ND was taking several medications, including MS Contin, Diazepam, and Ketamine. Respondent noted the following diagnoses: Crohn's disease, anemia, migraine, Lyme disease, and

babesiosis. His plan included Versed injections, IV iron infusions, referral to chronic pain management, and appropriate therapy.

63. Dr. Leung: Dr. Leung opined that the chart note was well-organized and stated the reason for the visit. However, the patient history and subjective information were insufficient to support the clinical situation. While multiple chronic pain issues were mentioned, no specific assessments were performed relating to each problem. It was also unclear from the note whether respondent was providing the narcotics and Ketamine listed, or if they had been prescribed by another physician. Dr. Leung noted that the combination of opiates, diazepam, and Ketamine was not usually used in the management of chronic pain. Dr. Leung also found it "very concerning" that respondent prescribed IV Versed without any justification. Dr. Leung opined that overall the chart note, and respondent's treatment and care for ND, did not meet the standard of care.

64. Dr. Wilcosky: Dr. Wilcosky opined that the chart note, and respondent's treatment and care for ND, met the standard of care. He explained that with chronic pain patients, a good amount of the physician's assessment will be based on the patient's subjective report of problems. Here, respondent documented ND's report of reported back pain, stomach cramps, and a migraine, all of which constitute part of his assessment of her. Dr. Wilcosky further asserted that the lack of SOAP format does not render the note below the standard of care, and that respondent would be more "apt to miss something important" if he were asked to change his practice "after all these years" to comply with an arbitrary format.

Dr. Wilcosky also opined that respondent adequately examined ND, noting the tenderness to palpation in her lower back. Respondent also sufficiently listed ND's medications. Regarding the medication regimen, Dr. Wilcosky posited the Versed

injections were appropriate to address ND's migraines, coupled with anxiety and muscle pain, as stress is a strong component of migraines. Although the note did not mention anxiety specifically, it listed ND's other related comorbidities, the recommendation for CBT, and that respondent spent half the session counseling ND, all of which indicated that respondent was aware of ND's other problems. The note also provided a medical indication for Ketamine (for pain generally), Phenergan (pain and migraine), and MS Contin (pain and cramps).

65. Dr. Brose: Similarly, Dr. Brose opined that respondent's treatment and care of ND, and documentation of the same, were within the standard of care. The chart note listed the patient's chief complaint of a migraine, which was supported by respondent's longitudinal care of the patient, as well as the fact she wore sunglasses to the visit, indicating a sensitivity to light common with migraines. The Versed injections were medically indicated by ND's complaints of muscle pain, stomach pain, and cramps, and her tenderness to palpation. The Versed injections were reasonable for either a pain specialist or primary care provider.

Respondent's testimony: Respondent took over ND's care from another practitioner in 2011, and was aware of her background prior to the April 14, 2017 visit. ND suffered from chronic Lyme disease, Crohn's disease, and anxiety, and was sensitive to medications generally used to treat these conditions. She had also suffered from chronic migraines since age 20, but was unable to tolerate triptans, which are typically used to treat migraines. Respondent also noted ND was weak and anemic, a result of blood loss from Crohn's disease. Respondent explained he was collaborating with ND's gastroenterologist, to whom respondent had originally referred ND.

Respondent's minimum office visit is 30 minutes, but typically last 45 to 60 minutes. Most of that time is spent in discussion with the patient. Respondent

explained that ND tended to "awfulize" her emotions, over-amplifying her feelings. She also had religious beliefs, as well as past history, which made her resistant to certain forms of therapy, so respondent had a long discussion with her regarding the benefits of CBT. Respondent physically examined ND's reported area of pain (head and back), as well as her lungs, heart, and abdomen. He prescribed the medications listed in the note except for the Clonaz and MS Contin, which had been prescribed by the gastroenterologist. Respondent wanted ND to taper her pain medication. However, she had severe, at times debilitating, pain as well emotional issues, and was using pain medications to treat both. He ordered IV Versed to help with ND's acute exacerbation of migraine, noting ND did not like to leave home and had difficulty "just getting to the office." He wanted her to be relaxed and have a better trip home. Respondent did not administer the Versed himself and likely had a nurse do it.

Patient BC

66. Patient BC was a 70-year-old chronic pain patient who saw respondent for a follow up visit on April 6, 2017. BC presented with right leg pain, stating he had good days and bad days. He had difficulty walking and would trip without falling. He had muscle weakness in his right leg and a history of severe sciatica which was relieved with chiropractic treatment. BC also reported back pain which limited his daily activities and for which pain medication did not offer much relief. Respondent conducted and documented a physical exam, and administered a Procaine injection to BC's paravertebral muscles at L4-L5, which slightly decreased the pain. Respondent charted that he spent more than half of the visit counseling BC, and believed the underlying cause of the pain may be neurological. He assessed BC as having low back

pain, chronic viral hepatitis-C, and weakness, and prescribed Opana[12] 5mg. He also ordered an MRI and referral to orthopedic and physical therapy.

67. Dr. Leung: Dr. Leung opined that respondent's treatment and care of BC, and documentation of the same, did not meet the standard of care. The chart note included a sporadic description of BC's current illness, and there was very little assessment of his pain, symptomology, and what treatment he had received in the past. Dr. Leung described the physical exam as very general and not specific to assess common issues with low back pain or leg pain, such as a neurological exam. Respondent did not document a clear medical indication for the Procaine injection, the patient's informed consent for the same, nor the amount of Procaine injected, or method of injection. Finally, there was no charted justification for the use of Opana, a Schedule II long-acting opioid.

68. Dr. Wilcosky: Dr. Wilcosky opined that respondent's treatment and care of BC, and documentation of the same, met the standard of care. He found respondent's chart note to be "above average" for an interval or follow up visit, noting he had no trouble understanding from the note the patient's status or treatment plan. Dr. Wilcosky explained there are different standards of care regarding documentation for hospitals and private practice. Hospitals have onerous EMR systems which result in significant redundancy in chart notes. Private practices have to be more practical and concise in their documentation. When an office transfers from handwritten records to

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[12] Opana, a trade name for oxymorphone hydrochloride, is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (b)(1), and a dangerous drug as defined in Business and Professions Code section 4022.

an EMR system, there are inherent risks of losing data or documents not being scanned appropriately. While SOAP is an acceptable format of documentation, it is not required so long as all of the elements are present.

Dr. Wilcosky posited that the treatment of chronic pain patients is a "constant process of refinement, and trying different things" to bring pain relief. Here, respondent performed an appropriate neurological exam specific for BC's complaints. A full neurological exam is rarely required unless referred to a neurologist. Finally, respondent was not required to obtain and record the patient's informed consent if he had done the procedures previously and obtained informed consent at that time.

69. Dr. Brose: Dr. Brose also opined that respondent's treatment and care of BC, and documentation of the same, met the standard of care. The chart note was sufficient. It is not required to obtain informed consent for each instance a repeat procedure is performed; consent is implied through the patient's continued presentation and discussion with the physician. Dr. Brose also asserted the Procaine injection was appropriate as BC presented with pain complaints, had a long-term treatment relationship with respondent, and a history of the injections creating pain relief.

70. Respondent's testimony: Respondent had treated BC for approximately five years for chronic back and hip pain. After receiving a liver transplant, BC did better but he had a difficult with the post-surgery medications. Prior to this visit, respondent and BC had discussed what kind of treatment would work, what activities aggravated or relieved the pain. Respondent conducted a neurological exam but did not document it. He recommended injections of Opana, a longer-acting opioid, because the shorter-acting ones had not worked well. BC had already tried nonsteroidal medications on his own. Respondent ordered a low dose (5mg) Opana and obtained

BC's informed consent. It was not his practice to document every time he obtained informed consent unless it was a chest injection. Here, the needle was so small and injected into the skin, there was minimal risk and respondent did not believe informed consent was required.

Patient DN

71. Patient DN was a 36-year-old patient who had a phone consultation with respondent on September 21, 2017. She presented with constant pain and was no longer responding to her intramuscular (IM) injections. Respondent documented his plan to remove DN from opiates for 24 hours, and replace the medication with IV Precedex in order to transition her to Subutex[13]. He also discussed this patient with a pain specialist. Respondent further documented that Demerol helped ease DN's headaches, and ordered a refill. Over the last few days, DN had taken morphine every three to four hours for severe joint pain. Respondent made the following assessment: rheumatoid arthritis, unspecified, arthritis due to Lyme disease, and migraine.

72. Dr. Leung: Dr. Leung opined that the chart note did not meet the standard of care. It did not specify the location of asserted pain. While Dr. Leung agreed that transitioning to Subutex was generally good, the chart note did not list any rationale for doing it in this instance. Also, the transition is typically performed by doctors with training and expertise in opioid detoxification. Dr. Leung was "highly concerned" that DN was receiving morphine without an adequate evaluation, and that

[13] Subutex, a brand name for buprenorphine, is a Schedule V controlled substance as defined by Health and Safety Code section 11058, subdivision (d).

Demerol is not recommended for migraines due to the risk of rebound headaches and opioid tolerance.

73. Dr. Wilcosky: Dr. Wilcosky opined that respondent's documentation of the phone consultation met the standard of care, noting it was a "very complete" note. While Precedex is often used for sedation, it has other properties that benefit neuropathic pain. As DN had many sensitivities to medications, this was a reasonable option to try. Dr. Wilcosky also opined that respondent's treatment and care of DN met the standard of care. DN was a difficult patient nearing the end of treatment regimen, and respondent's recommendations were appropriate. Prior to testifying, Dr. Wilcosky discussed the opioid detoxification with respondent, who asserted he did not intend to perform it himself, but to refer the patient to someone else.

74. Dr. Brose: Dr. Brose also opined that respondent's treatment and care of DN, and documentation of the phone consultation, was within the standard of care. Dr. Brose explained that the chart note contained an extensive amount of documentation for a phone consultation. Dr. Brose acknowledged that the dosing of IV Dilaudid and IV Demerol was an unusual treatment plan for rheumatoid arthritis and migraines, but that the use of two short-acting opioids concurrently were within the standard of care. However, the longitudinal history for this patient demonstrated these were the only medications to provide relief to DN and became the standard treatment after all usual treatment methods had been exhausted.

75. Respondent's testimony: The purpose of the phone consultation was that DN was in intractable pain and "was not getting anywhere" due to her severe allergies. The injectable opioids she could tolerate were very expensive and not working, so respondent intended to wean her off them. Respondent consulted with a pain specialist who recommended using Precedex to transition DN to Subutex.

Patient CT

76. Patient CT was a 59-year-old female chronic pain patient who saw respondent for a follow-up visit on April 5, 2017. Respondent documented that, ten days earlier, a Washington physician had injected CT with ropivacaine in the facet joint on the left side of her neck to address issues with her left second finger. Respondent further noted that CT "had difficulty achieving proper level of sedation with nitrous oxide – either too much or too little" and was in pain after the injections "with whole body shaking." Respondent also documented that CT had headaches and post-traumatic stress disorder (PTSD) following the injections. CT reported her medication regiment for pain control included oral cannabidiol (CBD), Ketamine cream, Valium,[14] Alprazolam, and Ambien (for sleep). Under physical examination, respondent noted that CT was tender to palpation on her right knee over the coronary ligament. He then made and documented the following assessment: enthesopathy, unspecified; headache; and "pain in unspecified right [*sic*] hip.

77. Dr. Leung: Dr. Leung opined that the chart note fell below the standard of care. It was not well-organized nor in the SOAP format. It did not list a chief complaint or otherwise explain the reason for the visit. The documented subjective complaints were not sufficiently specific to formulate a diagnosis, but rather were a random discussion of a variety of problems and events. The physical exam was very general and non-specific, and respondent's assessment and diagnoses "were not well

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[14] Valium is the trade name for diazepam, a psychotropic drug used for the management of anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057. It is a dangerous drug as defined by Business and Professions Code section 4022.

supported by the subjective and objective findings." For instance, there is no mention of hip pain in to support respondent's diagnosis of "pain in unspecified hip." While respondent assessed that CT had headaches, he did not document an actual assessment of that complaint. The chart note did not specify why nitrous oxide was used with this patient, and did not adequately address "whole body shaking." Overall, Dr. Leung rated this chart note as unsatisfactory, and recommended that respondent provide specific assessments for the pain complaints reported.

78. Dr. Wilcosky: Dr. Wilcosky opined that respondent's chart note met the standard of care as it included "all essential elements to assess and determine treatment." Respondent's assessment of CT's headache was also adequate. This was a follow-up visit with a patient respondent knew well. The chart note noted CT's chief complaint of head and neck pain, and continued tenderness in her temporal area; this is where respondent focused his treatment and attempts to further refine the diagnosis. The patient had difficulty achieving a proper level of sedation with nitrous oxide, relating to the pain and "whole body shaking." Many patients have some hallucinations from nitrous oxide.

79. Dr. Brose: Dr. Brose opined that respondent's treatment and care of CT, and documentation of the same, met the standard of care. He explained that Ketamine is a dissociative anesthetic used in the 1980s to introduce general anesthesia. In the last decade, it has been used in low-dose intramuscular or intravenous administration as an analgesic. It could also be used for purposes of minimal sedation. Dr. Brose conceded there were no objective findings listed which related to enthesopathy or hip pain, but noted that tenderness to palpation of the temples was an objective indication of headache.

80. Respondent's testimony: Respondent began treating CT in 2009 or 2010. She had been referred to respondent for treatment of Lyme disease and Bartonella, both chronic tick-borne diseases. As CT got older, she also developed chronic inflammation. Respondent had referred her to the Washington physician, who specialized in musculoskeletal pain. On the April 5, 2017 visit, CT was in pain and had headaches from recent injection treatments in Washington, as well as PTSD from the experience. Respondent's main concern was to get her pain under control. Respondent knew this patient well and assessed "only the part I needed to assess" on that day. He prescribed Ketamine, Valium, and alprazolam on as-needed basis because CT's pain eased when her muscles were relaxed. Respondent conceded he should have documented this better on the chart note.

Patient EJ

81. Patient EJ was a 60-year-old female chronic pain patient who saw respondent for a follow-up visit on May 9, 2017. Respondent documented that EJ was experiencing sleep problems, and that her pain worsened with lack of sleep and too much activity. She took cannabis to help with sleep. She tried trazodone and Seroquel in the past, but did not like their side effects. She also meditated before bed to help fall asleep. Respondent also noted that EJ was a recovering alcoholic and had been sober for 19 years. EJ also complained of neck and back pain that was exacerbated by stress. The pain in her hip, arm and shoulder had resolved, but "throbbing leg pain" persisted. She planned to start physical therapy for her neck. During the physical exam, respondent noted EJ was tender to palpation at her back and neck, more on the right

than the left. Her pain medication regimen included Nucynta,[15] oxycodone[16], and Xanax. Respondent further documented that he counseled EJ for more than half the visit, advising the patient to seek psychotherapy. He also recommended decreasing her use of Xanax as tolerated.

82. Dr. Leung: Dr. Leung opined that the chart note fell below the standard of care. It was not well-organized nor in the SOAP format. It did not list a chief complaint or otherwise explain the reason for the visit. Although respondent noted she had chronic neck and back pain being treated with cannabis and oxycodone, there was "very little information," assessments, or specific findings upon physical exam to support the asserted chronic pain conditions. Moreover, no pain diagnosis was documented. Dr. Leung was particularly concerned that the patient was taking three different medications to manage her pain. He was also concerned that EJ was a recovering alcoholic, noting that prior substance abuse is "a big red flag for opioid abuse." Although the use of cannabis to manage pain is not prohibited, Dr. Leung opined respondent did not conduct an adequate risk assessment, including running a

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[15] Nucynta, a trade name for tapentadol hydrochloride, is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (b)(1) and a dangerous drug as defined by Business and Professions Code section 4022.

[16] Oxycodone is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (b)(1) and a dangerous drug as defined by Business and Professions Code section 4022.

CURES[17] report to check EJ's prescription history. Overall, Dr. Leung rated this chart note as unsatisfactory, and recommended that respondent provide adequate objective and subjective findings to support the pain assessment and management plan.

83. Dr. Wilcosky: Dr. Wilcosky opined that the chart note "easily" met the standard of care as it included all of the SOAP elements. He further noted the use of cannabis was appropriate to help a chronic pain patient with sleep issues, considering she had exhausted other more conservative treatments. Finally, Dr. Wilcosky noted that, in 2017, it would be "very unusual" for a private practice to routinely run a CURES report on a long-time patient, noting the system was cumbersome. Additionally, running a CURES report when prescribing controlled substances did not become mandatory until 2018.

84. Dr. Brose: Dr. Brose agreed that the chart note contained all of the SOAP elements, and appropriately documented a pain diagnosis in the patient's neck, back, hip, arm and shoulder. Dr. Brose further opined that, because this was a follow-up appointment and the patient was being seen on an ongoing basis, the chart note is shorter. Respondent was appropriately aware of EJ's substance abuse history and included a plan to wean her off of Xanax. Finally, running a CURES report was not mandatory in May 2017.

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[17] CURES is an acronym for Controlled Substance Utilization Review and Evaluation System. CURES is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. (https://oag.ca.gov/cures)

85. Respondent's testimony: Respondent treated EJ for 16 years, after she was referred to him by a pain specialist for hormone management in 2001. She had been disabled with sciatica since the mid-1990s. She tested positive for Lyme disease but was never treated. The chronic infection resulted in chronic pain all over her body that would last for months. She had been in and out of therapy, which she believed in and had helped her. Prior to this visit, respondent had obtained EJ's informed consent and "always discussed everything" he was going to do with patients in depth. EJ had been using cannabis for sleep, and they discussed her using a higher amount of CBD as an anti-inflammatory. Respondent was concerned about the number of medications EJ was taking. She had been on opiates, benzodiazepines, and Abilify for several years and was not impaired mentally. Respondent counseled her about tapering down from Xanax.

Patient FL

86. Patient FL was a 70-year-old female chronic pain patient who saw respondent for a follow up visit on June 30, 2017. FL reported that her low back pain had improved but persisted, and was exacerbated by sitting in the car. Respondent documented a procedure of intramuscular Procaine injections which FL tolerated well. Respondent's assessment was cervicalgia and low back pain.

87. Patient FL again saw respondent for a follow up visit on July 14, 2017. Respondent noted FL's chronic neck and back pain, which had improved, and her good response to her new chiropractor. He again documented a series of Procaine injections, and noted FL tolerated them well. The assessment remained the same.

88. Dr. Leung: Dr. Leung opined the chart notes fell below the standard of care because: the injections are considered an interventional procedure and neither

FL's informed consent nor the amounts of medication given per location was documented. Dr. Leung also noted that pain injections are typically administered on a monthly basis, though he conceded it is sometimes appropriate to administer them more frequently.

89. Dr. Wilcosky: Dr. Wilcosky opined the chart notes, and respondent's treatment and care of FL, met the standard of care. Trigger point injections of a small amount of local anesthesia can be an effective means of treating pain, and not documenting such an innocuous amount given is not uncommon. It is not required to obtain and document the patient's informed consent for each treatment; it is sufficient if the patient gave their informed consent previously. Similarly, as these were repeat treatments, it was unnecessary for respondent to expand on his documentation of these follow-up encounters.

90. Dr. Brose: Dr. Brose also opined that respondent's treatment and care of FL, and documentation of the same, met the standard of care. Intradermal injections were appropriate to treat cervical spine pain. He further noted that respondent added sodium bicarbonate to lessen the acidity of the Procaine, making it less painful upon injection. The chart notes were sufficient because it was strictly focused on the purpose of those visits – the injection procedure. While it was usual to document the amount of local anesthesia if administered by IM or IV, it was not below the standard of care to not include the amount administered intradermally as the amount was so small (approximately 1/2ml). Finally, Dr. Brose opined it was not necessary to obtain or document FL's informed consent because these were repeat procedures.

91. Respondent's testimony: Respondent began treating FL in 2001; she was referred to him by another physician for treatment of fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome. FL generally functioned well, but had to be

careful not to overexert herself. A few months prior to her June 30, 2017 visit, she was involved in a minor motor vehicle accident injuring her neck and aggravating her preexisting pain issues. The purpose of the June 30, 2017 and July 14, 2017 visits was for continued neurotherapy. Respondent administered a small amount of local anesthetic under the skin, which diminished FL's pain and acupuncture points, and regulated the sympathetic neurological system. Respondent had given FL such injections for many years, and had discussed thoroughly with her the risks and benefits when he first began the treatments. He never documented the amount administered because it was "so tiny" and not germane to patient care. Nevertheless, he will write down the amounts in the future to comply with Board rules.

Patient HL

92. Patient HL was a chronic pain patient in his 70s who saw respondent on a follow up visit on August 29, 2017. HL had been experiencing pain and fatigue. Respondent documented a review of systems which indicated fatigue, sleep apnea, shoulder, knee and back pain, and difficulty focusing. HL was "able to function with Norco and morphine but also feels clearer as he [was] tapering [MS Contin]." HL was on the following medications: Norco, Valium, morphine, Atenolol, and Buspirone. Respondent made the following assessment: chronic fatigue, unspecified; pain in unspecified knee; and unspecified atrial fibrillation. He referred HL to an endocrinologist for hyperparathyroidism and increased his Vitamin D.

93. Dr. Leung: Dr. Leung opined that respondent's treatment and care of HL, and documentation thereof, were below the standard of care. There was insufficient detail noted in the review of present illness. Though multiple pain problems were listed, there was little to no assessments of those problems. The chart note also did not include sufficient justification for the mediations prescribed. There was no detailed

physical examination performed for the pain problems identified. There was no documentation of an opioid-related risk assessment – such as a check of the pupils, mental status, coherence, and speech, or running of a CURES report. Additionally, HL utilized a CPAP[18] machine for sleep apnea; this is problematic because opioids decreases respiratory drive in those patients.

94. Dr. Wilcosky: Dr. Wilcosky opined that respondent's treatment and care of FL, and documentation of the same, met the standard of care. The chart note includes all of the SOAP elements, including chief complaint of pain and fatigue. Dr. Wilcosky disagrees that the note is not sufficiently detailed, noting "I'm not sure what other substance should be added." Chart notes on a follow-up visit do not always include a physical exam unless there is something noteworthy. He again pointed out that the CURES database was not widely used at this time, and that the best risk assessment for opioid abuse is done through serial exposure to the patient. Regarding treatment, Dr. Wilcosky posited respondent was constantly making refinements to HL's medication regimen, paying attention to what medications were being taken and what effect they had on HL's ability to function. The physical exam performed (heart and lungs) was sufficient. Regarding HL's use of a CPAP machine, Dr. Wilcosky pointed out that HL had been treated chronically with opioids, and the associated respiratory risks dissipate once initiated.

95. Dr. Brose: Dr. Brose opined that respondent's treatment and care of FL, and documentation of the same, met the standard of care. His opinion was largely consistent with that of Dr. Wilcosky. He agreed that a CURES report was not required at this time; based on his discussions with respondent prior to testifying, he presumed

[18] CPAP is an acronym for Continuous Positive Airway Pressure.

respondent had done an adequate risk assessment due to his historical knowledge of the patient.

96. Respondent's testimony: Respondent had been treating HL for one to two years; he had previously treated his wife for several years. Although respondent was not accepting new patients at the time, he agreed to see HL as a favor to his wife. LH needed several specialists. Respondent was orchestrating his care and trying to move things forward. At this visit, respondent conducted a brief cardiovascular exam but did not consider a full physical exam to be a high priority. Rather, respondent's intent was to help HL get the minimum amount of medication he needed for comfort and to ensure his exacerbating issues, particularly sleep apnea and hyperparathyroidism, were addressed. Respondent did not run a CURES report or other risk assessment for possible opioid abuse. However, CURES was not a requirement at that time, and the patient had cooperated with decreasing his opiates.

Patient LM

97. Patient LM was a 48-year-old patient who had a phone consultation with respondent on August 23, 2017. LM reported feeling nauseous, and had intravenous treatment which seemed to help. Under prior medical history, respondent listed a number of issues, including Lyme disease, headache, temporomandibular joint (TMJ) syndrome, and "chronic regional pain syndrome." Under review of systems, he listed examinations of LM's teeth, respiratory system, and head, back of neck, face, throat, and back. He recommended IV Ketamine for the "chronic regional pain syndrome."

98. Dr. Leung: Dr. Leung opined that respondent's treatment and care of LM, and documentation of the same, were below the standard of care. The chart note did not clearly state LM's pain problems under history of present illness, and did not list

any detailed assessment of them. Chronic regional pain syndrome is not proper terminology; the correct term is complex regional pain syndrome. Moreover, Ketamine is not generally used to treat complex regional pain syndrome. Respondent documented a physical exam, even though this was a phone consultation.

99. Dr. Wilcosky: Dr. Wilcosky testified respondent's treatment and care of LM, and documentation of the same, met the standard of care. He asserted the chart note was "more complete" than most phone notes, exceeding acceptable standards and demonstrating the considerable amount of thought respondent put into gaining information and forming a plan. The transposition of "chronic regional pain syndrome" and "complex regional pain syndrome" is common and does not alter the quality of the substance of the note, as another physician would understand what it meant. Finally, IV Ketamine can be effective and very helpful for neuropathic-type pain, and is "being utilize more and more" for this purpose. Here, LM had exhausted most other reasonable forms of pain control.

100. Dr. Brose: Dr. Brose also opined that respondent's treatment and care of LM, and documentation of the same, met the standard of care. The chart note was "fairly extensive" for a telephone consultation. Like Dr. Wilcosky, Dr. Brose noted that "complex regional pain syndrome" is commonly mislabeled as "chronic regional pain syndrome." Dr. Brose explained that changes in LM's nervous system led to an altered response to pain. The Ketamine was intended to modify her altered response. Finally, although treatment of chronic pain is an off-label use for IV Ketamine, it is nonetheless within the standard of care.

101. Respondent's testimony: Respondent has treated LM "a handful of times" over a year, upon another physician's referral. In her early 20s, LM fell down some stairs and severely injured her ankle. Her ankle pain never improved. She also suffered

from "poorly defined facial pain" and had arrhythmia problems, resulting in several emergency room visits. She presented with multiple diffuse pain complaints whose etiology was unclear to respondent. Respondent documented LM's past medical history in the first visit chart note.

The August 23, 2017 phone consultation was a scheduled follow-up. LM lived in San Jose, so a phone consultation was more feasible. They mostly discussed her care by other physicians. Another physician had diagnosed LM with complex regional pain syndrome, and respondent was not treating her for this condition. However, he thought he could help her if he could address her shortness of breath and heart issues.

Patient HM

102. Patient HM was a 69-year-old chronic pain patient who had a phone consultation with respondent on October 19, 2017. She presented with pain in her ankles, legs, hips, pelvis and low back, which was intermittent but worse with standing or activity. She had recently sprained her forefoot. In the chart note, respondent documented he examined HM's lungs (clear), heart and multiple upper body trigger points.

103. Dr. Leung: Dr. Leung opined that respondent's documentation of this phone consultation did not meet the standard of care. Specifically, the chart note denotes that respondent conducted a physical exam of HM's lungs, heart, and upper body trigger point areas, notwithstanding it is impossible to do a physical exam over the telephone. When Dr. Leung asked respondent to pull up HM's longitudinal record, respondent was unable to do so, asserting he was not good with computers. Respondent never provided the longitudinal record, preventing Dr. Leung from performing a complete review of this patient. Dr. Leung notified PACE which wanted to

notify the Board. Dr. Leung stepped down as respondent's mentor following this incident because of the potential conflict.

104. Dr. Wilcosky: Dr. Wilcosky opined respondent's documentation of this phone consultation was within the standard of care. He posited the chart note was very complete in addressing the purpose of the phone call. The patient had continued pain in multiple areas and took Percodan to function. He blamed the listing of a physical examination on a phone consultation chart note on the EMR system employed by respondent, noting those systems often auto-populate the wrong information.

105. Dr. Brose: Dr. Brose opined that respondent's documentation of the phone consultation met the standard of care. It listed the reason for the call and the issues presented by the patient. It also reflects respondent's attempts to manage rapport with a difficult patient.[19]

Discussion

ACCUSATION

Recordkeeping

106. Dr. Leung and Drs. Wilcosky and Brose disagree on whether respondent's charting of follow up, or interval visits, met the standard of care. Notably, none of the experts stated a single clear definition of the standard of care for recordkeeping, either in their respective reports or in their testimony. While Dr. Leung prefers the SOAP format, he conceded the use of this format is not required by the standard of care.

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[19] Respondent did not testify regarding patient HM.

Still, Dr. Leung opined that each chart note should list the chief complaint, prior medical history, full assessment and physical examination, list of current medications, and a diagnosis and treatment plan supported by subjective and objective findings. Dr. Leung's requirement of including a full laundry list in every chart note, regardless of the purpose of the visit, would appear incongruous with the long-term treatment of chronic pain patients, especially when such information is included in the patient's longitudinal record.

107. Drs. Wilcosky and Brose's opinions that respondent's charting was adequate are likewise problematic. Both physicians admitted they had to consult with respondent to obtain clarification or further information regarding his chart notes. This was information specific to that particular follow up visit which should have been included the chart note in the first place. Both doctors also asserted that the interval charting was sufficient because any other information needed would be included in the patient's longitudinal chart. However, this ignores the undisputed fact that respondent was unable to produce a single longitudinal patient record to Dr. Leung, despite the request being made several weeks in advance. It also ignores that respondent, himself, conceded that his charting had become sloppy over the years and were intended for an audience of himself only, tacitly admitting they were insufficient to be useful to other treating or subsequent treating physicians.

108. When all the evidence is considered, it was established that respondent engaged in unprofessional conduct when he failed to maintain adequate recordkeeping.

Excessive Prescribing and/or Treatments

109. Dr. Leung opined that, in several instances, the prescriptions and/or treatments furnished by respondent were below the standard of care. Again, Dr. Leung did not clearly define the applicable standard of care in any of his written reports or during his hearing testimony, rendering it difficult to determine if respondent met or failed to meet it. This difficulty notwithstanding, respondent's continued administration of IV Fentanyl treatments to JP is the same or substantially similar as the misconduct which was the subject of the 2015 accusation, and which misconduct respondent, as a condition of the Stipulation, conceded met the definition of excessive prescribing and/or treatments. Respondent cannot now use the current proceeding to impeach or re-litigate facts established by the prior action. Respondent's assertion that he did not know he could not administer IV Fentanyl to JP on an outpatient basis, and the prohibition was for the home only, was not credible.

110. When all of the evidence is considered, it was established that respondent engaged in unprofessional conduct when he excessive prescribed and/or rendered treatment with respect to JP.

Gross Negligence, Repeated Negligent Acts, Prescribing without a Prior Exam or Medical Indication

111. The record included multiple instances where respondent prescribed a particular course of treatment for which no examination or medical indication was noted in the patient's chart note. The opinions by Drs. Wilcosky and Brose that respondent had conducted an appropriate exam and/or had previously documented a medical indication were based entirely on their discussions with respondent only days before this hearing. Respondent's assertion that examination and/or medical

indication was documented in the longitudinal record is equally problematic as he was unable to produce any such longitudinal record to Dr. Leung upon request. Nor did he produce any such record to corroborate his testimony at this hearing, more than two years after the fact. Therefore, the only credible evidence as to whether an appropriate exam was conducted or medical indication existed are respondent's interval chart notes.

112. When all of the evidence is considered, it was established that respondent engaged in unprofessional conduct when, on multiple occasions, he prescribed treatment without conducting an appropriate prior exam or having a medical indication.

113. The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) In comparison, simple negligence is merely a departure from the standard of care. While Dr. Leung opined that respondent's acts departed from the standard of care on multiple occasions, he did not specify whether or not such departures were extreme. Accordingly, it was established that respondent engaged in repeated negligent acts. However, gross negligence was not established.

PROBATION

114. Given the above, respondent violated probationary Condition 9, by failing to comply with all rules governing the practice of medicine in California. Effective December 16, 2016, respondent became subject to probationary terms and conditions detailed in the Decision and Order, Case No. 12-2012-227503, including Condition 9. As such, respondent's license was under heightened scrutiny for the term

of probation, and he knew it. Even still, respondent violated the terms and conditions of probation and provided excuses to the Board for his behavior.

APPROPRIATE PENALTY

115. As cause for discipline has been established, it is necessary to look to the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016) (Guidelines) to determine the appropriate level of discipline. The Guidelines recommend, at a minimum, stayed revocation and five years' probation for respondent's misconduct under Business and Professions Code sections 725, 2234, 2242, and 2266. The maximum discipline for each of these violations is license revocation.

116. In the instant case, it was established that respondent engaged in unprofessional conduct as a result of his excessive prescribing practices, inadequate recordkeeping, and deficient prescribing practices. This notwithstanding, the proven misconduct occurred during the first nine months of respondent's three-year probation. While respondent was initially resistive and resentful of the discipline process and requirement of practicing under a monitor, he nevertheless demonstrated a willingness and ability to improve his practices to achieve the standard of care.

117. The evidence demonstrated that Dr. Leung's communications with respondent were infrequent and difficult. When Dr. Leung discussed with respondent deficiencies in his charting, he did not identify any specific chart for respondent to review. Nor did Dr. Leung specify any particular patient visit or chart note in his quarterly reports or other reports. The Accusation, which was based entirely on Dr. Leung's written reports, likewise included no allegations specific to any patient visit or chart note. Indeed, the first time any specific patient encounter and/or chart notes was

identified to respondent was during Dr. Lueng's testimony at hearing. In light of these facts, respondent should be given an opportunity to demonstrate he is capable of complying with probation and the Board's rules, and improving his overall practice to a satisfactory level.

118. In exercising its disciplinary functions, protection of the public is the highest priority of the Board. (Bus. & Prof. Code, § 2229, subd. (a).) To the extent it is not inconsistent with public protection, disciplinary action taken against a physician should be calculated to aid in his or her rehabilitation. (Bus.& Prof. Code, § 2229, subd. (b).) Considering the evidence as a whole, it is appropriate to allow respondent to maintain his licensure on a restricted basis and to extend his term of probation by three years, the same length as the original term of probation.

LEGAL CONCLUSIONS

1. The Medical Practices Act, Business and Professions Code section 2000, et seq., provides that "protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

Accusation

2. Complainant bears the burden of proving, by clear and convincing evidence, each of the grounds for discipline alleged in the Accusation. (*Ettinger v. Board of Medical Quality Assurance* (1985) 135 Cal.App.3d 853, 856; *James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1104.) This means that the burden rests on complainant to establish the charging allegations by proof that is clear, explicit and

unequivocal – so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84 [citations omitted].)

3. Business and Professions Code section 2227 provides, in pertinent part, that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

> (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.

4. The Board is authorized to "take action against any licensee who is charged with unprofessional conduct." (Bus. & Prof. Code, § 2234.) Section 2334 defines unprofessional conduct to include, in pertinent part:

> [¶] . . . [¶]

(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.

[¶] . . . [¶]

5. The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) In comparison, simple negligence is merely a departure from the standard of care.

6. Business and Professions Code section 2242 further defines unprofessional conduct to include the "prescribing, dispensing, or furnishing

dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication . . . "

7. Business and Professions Code section 725, subdivision (a), provides:

> (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.

8. Finally, "Business and Professions Code section 2266 states, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients" constitutes unprofessional conduct.

CAUSE FOR DISCIPLINE

9. As set forth in the Factual Findings as a whole, and Legal Conclusions 10 and 11 below, clear and convincing evidence established that respondent engaged in repeated negligent acts and prescribing without a prior exam or medical indication. Cause for discipline therefore exists pursuant to Business and Professions Code sections 2234, subdivision (c), and 2242. However, cause for discipline pursuant to Business and Professions Code section 2234, subdivision (b), gross negligence, was not established.

10. As set forth in the Factual Findings as a whole, clear and convincing evidence established that respondent engaged in excessive prescribing and/or treatment when he administered high doses of IV Fentanyl to JP in his office on an outpatient basis. Cause therefore exists to discipline his license for unprofessional conduct pursuant to Business and Professions Code section 725, subdivision (a).

11. As set forth in the Factual Findings as a whole, clear and convincing evidence established that respondent failed to maintain adequate and accurate records of his treatment of chronic care patients. Cause therefore exists to discipline his license for unprofessional conduct pursuant to Business and Professions Code section 2266.

Petition to Revoke Probation

12. Complainant bears the burden of proving the matters alleged in the Petition to Revoke Probation by a preponderance of the evidence. (*Sandarg v. Dental Board of California* (2010) 184 Cal.App.4th 1434.) Evidence that is deemed to preponderate must amount to "substantial evidence," which means evidence that is reasonable in nature, credible, and of solid value. (*Weiser v. Board of Retirement* (1984) 152 Cal.App.3d 775, 783; *In re Teed's Estate* (1952) 112 Cal.App.2d 638, 644.)

13. Effective December 16, 2016, respondent became subject to the probationary terms and conditions detailed in the Decision and Order, Case No. 12-201227503, including Condition 9, which states:

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

14. As set forth in the Factual Findings as a whole, cause exists to revoke respondent's probation.

Penalty

15. As set forth in the Factual Findings as a whole, and in particular Findings 114 through 117, it is not inconsistent with the public health, safety and welfare to allow respondent to maintain licensure subject to the terms and conditions below.

ORDER

Physician's and Surgeon's Certificate No. G 82342 issued to Eric David Gordon, M.D., is REVOKED. However, the revocation is stayed and respondent is placed on probation for three years upon the following terms and conditions:

1. Controlled Substances – Partial Restriction

Respondent shall not order, prescribe, dispense, administer, or possess any Schedule II controlled substances as defined by the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5. If respondent forms the medical opinion, after a good faith prior examination, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following a good faith examination, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of

marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. Controlled Substances – Maintain Records and Access to Records and Inventories

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

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its

designee at all times during business hours and shall be retained for the entire term of probation.

3. Monitoring – Practice

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

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and

copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

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

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

4. Notification

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

5. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

6. Obey All Laws

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

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

LICENSE RENEWAL

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

TRAVEL OR RESIDENCE OUTSIDE OF CALIFORNIA

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days. In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. Interview with the Board or Its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be

considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation.

Upon successful completion of probation, respondent's certificate shall be fully restored.

12. Violation of Probation

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

13. License Surrender

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

14. Probation Monitoring Costs

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

DocuSigned by:
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DATE: December 11, 2019

TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings