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

In the Matter of the Accusation Against:	)	
	)	
	)	
Jonathan Benton Cantwell Humphrey, M.D.	)	MBC File # 800-2015-017938
	)	
	)	
Physician's & Surgeon's	)	
Certificate No. G66292	)	
	)	
Respondent.	)	

ORDER CORRECTING NUNC PRO TUNC
CLERICAL ERROR IN "SIGNATURE BLOCK" PORTION OF DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the "signature block" portion of the Decision in the above-entitled matter and that such clerical error should be corrected so that the title will conform to the Board's issued Decision.

IT IS HEREBY ORDERED that the signature block contained on the Decision Order Page in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "Ronald H. Lewis, M.D., Chair, Panel A."

February 13, 2020

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 Against: Jonathan Benton Cantwell Humphrey, M.D. Physician's and Surgeon's Certificate No. G66292 Respondent	)	Case No. 800-2015-017938

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct a clerical error that does not affect the factual or legal basis of the Proposed Decision. The Proposed Decision is amended as follows:

1. Page 21, paragraph 63, line 1; the patient reference is corrected to read "Patient 2."

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 20, 2020.

IT IS SO ORDERED: January 21, 2020.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

JONATHAN BENTON CANT[1] HUMPHREY, M.D.

Physician's and Surgeon's Certificate No. G 66292,

Respondent.

Case No. 800-2015-017938

OAH No. 2018100149

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on November 18 through 20, 2019, in Oakland, California.

Deputy Attorney General Rebecca D. Wagner represented complainant Kimberley Kirchmeyer, Executive Director of the Medical Board of California.

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[1] Records from the Medical Board of California show respondent's name in this manner. His curriculum vitae states that respondent's full third name is Cantwell.

Attorney John L. Fleer represented respondent Jonathan Benton Cantwell Humphrey, M.D., who was present for the hearing.

The matter was submitted for decision on November 20, 2019.

FACTUAL FINDINGS

1. Respondent Jonathan Benton Cantwell Humphrey first received Physician's and Surgeon's Certificate No. G 66292 on July 11, 1989. At the time of the hearing in this matter, this certificate was active, and was scheduled to expire on May 31, 2021.

2. On January 30, 2018, acting in her official capacity as Executive Director of the Medical Board of California, complainant Kimberly Kirchmeyer filed an accusation against respondent. Complainant alleges that respondent has violated laws and regulations governing the practice of medicine by prescribing controlled substances to three patients without conducting proper examinations and without monitoring these patients' medication use prudently. Complainant seeks revocation of Physician's and Surgeon's Certificate No. G 66292, or an order placing this certificate on probation. Respondent timely requested a hearing.

Respondent's Training and Medical Practice

3. Respondent graduated from medical school in 1988. He completed a family practice residency in 1991. Respondent is board-certified in family practice.

4. Early in his career, respondent worked in emergency rooms and urgent care clinics. Since 1994, he has been in private practice, offering primary care. Respondent's patient population includes several multigenerational families, and he

estimates that he has not accepted new patients outside his existing patients' families for about ten years. At the time of the hearing, respondent's practice group included four physicians and several nurse practitioners.

5. Respondent holds certification permitting him to prescribe buprenorphine[2] as a treatment for opioid use disorder. He obtained this certification to benefit his existing patients, rather than with the intention of expanding his practice.

Standards of Care for Pain Treatment With Controlled Substances

6. Shafi Khalid, M.D., is board-certified in internal and geriatric medicine, and in pain medicine through the American Board of Psychology and Neurology. He is in private clinical practice as a pain management physician in San Diego, and has practiced pain medicine in Texas and California for more than 15 years. Although he is a pain specialist, Dr. Khalid understands how California internists and family practice physicians address pain in their primary care practices, both from training such physicians and from working with them to treat referred patients.

7. William G. Brose, M.D., is board-certified as an anesthesiologist with a subspecialty in pain medicine. He serves as an adjunct clinical professor at the Stanford University School of Medicine, seeing patients one day each week with pain management residents. Dr. Brose spends the rest of his professional time consulting with multi-specialty physician groups about pain management and opioid risk

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[2] Buprenorphine is an opioid medication that sometimes is used to treat opioid use disorder. Buprenorphine is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11058, subd. (d)).

reduction, and in forensic work including acting as a qualified medical examiner in workers' compensation matters. He has extensive clinical and research experience in pain management.

8. Dr. Brose's curriculum vitae states that he is a Board expert witness. He has never consulted for the Board. His explanation for this misrepresentation (that he intended this phrase to describe his work as an expert reviewer on behalf of physicians facing potential Board discipline) is not credible. Moreover, Dr. Brose expressed reservations about respondent's patient care and record-keeping to respondent in correspondence that he disavowed in his report and his testimony; this divergence further undermined Dr. Brose's testimonial credibility.

9. Dr. Khalid testified that community standards in California for prescribing opioid pain medication reflect procedures similar to those for other medications.

a. A reasonably prudent physician acting in accordance with standards in the medical community should not prescribe opioid pain medication without a thorough physical examination and patient history confirming not only the patient's need for pain control but also the likely existence of a condition for which controlled substances are the most appropriate form of pain control.

b. A physician also should evaluate the risks and benefits to the patient of using opioid pain medications, and should communicate those risks and benefits to the patient.

c. A physician should use opioid pain medication as part of a treatment plan, which should include efforts to diagnose and address the underlying causes of pain as well as criteria for evaluating the treatment's success. The physician

should make referrals to other providers, including to specialist physicians, as necessary to carry out the treatment plan.

d. The physician should review the course of treatment periodically, to consider whether the treatment plan is effective, whether it has resulted in any undesirable or unintended consequences, and whether to modify the plan to reflect new information about the patient or changes in the patient's condition.

e. The physician should keep accurate and complete records reflecting his or her prescribing decisions and treatment plan.

10. Dr. Brose testified similarly. He stated that a reasonably prudent primary care physician should prescribe pain medication only to treat pain for which the physician has diagnosed an explanation, and as part of a treatment plan relating to the working diagnosis. He also stated that the physician should evaluate the risks and benefits of medication for the patient, communicate with the patient about those risks and benefits, and document both the risk-benefit analysis and the patient communication.

11. Dr. Khalid and Dr. Brose concur that since 2006 (when Dr. Khalid began practicing pain medicine in California), community standards have changed to reflect greater understanding of the risks that opioid medications present, even when patients use them as prescribed. Community standards today require greater attention than in the past to limiting opioid use to the smallest effective dose, and to recognizing and averting harms that may indicate overuse such as digestive upset, sedation, and habituation.

12. Dr. Brose noted in particular that the shift in standards described in Finding 11 has created tension for some primary care physicians and their patients.

Patients who became dependent on, and habituated to, higher doses of opioid pain medication when community prescribing standards permitted such use should not abruptly reduce or discontinue these medications, even if their primary care physicians have become warier than before of the risks these patients face from chronic opioid use. Dr. Brose's identification of this problem is persuasive; but as stated in greater detail in Finding 63, below, his opinion that respondent acted prudently in continuing to prescribe chronically high doses of opioid pain medication to one of the three patients whose care is at issue in this matter is not.

13. Dr. Khalid also testified about the standard of practice for using buprenorphine in treating opioid use disorders.

a. The physician should follow a standard protocol in introducing buprenorphine to replace other opioid drugs. A patient who is dependent on opioid drugs must stop using those drugs for several days, until the patient begins to suffer withdrawal symptoms. The patient then should begin to take buprenorphine to blunt the most unpleasant symptoms of opioid withdrawal, including cravings for other opioid drugs. Dr. Khalid emphasized that the physician must explain this protocol carefully to the patient and ensure that the patient follows it; otherwise, the patient not only may suffer extremely unpleasant opioid withdrawal symptoms but also may associate the withdrawal symptoms themselves, rather than their relief, with buprenorphine.

b. Buprenorphine compounds can help patients maintain abstinence from opioid medications, but they are most effective as part of a comprehensive addiction treatment program that includes counseling, behavior modification, and peer support.

c. A patient who is using or has used buprenorphine to achieve and maintain abstinence from other opioids may need to resume using opioid pain control medications, such as during and immediately after surgery. Nevertheless, a physician should not reintroduce these medications to a patient who has quit them with buprenorphine support without careful consideration of the risks and benefits, or without developing a plan to avoid the patient's relapse into active opioid use disorder.

14. Dr. Brose did not testify in any detail regarding proper use of buprenorphine. His report states vaguely that "multiple alternative prescribing patterns" for buprenorphine may meet the standard of care, but he did not state any clear, persuasive opinion regarding respondent's use of buprenorphine for any of the three patients whose care is at issue in this matter.

Patient 1

15. Respondent began treating Patient 1 in the mid-1990's. He did not act as her primary care physician. Instead, Patient 1 came to respondent almost exclusively for complaints of pain or anxiety, seeking (and usually receiving) prescriptions for controlled substances including opioid pain medications and benzodiazepines.

RESPONDENT'S TREATMENT OF PATIENT 1

16. Records in evidence from respondent's medical practice regarding Patient 1 begin in late 2007. The earliest few visit records do not state that respondent or any of his colleagues prescribed opioid medications to Patient 1. They do show that in January 2008, respondent counseled Patient 1 to consider an alcohol abuse treatment program.

17. Respondent and his colleagues prescribed Norco[3] and oxycodone[4] to Patient 1 during spring 2008, for various and apparently unrelated complaints including headache, abdominal pain, and back pain, even as their notes also expressed concern about her overuse of and dependency on these drugs. Visit notes from June 2008 state that Patient 1 intended to undertake a "pain management" program at Kaiser Permanente, but not that she actually did so or that respondent conferred with anyone at Kaiser Permanente regarding Patient 1's pain complaints or drug use.

18. On August 21, 2008, Patient 1 came to respondent's practice showing "severe withdrawal symptoms." Physician Assistant Erin Thurman referred her to "Dr. Gracier . . . for pain management and opiate withdrawal."

19. Respondent's records reflect no further care for Patient 1 in his practice until May 2010, when she saw respondent complaining of "anxiety." She saw him again complaining of "anxiety" in January 2013, and in September 2013 complaining of back pain. A September 2013 note states that respondent considered Patient 1 to have a history of "narcotic abuse."

20. Patient 1 began seeing respondent regularly again in mid-2014. She complained of abdominal pain, for which respondent prescribed Norco. Although his

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[3] Norco is a trade name for hydrocodone with acetaminophen. Hydrocodone is a narcotic analgesic that is both a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(I)).

[4] Oxycodone is a short-acting opioid analgesic that is both a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(M)).

notes refer to possible "nerve entrapment" and to treatment at a pain management clinic, his records reflect no further efforts to diagnose Patient 1's abdominal pain or to address its cause.

21. In August 2014, respondent prescribed Suboxone[5] to Patient 1. She continued using Suboxone until November 2014, when he prescribed Norco again to her after she broke her toe. His notes reflect no advice to Patient 1 about how to use Suboxone to maintain abstinence from other opioid drugs, and no discussion in November 2014 regarding the risks and benefits of resuming Norco use after several months of Suboxone treatment.

22. In late 2014 or early 2015, Patient 1 developed a benign growth at the bridge of her nose that caused pain. Respondent prescribed Norco, then Percocet,[6] and then oxycodone to Patient 1, advising her not to use Suboxone at the same time as these medications. She had surgery in late January 2015 to remove the growth.

23. Respondent continued to prescribe oxycodone and Norco to Patient 1 for about six weeks after this surgery. By late March 2015, she had begun using

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[5] Suboxone is a trade name for a combination of buprenorphine and naloxone. This combination is used to treat opioid use disorder. Because it contains buprenorphine, Suboxone is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11058, subd. (d).)

[6] Percocet is a trade name for a combination of oxycodone and acetaminophen. Because it contains oxycodone, Percocet is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(M)).

Subutex;[7] a note from April 2015 states that respondent intended to switch Patient 1 from Subutex to Suboxone.

24. Respondent's records are not clear as to when he resumed prescribing opioid medications to Patient 1. In July 2015, she saw him, stating that someone had "robbed" her house and stolen her medication; he prescribed 120 Percocet tablets, describing them as a "refill" and noting that he would not prescribe more that month.

25. In August 2015, respondent resumed prescribing oxycodone to Patient 1. She also received prescriptions for Percocet this month from different physicians, although respondent's records do not reflect that he knew Patient 1 had obtained this medication. Respondent apparently prescribed this medication to address abdominal pain; Patient 1 had surgery to remove a uterine fibroid in early September 2015.

26. After her September 2015 gynecological surgery, Patient 1 used hydromorphone[8] prescribed by her surgeon, followed by Percocet, oxycodone, and Norco prescribed by respondent. A note from September 21, 2015, states, "continues to struggle with post-operative pain, after long discussion agreed it is time to detox her." Respondent advised Patient 1 to discontinue using opioid medication, and again prescribed Subutex.

27. On September 22, 2015, Patient 1 filled a prescription from another physician for hydromorphone. On September 25, 2015, she filled a prescription for

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[7] Subutex is a trade name for buprenorphine.

[8] Hydromorphone, an opioid analgesic, is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11055, subd. (b)(1)(J)).

Percocet. Respondent's records do not reflect that he knew about either prescription; to the contrary, a note from an appointment with Patient 1 on September 28, 2015, states, "[h]as not been taking any narcotics."

28. In mid-November 2015, Patient 1 saw respondent about abdominal pain he believed to be "likely musculoskeletal." Despite having advised her just two months earlier to stop using opioid pain medication, he prescribed Percocet to her. He continued prescribing Percocet to Patient 1 (as did other physicians, apparently without respondent's knowledge) during November and December 2015.

29. In January 2016, respondent again advised Patient 1 to "stop opiates and use 4 days of Suboxone." He prescribed Suboxone and Valium[9] to Patient 1 throughout spring 2016, and also conducted regular urine drug screens at her appointments to confirm that she was taking only these two controlled substances.

30. Respondent testified that Patient 1 later undertook inpatient substance use disorder treatment. At the time of the hearing he had not seen her in a few years.

31. Patient 1 provided a declaration confirming that she had undergone inpatient treatment before 2007 for addiction to pain medication. She confirmed as well that she had undergone such treatment again in late 2016.

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[9] Valium is a trade name for diazepam, a benzodiazepine drug used to quell anxiety. It is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11057, subd. (d)(9)).

EXPERT OPINIONS REGARDING RESPONDENT'S TREATMENT OF PATIENT 1

32. Dr. Khalid testified that respondent acted well below the standard of care by failing to refer Patient 1 to an addiction specialist, in light of both her opioid use disorder and her other co-morbid psychiatric disorders. Dr. Khalid testified further that respondent acted well below the standard of care by using buprenorphine to treat Patient 1 without explaining its benefits and risks clearly, and without documenting and implementing a plan either for its induction or for its ongoing use. He left Patient 1 to make her own decisions, despite her other mental health challenges and without support such as professional counseling or peer support. Furthermore, respondent switched back and forth for Patient 1 between buprenorphine compounds and other opioid medications without any clear rationale, and without evaluating or documenting the risks and benefits of using opioid medications after having experienced prior substance use disorder. In light of all the matters stated in Findings 15 through 31, Dr. Khalid's opinions that respondent's treatment decisions with respect to Patient 1 were not only extreme departures from the standard of care but also incompetent are persuasive.

33. Dr. Khalid stated as well the opinion that respondent's medical records regarding Patient 1 are inadequate, because they fail to document examinations that would justify prescribing pain medications and because they fail to show clearly what

medications respondent prescribed.[10] In light of the matters stated in Findings 15 through 31, this opinion also is persuasive.

34. Dr. Brose believes that respondent acted responsibly by prescribing pain medication to Patient 1, as part of a "compassionate but difficult treatment plan." This opinion is not persuasive, primarily because the matters stated in Findings 15 through 31 demonstrate that respondent had no treatment plan for Patient 1 other than to prescribe pain medication to her when she approached him for it.

35. Dr. Brose sees "no evidence of treatment related harms" in Patient 1's records. Dr. Khalid, in contrast, holds the opinion that Patient 1 suffered needlessly because of respondent's failure to exercise skill and good judgment in treating Patient 1's mental health issues and pain. Dr. Khalid's opinion is persuasive; Dr. Brose's is not.

Patient 2

36. Respondent began treating Patient 2 in 1994. As with Patient 1, respondent did not act as Patient 2's primary care physician. Instead, Patient 2 obtained primary medical care through Kaiser Permanente.

37. Patient 2 received treatment from other physicians for several painful health problems during the period at issue in this matter. From respondent, she received primarily opioid pain medication. He testified that she came to him for these

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[10] Although Dr. Brose declined in testimony to criticize respondent's record-keeping, he noted in correspondence to respondent that he does "not know how a provider would practice without some in chart or in office documentation of the prescriptions written for each patient when they are delivering longitudinal care."

medications because she was "comfortable" with him, and not because other members of her care team believed more strongly than he did that Patient 2 should reduce her opioid use or undergo addiction treatment. This testimony is not credible.

RESPONDENT'S TREATMENT OF PATIENT 2

38. Patient 2 completed a health history survey for respondent on May 29, 2008. It stated that she had come to respondent for "second opinion breast cancer" and was taking 480 milligrams of OxyContin[11] per day. Respondent's notes from May 29, 2008, show that Patient 2 came to him because she wanted OxyContin that she could not get from her regular provider. They do not show that respondent performed any physical examination of Patient 2.

39. Patient 2 visited respondent's medical practice, and received prescriptions for OxyContin there, sporadically between May 2008 and July 2010. A note from this period explains that she was receiving regular care, including prescriptions for pain medication, at Kaiser Permanente, but came to respondent's medical practice to obtain additional medication beyond what her Kaiser Permanente physicians had prescribed.

40. In September 2010, respondent began prescribing OxyContin regularly to Patient 2. His notes from a visit on September 8, 2010, say that Patient 2 had "failed

[11] OxyContin is a trade name for extended-release oxycodone.

[S]uboxone, methadone"[12] and was "doing poorly on chronic pain meds." Respondent's records do not reflect any consultation about Patient 2 with any other physician who might have given him more detail about her experiences with either Suboxone or methadone; further, they do not explain why he continued prescribing OxyContin to her, without any other intervention, if she was "doing poorly." He did not make any form of medication agreement with Patient 2 to document conditions under which he would or would not continue to treat her with opioid pain medications.

41. Respondent continued prescribing OxyContin regularly to Patient 2 throughout 2011 and 2012. His visit notes refer regularly, but vaguely, to the possibility of switching Patient 2 to Subutex, or to a "detox." No notes explain why respondent did not follow up on these plans, or refer Patient 2 to an addiction specialist.

42. Respondent also referred Patient 2 to a surgeon, who evaluated her in September 2011 and concluded that her persistent breast pain likely resulted from "intercostal neuromas." She had surgery to address this problem in mid-2012. Respondent testified that the surgery's effectiveness was "quite dramatic," but his records do not reflect that he prescribed any less OxyContin to Patient 2 after this surgery than he had before it.

43. At the beginning of April 2013, Patient 2 decided to try to stop using opioid pain medications. Respondent's notes imply that he discussed a withdrawal and

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[12] Methadone is an opiate drug used both to treat pain and to treat opioid use disorder. It is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11057, subd. (c)(14)).

treatment plan with Patient 2 and her family, but they do not document that plan. By April 9, 2013, Patient 2 was experiencing "severe" opiate withdrawal symptoms. Respondent's records show that he prescribed first Suboxone and then Subutex to her; they do not reflect any short- or long-term plan for either drug's use. Notes from an April 30, 2013, visit state that respondent advised Patient 2 to "[t]aper Subutex very slowly."

44. Respondent changed his advice on May 30, 2013, advising Patient 2 to resume taking Subutex twice each day. His notes from that date say that he provided "[e]ducation on the plan," but they do not describe the plan.

45. Patient 2 continued to receive Subutex from respondent, and not OxyContin, until July 22, 2013. That day, she saw him stating that she had been having "severe foot pain," and was planning to have surgery to address it. If respondent and Patient 2 discussed the risks and benefits to her of resuming regular use of opioid pain medication, or a plan for discontinuing Subutex to allow her to use opioid medication successfully but minimally to control pain during and immediately after surgery, he did not document this discussion. He did prescribe both oxycodone and OxyContin to Patient 2 on this date.

46. Patient 2 had the surgery described in Finding 45 in late July or early August 2013. She continued after surgery and into early 2014 to use both oxycodone and OxyContin, prescribed by respondent. His records suggest that he had discontinued prescribing OxyContin to Patient 2 by March 2014, however.

47. Respondent's notes about Patient 2 from spring 2014 state that she was being "worked up" at Kaiser for her persistent pain. He continued to prescribe

oxycodone to her, and information in his records about her care elsewhere reflects only her reports to him at regular appointments.

48. In late August 2014, respondent prescribed Zohydro[13] to Patient 2, along with continuing oxycodone for "break-through pain." By November 2014, respondent was prescribing three 50-milligram doses of Zohydro and up to 12 30-milligram doses of oxycodone to Patient 2 for each day.

49. On January 19, 2015, Patient 2 filled prescriptions from respondent for 300 50-milligram doses of Zohydro and 300 30-milligram doses of oxycodone. She filled prescriptions from respondent for 460 more 30-milligram doses of oxycodone during February 2015, but not for more Zohydro. Notes from an appointment Patient 2 had with respondent on February 6, 2015, state his intention to "Consider methadone," but later notes that spring do not follow up on this suggestion.

50. Patient 2's oxycodone use escalated during spring 2015 until by May 2015 respondent was prescribing 20 30-milligram tablets to her for each day. He also prescribed lorazepam[14] (1 milligram per day) and zolpidem[15] (10 milligrams) per day regularly during this period.

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[13] Zohydro is a trade name for extended-release hydrocodone.

[14] Lorazepam is a benzodiazepine drug used to quell anxiety. It is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11057, subd. (d)(16)).

[15] Zolpidem is a sleep aid. It is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11057, subd. (d)(32)).

51. In December 2014, respondent's notes show that Patient 2 had developed a skin rash on her hands and feet. By late 2015, his notes refer regularly to "pustular psoriasis" and state that Patient 2 was receiving immunosuppressant drugs to treat it.

52. By March 2016, respondent had reduced Patient 2's oxycodone prescription from 20 to 16 30-milligram tablets per day. She remained on this medication, along with lorazepam and zolpidem, through June 2016, when the records in evidence end.

53. Respondent stated at an interview in May 2017 with a Board investigator that Patient 2 was "off all pain medicine," and was participating in a "pain program" through Kaiser Permanente. At the November 2019 hearing, he testified similarly that Patient 2 was "stable," and using Suboxone.

54. Patient 2 provided a declaration in this matter dated May 1, 2019, stating that she takes 30 milligrams of oxycodone every four to six hours, and some days "1 or 2 extra." Her declaration states that she sees respondent monthly.

55. The contradiction between the matters stated in Findings 53 and 54 shows that respondent has little understanding of Patient 2's current condition, and casts doubt on his testimony that he has followed Patient 2 closely throughout the years he has prescribed opioid medications to her.

EXPERT OPINIONS REGARDING RESPONDENT'S TREATMENT OF PATIENT 2

56. Dr. Khalid testified that respondent's records demonstrate that Patient 2 had an opioid use disorder, and that respondent committed extreme departures from the standard of care in addressing this disorder. Specifically, Dr. Khalid's opinion is that

respondent failed to assess and document this disorder properly; failed to develop or document a treatment plan; failed to use buprenorphine appropriately to help Patient 2 break her dependence on pain medication; and failed to refer Patient 2 to appropriate specialists. In light of the matters stated in Findings 36 through 55, Dr. Khalid's opinion is persuasive.

57. Dr. Khalid testified further that respondent's poor treatment for Patient 2's opioid use disorder reflects incompetence both in understanding opioid use disorder and in treating it with buprenorphine. He highlights respondent's failure to document and supervise Patient 2's use of buprenorphine to replace pain medication (as described in Findings 43 and 44); his prescribing oxycodone to Patient 2 only months after she had discontinued it with some difficulty (as described in Finding 45); and his failure to refer Patient 2 to an addiction treatment program or specialist. In light of all the matters stated in Findings 36 through 55, Dr. Khalid's opinion is persuasive.

58. Dr. Khalid acknowledges that respondent was not the first physician to prescribe comparatively high opioid doses to Patient 2. His opinion is that when respondent assumed responsibility for prescribing pain medication to Patient 2, respondent should have performed a thorough physical examination to establish Patient 2's condition at that time. He also should have obtained and considered detailed records about Patient 2's prior experience with opioid pain medications; he should have established a clear treatment plan, including boundaries and expectations, to avoid escalating Patient 2's opioid use; and he should have made a written medication agreement with Patient 2 to reflect the boundaries and expectations in the treatment plan. Dr. Khalid believes that respondent's failure to examine Patient 2 (as described in Finding 38), to take and document a thorough, relevant history (as

described in Finding 40); to establish and document a plan for using opioid drugs in her treatment (as described in Findings 40 through 45); and his failure to use a medication agreement with her (as described in Finding 40) are extreme departures from the standard of care, and this opinion is persuasive.

59. Dr. Khalid believes further that respondent departed extremely from the standard of care by failing to refer Patient 2 to a pain management specialist or an addiction specialist. The matters stated in Findings 38 through 55 demonstrate Patient 2's struggle with persistent pain despite significant amounts of medication; the matters stated in Findings 43 through 45 demonstrate her diminished capacity to make decisions about opioid use; and the matters stated in Findings 47 and 53 demonstrate that even when Patient 2 did consult pain specialists, respondent failed to encourage or require her to rely on their expertise. In light of all these matters, Dr. Khalid's opinion is persuasive.

60. Dr. Khalid also testified that respondent committed extreme departures from the standard of care by prescribing very high doses of opioids to Patient 2, sometimes in dangerous combination with other controlled substances, and by failing to document exactly what drugs he had prescribed or how he had instructed Patient 2 to use them. In light of the matters stated in Findings 38 through 55, Dr. Khalid's opinion that respondent departed from the standard of care simply by prescribing high opioid doses to Patient 2 is not persuasive. Particularly because of the high drug doses respondent prescribed for Patient 2, however, Dr. Khalid's opinion that respondent departed from the standard of care by failing to document his prescriptions and instructions carefully is persuasive, as is his opinion that this departure was extreme.

61. Dr. Khalid's opinion is that the errors described in Findings 43 through 45 also reflect respondent's incompetence. Although the evidence established (as described in Findings 56 through 60) that respondent did not act prudently, it did not establish that these extreme departures from the standard of care resulted from incompetence.

62. Dr. Khalid stated as well the opinion that respondent's medical records regarding Patient 2 are inadequate, because they fail to document examinations that would justify prescribing pain medications and because they fail to show clearly what medications respondent prescribed. In light of the matters stated in Findings 46 and 54, this opinion is persuasive.

63. As for Patient 1, Dr. Brose believes that respondent acted responsibly by continuing to prescribe pain medication to Patient 2, as part of a "compassionate but difficult treatment plan." This opinion is not persuasive, because the matters stated in Findings 36 through 55 demonstrate that respondent had no treatment plan for Patient 2, other than continuing to prescribe pain medication.

64. Dr. Khalid acknowledged that Patient 2 had many painful health issues that persisted despite significant care from specialists. Nevertheless, his opinion is that respondent's errors, and primarily those described in Findings 40 through 45, caused Patient 2 to experience harm that better care would have avoided. This opinion is persuasive.

Patient 3

65. Respondent testified that Patient 3 also has been his patient since 1994, although the earliest treatment record in evidence regarding Patient 3 is from October

2007. Respondent provided primary care to Patient 3, treating her for several health problems including, but not limited to, painful conditions.

RESPONDENT'S TREATMENT OF PATIENT 3

66. In October 2007, respondent's records state that Patient 3 was using fentanyl[16] to address neck pain. In February 2008, the records state that Patient 3 was using oral OxyContin. No records explain this change. No records from this period reflect any effort, through tests or referrals, to diagnose or treat the cause of Patient 3's neck pain.

67. A visit record from March 14, 2008, states that Patient 3 "wants to detox." The only plan stated in the record to address this request is "trial [K]adian[17] 100 til detox plus [N]orco #40." The records in evidence do not state whether respondent actually prescribed these drugs at this time, or whether Patient 3 obtained and took them.

68. Through summer 2008, Patient 3 remained on opioid pain medication. A visit record from June 17, 2008, states that Patient 3 had seen a "Dr. Gracer . . . who felt she was not a candidate for Suboxone."

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[16] Fentanyl is an opiate pain medication. It is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11057, subd. (c)(8)).

[17] Kadian is a trade name for morphine, an opioid analgesic. Morphine is a dangerous drug (Bus. & Prof. Code, § 4022) and a controlled substance (Health & Saf. Code, § 11057, subd. (b)(1)(L)).

69. A March 20, 2008, letter in respondent's records from Richard I. Gracer, M.D., states that Patient 3 "was asked to sign a pain agreement stating that she would get her pain medications through this office." It also states Dr. Gracer's opinion that Patient 3 "may very well do well on buprenorphine, but for now, getting a proper diagnosis relative to her cervical problem and providing treatment possible towards that is probably the best way to go."

70. In August 2008, for reasons the records do not explain, respondent discontinued prescribing OxyContin to Patient 3 and prescribed Kadian and Dilaudid[18] instead. She took these medications for a few weeks; then on August 18, 2008, a visit record states that she "started on [m]ethadone 5 days ago and has had bad side effects," which caused her to discontinue this drug on August 17. Respondent's records do not indicate who prescribed methadone to Patient 3, or whether respondent consulted this prescriber either before or after Patient 3 tried it. Respondent's assessment of the patient's self-report was "reaction to medication." He re-prescribed Kadian to her.

71. Patient 3 saw respondent several times between August and December 2008. A record from an office visit on December 3, 2008, lists numerous medications for Patient 3, including Ambien,[19] Norco, Lamictal,[20] and Valium. The records from respondent's interactions with Patient 3 between August and December 2008 state no

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[18] Dilaudid is a trade name for hydromorphone.

[19] Ambien is a trade name for zolpidem.

[20] Lamictal is a trade name for lamotrigine, a dangerous drug (Bus. & Prof. Code, § 4022) used to treat bipolar disorder.

rationale or plan for any of these medications, and document no discussion of their advantages or disadvantages for this patient.

72. Patient 3 continued to see respondent regularly during 2009. A note from August 25, 2009, states under "Assessment/Plan," "consider DETOX." The records document no further discussion between respondent and the patient regarding opioid abuse, and no referral to any mental health professional or addiction treatment professional. They also continue to reflect no effort, through tests or referrals, to diagnose or treat the cause of Patient 3's neck pain. Instead, in November 2009, respondent again prescribed OxyContin to Patient 3.

73. Patient 3 continued using various opioid pain medications, prescribed to her by respondent, until June 2011. Her records show that she and respondent discussed "detox" treatment on a few occasions during this period, but not that Patient 3 or respondent actually took any steps to address her opioid dependence.

74. A visit note on June 24, 2011, states, "Pt started back on the [Subutex] pt started on 5 days ago." Respondent's records do not indicate who prescribed this medication to Patient 3 before this date, or counseled her about its use.

75. Patient 3 continued to take Subutex for several months, but a visit note from March 27, 2012, does not list this medication. Respondent's records do not explain whether Patient 3 had stopped using Subutex at this time, or had begun receiving it elsewhere.

76. On February 19, 2013, Patient 3 saw respondent after a skiing accident. Respondent believed she had broken a rib. Without documenting any discussion of the risks or benefits of resuming opioid use after almost two years of abstinence, respondent prescribed oxycodone to Patient 3. Six weeks later, on April 1, 2013,

Patient 3 reported to respondent that she was "having difficulty coming off pain medications."

77. Patient 3 had an appendectomy in mid-April 2013, and continued using oxycodone until mid-May. Between mid-May and late October, respondent's records show that Patient 3 used Subutex; in late October, respondent again prescribed oxycodone to Patient 3. Respondent's records do not state clearly how much medication he prescribed to Patient 3, but by January 2014 his records state that she was taking six 80-milligram OxyContin tablets each day.

78. Records from the first quarter of 2014 state several times that Patient 3 wished to stop taking pain medications, but also that she repeatedly postponed resuming her use of Subutex. In June 2014, respondent's notes reflect Patient 3's report that she planned to schedule cervical fusion surgery later that summer; they do not reflect any consultation with any surgeons, or any coordination between respondent and surgeon regarding Patient 3's care in the meantime.

79. In August and September 2014, respondent's notes state that Patient 3 was "attempting to taper" her opioid pain medication, but by September 23, 2014, she still had not scheduled any neck surgery. In December 2014, respondent's notes state that Patient 3 planned surgery in January 2015, and would continue to take "high-dose pain medicine" until then.

80. Respondent's records include no direct communications between Patient 3's surgeon and respondent. His records state, however, that Patient 3 had cervical fusion surgery on January 20, 2015. During February and March 2015, respondent prescribed less OxyContin and oxycodone to Patient 3 than he had before her surgery. Her use increased again in April and May.

81. Patient 3 again gradually reduced her oxycodone use in late 2015 and early 2016. A note from February 17, 2016, states that she had "successfully transferred to [S]uboxone." During March and April 2016, however, respondent prescribed both Suboxone and oxycodone simultaneously; his notes do not explain this combination.

82. In May 2016, Patient 3 again was using oxycodone, although in smaller doses than she had in 2015. In June 2016, respondent again referred Patient 3 to Dr. Gracer.

83. Records in evidence about Patient 3 end in June 2016. Respondent testified that Patient 3 has learned since June 2016 that she has an autoimmune disorder that has responded well to dietary intervention. He believes that she no longer uses opioid pain medication.

EXPERT OPINIONS REGARDING RESPONDENT'S TREATMENT OF PATIENT 3

84. Dr. Brose did not review Patient 3's records, and expressed no opinion specifically about the care she received from respondent.

85. Dr. Khalid testified that respondent's records demonstrate that Patient 3 had an opioid use disorder, and that respondent committed extreme departures from the standard of care in addressing this disorder. Specifically, Dr. Khalid's opinion is that respondent failed to assess and document this disorder properly; failed to develop or document a treatment plan; failed to use buprenorphine appropriately to help Patient 3 break her dependence on pain medication; and failed to refer Patient 3 to appropriate specialists. In light of the matters stated in Findings 66 through 83, Dr. Khalid's opinion is persuasive.

86. Dr. Khalid testified further that respondent's poor treatment for Patient 3's opioid use disorder reflects incompetence both in understanding opioid use disorder and in treating it with buprenorphine. He highlights respondent's failure to document and supervise Patient 3's use of buprenorphine to replace pain medication (as described in Findings 74 and 75); his prescribing oxycodone to Patient 3 in early 2013 after her apparent success in discontinuing opioid medications in mid-2011 (as described in Finding 76); and his failure to refer Patient 3 to an addiction treatment program or specialist. In light of all the matters stated in Findings 66 through 83, Dr. Khalid's opinion is persuasive.

87. Dr. Khalid testified that respondent committed extreme departures from the standard of care in prescribing opioid medications to Patient 3, because he did so without documenting any physical examinations and without formulating, documenting, or executing a treatment plan to address the likely causes of Patient 3's pain. The matters stated in Finding 66 through 83 do not establish that respondent never examined Patient 3 or documented his own understanding of her physical condition. The matters stated in Findings 68 through 70 do establish that respondent referred Patient 3 to a pain specialist but declined to insist that she follow that specialist's recommendations; and the matters stated in Findings 71 through 73 establish that respondent maintained Patient 3 on pain medication despite her stated misgivings about that medication and without insisting that she pursue diagnosis of and treatment for the cause of her neck pain. In light of all the matters stated in Findings 66 through 83, Dr. Khalid's opinion is persuasive.

88. Dr. Khalid also testified that respondent committed extreme departures from the standard of care by prescribing very high doses of opioids to Patient 3, sometimes in dangerous combination with other controlled substances, and by failing

to document exactly what drugs he had prescribed or how he had instructed Patient 3 to use them. In light of the matters stated in Findings 66 through 83, Dr. Khalid's opinion that respondent departed from the standard of care simply by prescribing high opioid doses to Patient 3 is not persuasive. Particularly because of the high drug doses respondent prescribed for Patient 3, however, Dr. Khalid's opinion that respondent departed from the standard of care by failing to document his prescriptions and instructions carefully is persuasive, as is his opinion that this departure was extreme.

89. Dr. Khalid's opinion is that the errors described in Findings 87 and 88 also reflect respondent's incompetence. Although the evidence established (as described in Findings 87 and 88) that respondent did not act prudently, it did not establish that his extreme departures from the standard of care resulted from incompetence.

90. Dr. Khalid testified that respondent's delay in addressing Patient 3's opioid dependence and misuse (as described in Findings 66 through 73) caused harm to her, as did his failure to help her avoid relapsing into opioid use disorder after having stopped using opioids (as described in Findings 76 through 80). These opinions are persuasive.

References

91. Mark Musco, M.D., is a family physician in San Ramon who has known respondent professionally since about 2004. Dr. Musco has worked temporarily in respondent's practice, and is in the same after-hours call group as respondent. Dr. Musco considers respondent to provide excellent care that is both "competent and

appropriate." He believes that other physicians in their community share his high opinion of respondent.

92. Joseph M. Grant, M.D., is an orthopedic surgeon whose practice emphasizes spinal care. Dr. Grant moved to Sonora full-time in 2019 but previously had practiced both in Sonora and in Pleasanton. Respondent has referred patients to Dr. Grant, and Dr. Grant believes respondent to be careful in using pain medications. Dr. Grant also refers patients to respondent for primary care because he respects respondent's skills.

93. C. Charles Wen, M.D., is a member of the Norcal Urology Medical Group. He provided a reference letter regarding respondent, describing him as "one of the most respected family medicine practitioners in the East Bay." Dr. Wen shares this view, and praises respondent's dedication to patient care.

94. William B. Workman, M.D., is an orthopedic surgeon who has known respondent for many years. Dr. Workman provided a reference letter stating that he and respondent have shared patients, and that respondent is Dr. Workman's personal physician. Dr. Workman states that respondent is "kind, caring, compassionate, and knowledgeable."

95. Ryan A. Brown, M.D., has referred family and friends to respondent for about ten years. He provided a reference letter praising respondent's "professionalism, ethics, and empathy."

96. Michael J. Schierman, M.D., has known respondent for more than 25 years. They work in the same medical building, and are in the same call group. Dr. Schierman provided a reference letter stating that he believes respondent to be a very

good family physician who uses "sound judgment in diagnosis and wisdom in formulating treatment plans."

97. Stephen R. Wells, M.D., provided a reference letter about respondent, based on their long professional acquaintance. Dr. Wells is an obstetrician and gynecologist who regularly refers his patients to respondent for primary care, and who treats patients who receive primary care from respondent. Dr. Wells also sees respondent as Dr. Wells's own primary care physician, and has "great confidence and trust" in respondent.

98. Richard Shinaman, M.D., is a pain management physician who has treated patients in common with respondent. He provided a reference letter praising respondent's "responsible team-based approach," and noting that respondent's patients who Dr. Shinaman also has seen "typically do not display issues of non-compliance or diversion when it comes to the use of analgesic medications."

99. Stephen J. Ronan, M.D., is a plastic surgeon who provided a reference letter for respondent. Dr. Ronan and respondent share patients, and Dr. Ronan has heard respondent's patients praise respondent's care when describing their own health histories to Dr. Ronan. Some of these patients also have received pre-operative clearance from respondent before surgery with Dr. Ronan. Finally, Dr. Ronan notes that respondent promotes "responsible" opioid usage.

100. Aaron K. Salyapongse, M.D., is an orthopedic surgeon who has known respondent and shared patients with him during the past about 12 years. Dr. Salyapongse provided a reference letter stating specifically that he has collaborated with respondent in treating several chronic pain patients. In Dr. Salyapongse's view,

respondent exhibits "sound judgment when prescribing medication for treatment" and also helps patients stop using medication after surgery.

101. Todd A. Auker, M.D., provided a reference letter for respondent noting that respondent has consulted with Dr. Auker (at the Auker Eye Institute) and referred patients to him. Dr. Auker is "unaware of the circumstances" leading respondent to request a reference letter, but states that respondent provides high-quality care and has a strong reputation among their shared patients.

102. Salim Shelby, M.D., is a gastroenterologist who has practiced in the same community as respondent for almost 20 years. Respondent has referred patients to Dr. Shelby. Dr. Shelby provided a reference letter stating that respondent is "well known for his excellent bed side manners and clinical skills."

103. Tim Scott, M.D., has known respondent for more than 25 years. He provided a reference letter noting that he knows why respondent asked for the letter. Dr. Scott describes respondent as "steady, conscientious and discerning," and as an "invaluable credit to our medical community."

104. Michel de Boisblanc, M.D., is a surgeon who has treated patients in common with respondent for almost 20 years. Dr. de Boisblanc provided a reference letter describing respondent as "amongst the top of his field in primary care." He has "no hesitation referring and receiving patients from" respondent's practice.

Other Evidence

105. Respondent has no formal training regarding substance use disorders aside from courses he has taken to fulfill regular continuing medical education requirements. He has not taken a prescribing practices course.

106. After receiving the accusation in this matter and reviewing his own records, respondent decided to refresh his medical record-keeping skills. In June 2019, he completed the PBI Medical Record Keeping Course at the University of California, Irvine, School of Medicine. Respondent believes that the course has been helpful and has incorporated several of its lessons into his practice already. He keeps more detailed records than he once did, even for patients about whom he has extensive background knowledge from their long relationship.

107. Respondent professes a strong interest in mental health, and in treating patients who have co-morbid physical and mental health problems. He is a member of four pharmaceutical companies' speakers' bureaus, through which he gives presentations to physicians about the value of those companies' medications in managing bipolar disorder, major depression, attention deficit disorder, and migraine in the primary care setting.

108. Respondent has become more knowledgeable in the last ten years or so about pain management, and about how subjective pain experiences can result from mental as well as physical dysfunction. He testified, for example, that his buprenorphine training showed him this drug's value in stabilizing people who have experienced chronic pain. Respondent also testified that he formerly believed that even relatively high daily opioid medication doses were safe, as long as the patient's opioid use was not escalating and as long as the drugs' pain control benefits outweighed any functional impairment. He understands now that higher doses involve greater risk even to stable, habituated patients.

109. Respondent and the physicians in his practice have changed their prescribing practices for opioid pain medications. They use urine drug screens as well as the Controlled Substance Utilization Review and Evaluation System database to

monitor their patients' opioid use, and they make medication use agreements with new opioid prescriptions. They refer patients who cannot achieve adequate pain control with low opioid doses to pain management specialists and to addiction specialists.

110. Respondent is active in his church, including as a youth group leader, and in community service activities. He has been part of a team teaching life skills to young adults in juvenile halls, and in a local homeless shelter. He and his wife also participate in Al-Anon.

LEGAL CONCLUSIONS

1. The Board may suspend or revoke respondent's physician's and surgeon's certificate if clear and convincing evidence establishes the facts supporting discipline. The factual findings above reflect this standard.

2. Business and Professions Code section 2234 makes a physician's unprofessional conduct grounds for suspension or revocation of the physician's certificate.

3. Unprofessional conduct includes:

a. Gross negligence, connoting an extreme departure from the minimum professionally accepted standard of care (Bus. & Prof. Code, § 2234, subd. (b));

b. Incompetence (*id.*, subd. (d)); and

c. Failing to maintain adequate and accurate patient records (*id.*, § 2266).

Causes for Discipline, Patient 1

4. The matters stated in Findings 32 and 33 constitute cause for discipline against respondent for gross negligence, incompetence, and inadequate patient recordkeeping, all relating to his failure to assess, document, and treat Patient 1's opioid use disorder and possible pain disorder properly.

5. The matters stated in Finding 35 show that Patient 1 suffered harm because of respondent's decisions.

Causes for Discipline, Patient 2

6. The matters stated in Findings 56 and 57 constitute cause for discipline against respondent for gross negligence, incompetence, and inadequate patient recordkeeping, all relating to his failure to assess, document, and treat Patient 2's opioid use disorder and possible pain disorder properly.

7. The matters stated in Findings 58 through 62 constitute cause for discipline against respondent for gross negligence and inadequate patient recordkeeping, all relating to respondent's failure to use opioid medications prudently in treating Patient 2's pain complaints.

8. The matters stated in Finding 64 show that Patient 2 suffered harm because of respondent's decisions.

Causes for Discipline, Patient 3

9. The matters stated in Findings 85 and 86 constitute cause for discipline against respondent for gross negligence, incompetence, and inadequate patient recordkeeping, all relating to his failure to assess, document, and treat Patient 3's opioid use disorder and possible pain disorder properly.

10. The matters stated in Findings 87 and 88 constitute cause for discipline against respondent for gross negligence and inadequate patient recordkeeping, all relating to respondent's failure to use opioid medications prudently in treating Patient 3's pain complaints.

11. The matters stated in Finding 90 show that Patient 3 suffered harm because of respondent's decisions.

Disciplinary Considerations

12. Respondent's lack of insight into his own role in facilitating opioid misuse among Patients 1, 2, and 3 is remarkable in light of the matters stated in Finding 110.

13. Nevertheless, as stated in Findings 91 through 104, respondent enjoys a strong reputation in his local medical community. In addition, and as summarized in Findings 106 through 109, despite defending this disciplinary matter, respondent also has used it as constructive criticism. He is receptive to new information, and already has used such new information to improve some of his practices.

14. Given respondent's active participation in primary care as well as his willingness to modify and improve his practices, public welfare does not require the Board to revoke his physician's and surgeon's certificate. A reasonable period of probation with relevant educational conditions (relating specifically to the matters

stated in Finding 105) will permit the Board to ensure that respondent further improves his prescribing practices, but will permit respondent to continue rendering primary care to his longstanding patients.

ORDER

Physician's and Surgeon's Certificate No. G 66292, first issued to respondent Jonathan Benton Cantwell Humphrey in July 1989, is revoked. The revocation is stayed, however, and respondent is placed on probation for five years upon the following terms and conditions:

1. 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.

2. Education Course

Within 60 calendar days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Prescribing Practices Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the accusation, but prior to the effective date of the decision may, in the sole

discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this decision.

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

4. Medical Record Keeping Course

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

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course,

or not later than 15 calendar days after the effective date of the decision, whichever is later.

5. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a professionalism program that meets the requirements of section 1358.1 of title 16 of the California Code of Regulations. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

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

6. Practice Monitor

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 monitor the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably 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 and accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, 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 three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor 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 medical practice, 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 five 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 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three 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.

7. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting 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 three calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this decision, respondent shall notify the Board or its designee within five calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

8. Notification to Hospitals, Other Providers, and Insurance Carriers

Within seven days of the effective date of this decision, respondent shall provide a true copy of the decision and the accusation in this matter to the Chief of

Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

9. Notification to Patients

While on probation, respondent must notify each patient (or the patient's guardian or health care surrogate) about his probation. Specifically, at the patient's first visit during respondent's probation, respondent must provide a written disclosure to the patient describing his probation status, the length of his probation, and its scheduled end date. This disclosure also must summarize all practice restrictions the Board has placed on respondent, and must state the Board's telephone number with an explanation of how the patient can find further information regarding respondent's probation on respondent's online license information profile page. Respondent must obtain signed acknowledgment from the patient (or from the patient's guardian or health care surrogate) confirming receipt of this disclosure.

10. Obey All Laws

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

11. 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.

12. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this decision.

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 and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 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.

13. Interview with the Board or its Designee

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

14. 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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a

clinical training 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 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 (Condition 10); and General Probation Requirements (Condition 12).

15. 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.

16. 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.

17. 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 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.

18. 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.

DATE: December 20, 2019

DocuSigned by:
Juliet E. Cox
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JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against: **JONATHAN BENTON CANT HUMPHREY, M.D.** 4165 Blackhawk Plaza Circle Ste 100 Danville, CA 94506 Physician's and Surgeon's Certificate No. G 66292, Respondent.	Case No. 800-2015-017938 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about July 11, 1989, the Medical Board issued Physician's and Surgeon's Certificate Number G 66292 to Jonathan Benton Cant Humphrey, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2019, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant part:

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

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

"(b) Gross negligence.

". . . .

"(d) Incompetence.

". . . ."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTS

7. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

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PATIENT P-1[1]

8. Respondent has been treating Patient P-1, a 42-year-old woman, for approximately ten years. She presented with headache, nausea, anxiety, manic depression, and abdominal pain from her earliest visits.

9. At a March 1, 2008 office visit, a Physician Assistant (PA) from Respondent's practice group discussed the possibility of opioid dependency treatment with P-1 and treatment with Suboxone.[2] At that time P-1 was being prescribed Oxycodone[3], 20 mg one tablet twice a day (bid), and Klonopin[4], 0.5 mg one tablet three times a day (tid).

10. P-1 enrolled in a pain management class at Kaiser scheduled to begin in May 2008 that required her to stop all opioid pain medications. The class kept being delayed and Respondent treated P-1 with opioid medications in the interim period. In August 2008, P-1 presented to Respondent's practice very sedated with slurred speech claiming drug withdrawal after large doses of morphine[5] in the hospital six days earlier and benzodiazepines in the Emergency Department that morning. A physician assistant sent her to a same day appointment with a pain specialist for pain management and opiate withdrawal. P-1's use of controlled substances over the next four years is not entirely clear, although it appears that she continued to be opioid dependent.

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[1] The patients are designated in this document as Patients P-1 through P-3 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Suboxone is a trade name for a combination of buprenorphine and naloxone. Buprenorphine is an opioid medication that relieves drug cravings without giving the same high as other opioid drugs and naloxone blocks the effects of opioid medication that can lead to opioid abuse. It is used to treat narcotic addiction. Suboxone is a dangerous drug as defined in section 4022 and a schedule III controlled substance.

[3] Oxycodone IR (a trade name for immediate release oxycodone hydrochloride) is a short-acting opioid analgesic. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic. It is a more potent pain reliever than morphine or hydrocodone.

[4] Klonopin is a trade name for clonazepam, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs.

[5] Morphine is an opioid analgesic and a dangerous drug as defined in section 4022 and a schedule II controlled substance. It is used for relief from moderate to severe pain.

11. On June 10, 2014, P-1 advised Respondent that she was waiting for a pain management evaluation at Stanford. Respondent prescribed Norco[6] 325/10 mg, 10 tablets per day, for the two months prior to her evaluation. On August 4, 2014, P-1's next documented visit with Respondent, Respondent noted that she was "feeling good on Subutex[7]" and continued her on a low dose for the following week. There is no documentation of the change from Norco to Subutex, no documentation of informed consent for buprenorphine, and no documentation of proper induction with buprenorphine. Nine days later, on August 13, 2014, Respondent documented that P-1 would be seen by Stanford shortly and "continued" P-1 on Norco, 6 tablets per day. There was no documentation of the reason for prescribing Norco or even that P-1 had begun taking it again except for the cryptic statement "subox got too high . . . called for Norco." Five days later, on August 18, 2014, Respondent's chart notes reflect that P-1 "wants to discuss getting back on Suboxone, wants to discontinue Norco." He started her on Suboxone 8 mg. Again, without a treatment plan, without informed consent, and without documented induction.

12. On September 2, 2014, Respondent's chart notes for P-1 reflect that the Stanford evaluation was scheduled to take place in a couple of days and to "[r]efill enough medications for two weeks. No further refills should be required." Although the specific medications prescribed are not listed, P-1's CURES Report reflects that Respondent prescribed hydrocodone with acetaminophen 325/10 mg for her. Other physicians were prescribing diazepam[8] for P-1 on a regular basis throughout the time Respondent was treating her and beginning in August 2015, Respondent prescribed it for her as well.

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[6] Norco is a trade name for hydrocodone bitartrate w/APAP (hydrocodone with acetaminophen) tablets. Norco 325/10 reflects that each pill contains 325 mg of acetaminophen and 10 mg of hydrocodone bitartrate. Hydrocodone bitartrate is semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled substance.

[7] Subutex is a trade name for buprenorphine. Buprenorphine is an opioid medication that relieves drug cravings without giving the same high as other opioid drugs. It is used to treat narcotic addiction. Subutex is a dangerous drug as defined in section 4022 and a schedule III controlled substance

[8] Diazepam (trade name Valium) is a benzodiazepine. It is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

13. On September 29, 2014, P-1 reported that 45 Suboxone tablets had been stolen from her purse while shopping. The incident report P-1 filed with the sheriff reflects that she had been court ordered to take six months of random drug testing monthly.

14. From August 2014 to March 2015, Respondent prescribed the opioids hydrocodone and oxycodone for P-1, as well as buprenorphine. Respondent often failed to document what medications he was prescribing for P-1, the amounts prescribed, or the instructions for use. Over that period of time, he prescribed oxycodone for P-1 for pain from a broken toe, hydrocodone for pain from a growth or cyst on her nose, oxycodone for post-surgical pain after removal of the cyst, and buprenorphine in between the opioid medications without explanation. He failed to provide sufficient objective reasons for switching back and forth between opioid medications and buprenorphine or to document having obtained informed consent from P-1 or induction of buprenorphine.

15. Without documenting a reason, Respondent began prescribing opioid medications for P-1 again in July 2015. On July 9, 2015, he noted that P-1 reported that her house had been burglarized and her medications stolen. He documented a refill of Percocet and noted "no further for this month." He continued to prescribe opioids for her for abdominal pain and post-surgical pain for fibroid surgery. He attempted detoxing P-1 using buprenorphine in late September 2015 but was prescribing oxycodone again for her by November 2015. On December 8, 2015, Respondent noted that he was giving P-1 a final refill of Norco and referring her to pain management. Again, while he documented that he discussed these decisions "at length" with P-1, he did not document a treatment plan or informed consent. On January 4, 2016, Respondent documented that P-1 wished to discontinue pain medications. He stopped opiate medications and prescribed four days of Suboxone. He did not document obtaining informed consent or induction of buprenorphine. He did not prescribe opioid medications for P-1 after this date.

16. Respondent's chart notes have little to no medical history and his physical examinations do not include detailed findings of areas where P-1 reports pain. He did not document clearly defined plans for periodic follow-up and monitoring, indications for tapering or

discontinuing medications, functional ability, progress toward achieving therapeutic goals, or counseling concerning the need for a multi-modal treatment plan.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence and/or Failure to Maintain Adequate Records)

17. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence), and/or 2266 (inadequate records) of the Code in that Respondent has committed gross negligence and/or exhibited incompetence and/or failed to maintain adequate records in the practice of medicine by failing to assess and document Patient P-1's opioid use disorder and underlying pain disorder, failing to document a treatment plan for the use of buprenorphine and buprenorphine induction, failing to obtain informed consent, failing to provide for periodic monitoring of progress toward goals, and failing to maintain adequate medical records as described above.

PATIENT P-2

18. Respondent has been treating Patient P-2, a 59-year-old woman, since approximately 1994. She had bilateral mastectomies to treat breast cancer in 1999, was treated with chemotherapy, and has had a number of breast surgeries since that time.

19. In 2008, Respondent's chart notes reflect that he was treating P-2 for chronic pain in her ribs and low back, although he did not document a physical examination of her back or ribs. Nor did he document a treatment plan or an assessment of her progress toward treatment goals. He prescribed oxycodone for her but it is not clear from the records exactly how much he was prescribing on each visit. The amounts appear to have toggled between daily dosages of 320 mg—or 480 MME[9]—and 480 mg—or 720 MME.

20. On September 8, 2010, Respondent noted that P-2 had failed Suboxone and methadone and was doing poorly on pain medications. Without documenting a physical

[9] MME stands for morphine milligram equivalency. This is used convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 320 mg of oxycodone is equivalent to 480 MME.

examination, treatment plan, or even the dosage instructions, he prescribed 90 tablets of OxyContin[10] 80 mg for P-2.

21. On February 7, 2011, it appears that P-2 was taking 240 mg of OxyContin daily although the medication documentation is not clear. She complained of breast tenderness. Respondent noted "subutex soon." P-2 obtained an early refill of medications in March 2011 because of dental work. In his April 2011 chart notes Respondent notes "trial subutex." In May 2011, Respondent noted "will try subutex next month." In June 2011, Respondent noted "consider subutex in 1-2 months." In July 2011, Respondent noted "consider next detox." In August 2011, Respondent's chart notes say "consider repeat suboxone." In September 2011, Respondent noted that P-2 still wished detox. Respondent referred P-2 to a plastic surgeon whom she saw for a consultation in September 2011. The plastic surgeon suggested that P-2's intercostal pain might be from neuromas and her foot pain from compressed nerves. He noted that she was taking 480 mg OxyContin daily. There is no mention of the plastic surgeon's findings in Respondent's chart notes for P-2. Respondent did not document physical examinations, a treatment plan, review of risks and benefits of medication, or progress toward treatment goals in 2011. He did not document with any specificity what medications he was prescribing or the reasons for prescribing them.

22. On May 1, 2012, Respondent performed a pre-operative examination of P-2 prior to left breast nerve reconstruction surgery by the plastic surgeon to whom he had referred her. On May 30, 2012, Respondent's chart notes reflect that P-2 was there for a med check and was mourning her mother's death. No further information was documented. P-2 had the breast surgery on June 19, 2012. She presented to Respondent for follow-up on June 28, 2012. Without documenting a complete physical examination or medical history, or even the medications prescribed, he noted that he refilled P-2's medications. Respondent did not document physical examinations, a treatment plan, review of risks and benefits of medication, or progress toward

[10] OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a dangerous drug as defined in section 4022 and a schedule II controlled substance. It is a more potent pain reliever than morphine or hydrocodone.

treatment goals in 2012. He did not document with any specificity what medications he was prescribing or the reasons for prescribing them.

23. On February 2, 2013, P-2 presented to Respondent for a medication check and refill and advised him that she was planning to attempt further pain management at Kaiser including a spinal injection. Respondent did not document a physical examination or a treatment plan other than to note "will plan on OxyContin detox in approximately 1-2 months." In March 2012, Respondent refilled P-2's medications and noted that she planned to detox after she returned from her trip to Europe. On April 2, 2013, Respondent noted that P-2 was ready for detox and would start Suboxone therapy—"Close follow-up next week. Up to 8 mg t.i.d. Will recheck in one week." She apparently started taking Suboxone on April 5, 2013 although there is no documentation of induction, in fact, no documentation at all on that date. On April 8, 2013, P-2 presented with symptoms of shaking and losing control of her legs. The next day P-2 saw Respondent again, this time with severe detox symptoms. Respondent noted that she had decided to electively stop all OxyContin, that she had been through multiple surgeries and felt that she could get off her pain medications. He said that she was attempting to use Suboxone. He diagnosed her with opioid dependence with withdrawal and advised her to continue the Suboxone and see him in 24 hours. On April 24, 2013, Respondent switched P-2 to Subutex. She continued taking Subutex through June, periodically attempting unsuccessfully to taper off of it. On July 22, 2013, Respondent prescribed oxycodone and OxyContin for P-2 without documenting the reason or the strength or dosing instructions. P-2 had foot surgery in July or August and complained of continuing foot pain throughout the rest of the year. Respondent continued prescribing oxycodone and OxyContin but did not document with any specificity the reasons for prescribing the medications or the strength or dosing instructions. He did not for the most part document physical examinations of P-2's feet, did not document a treatment plan, review of risks and benefits of medication, or progress toward treatment goals in 2013.

24. On January 21, 2014, P-2 presented with diffuse body pain, joint pain, and lower extremity pain. The physical examination notes only "tenderness diffusely." On April 28, 2014, Respondent noted that P-2 was being worked up by Kaiser and pending a spinal nerve stimulator

for her lower extremity pain. His physical examination noted only tenderness throughout lower extremities and he refilled P-2's medications. He did not identify the medications or the dosages. On August 5, 2014, Respondent did not mention any complaints by P-2, stated "continue pain management," and refilled P-2's medications. On August 20, 2014, P-2 presented with severe lower extremity neuropathy and was planning to get a nerve stimulator from Kaiser. Respondent documented that he would continue medication management, consider Zohydro[11] for pain, and refer P-2 to the plastic surgeon again. His physical examination was negative and did not address the specific area of P-2's pain complaint. Respondent's September 3, 2014 chart notes state "continue Zohydro"—although he never documented prescribing Zohydro for P-2—increase the strength to 40 mg and refill oxycodone for break through pain. Again, there is a negative physical examination and no documentation of the amount or dosage instructions for either the Zohydro or the oxycodone. By November 12, 2014, it appears that Respondent is prescribing 100 mg of Zohydro daily and up to 360 mg of oxycodone or a total of 640 MME. On December 2, 2014, P-2 presented with pustular lesions on her hands and feet. Respondent diagnosed her with possible psoriatic dermatitis. On December 23, 2014, Respondent saw P-2 for follow-up after the surgical implant of a spinal stimulator and medication refill. The physical examination was again negative. Respondent prescribed varying combinations of OxyContin, oxycodone, and Zohydro throughout 2014 but did not document with any specificity the reasons for prescribing the medications or the strength or dosing instructions. He did not for the most part document physical examinations of the area of P-2's complaints and did not document a treatment plan, review of risks and benefits of medication, or progress toward treatment goals in 2014.

25. Respondent continued "pain management" for P-2 through 2015 primarily for complaints of pustular psoriasis and peripheral neuropathy in her lower extremities. It appears that he discontinued Zohydro at some point and that, around March 2015, he added lorazepam.[12]

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[11] Zohydro ER is an extended-release form of hydrocodone that is used for around-the-clock treatment of severe pain. Hydrocodone bitartrate is semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled substance.

[12] Lorazepam (trade name Ativan) is a benzodiazepine. It is a sedative used to treat anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance. Since lorazepam has a central nervous system (CNS) depressant effect, special care should be taken when prescribing lorazepam with other CNS depressant drugs.

On May 21, 2015, Respondent noted that P-2 presented with a severe exacerbation of pustular psoriasis and noted that she was being followed by dermatology and rheumatology at Kaiser. He prescribed oxycodone 30 mg 5 tablets qid (600 mg oxycodone daily) for a total 900 MME. On October 15, 2015, Respondent refilled P-2's oxycodone and stated that he would refer her for "tertiary care management."

26. P-2's pustular psoriasis became worse during 2016. On March 11, 2016, Respondent wrote a letter "To Whom It May Concern" stating that P-2 was stable on 16 tablets of high-dose oxycodone daily and would likely need to remain on a similar regimen indefinitely. By May 20, 2016, Respondent was prescribing oxycodone 30 mg, 4 tablets every 4 hours for a total of 720 mg per day or 1080 MME. Respondent's chart notes for 2016 continue to have little to no medical history and his physical examinations generally do not include detailed findings of areas where P-2 reported pain. He did not document clearly defined plans for periodic follow-up and monitoring, indications for tapering or discontinuing medications, functional ability, progress toward achieving therapeutic goals, or counseling concerning the need for a multi-modal treatment plan.

27. Respondent reports that as of early 2017, P-2 is off all opioid medications except Suboxone which she is getting from Kaiser.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence and/or Failure to Maintain Adequate Records)

28. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence), and/or 2266 (inadequate records) of the Code in that Respondent has committed gross negligence and/or exhibited incompetence and/or failed to maintain adequate records in the practice of medicine by failing to assess and document Patient P-2's opioid use disorder, failing to document a treatment plan for the use of buprenorphine and buprenorphine induction, failing to obtain informed consent for the use of buprenorphine, failing to properly refer P-2 to appropriate specialists, and failing to maintain adequate medical records as described above.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence and/or Failure to Maintain Adequate Records)

29. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence), and/or 2266 (inadequate records) of the Code in that Respondent has committed gross negligence and/or exhibited incompetence and/or failed to maintain adequate records in the practice of medicine in his clinical assessment of Patient P-2, his failure to formulate a treatment plan, his failure to obtain informed consent, his failure to arrange appropriate referrals, and his failure to maintain adequate medical records during ongoing care of P-2 with very high dose opioids as described above, including, but not limited to, the following:

A. Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient P-2 without documenting specific informed consent, thorough histories and physical examinations with detailed findings on the areas where P-2 described having pain, a clear treatment plan, defined expectations for clinic visits for periodic follow up and monitoring, potential indications for tapering or discontinuing opioids, assessment and documentation of pain severity and functional ability, progress toward achieving therapeutic goals, and adequate monitoring of P-2's drug use.

B. Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient P-2 without documenting why Respondent was prescribing such high dosages and without documenting the names, quantities, and dosages of medication prescribed; stated in a letter dated March 11, 2016 that P-2 would likely remain on a high dosage of oxycodone indefinitely; and treated P- 2 with extremely high morphine milligram equivalents—up to 1080 MME—when opioid dosages over 50 MME should be carefully used and dosages exceeding 80 MME should be very limited.

PATIENT P-3

30. Respondent has been treating Patient P-3, a 59-year-old woman, for many years. She was diagnosed with cervical radiculopathy and complained of neck and right arm pain and numbness in her right hand.

31. P-3 told Respondent on March 14, 2008 that she wanted to detox from opioid medications. At that time Respondent was prescribing OxyContin 40 mg 3 tablets every 8 hours (360 mg or 540 MME). He prescribed a trial of Kadian[13] 100 mg per day until detox along with Norco 325/10 2 to 4 tablets per day as needed (140 mg and 140 MME). He did not do a physical examination or document P-3's reason for wanting to detox. Without documenting the referral, he referred P-3 to a pain and addiction specialist for a pain evaluation and possible use of buprenorphine.

32. The pain and addiction specialist saw P-3 on March 20, 2008. He recommended that she continue with her current pain medications and have a cervical MRI and nerve conduction study done. He reported to Respondent that P-3 was going to sign a pain agreement to get her pain medications through the specialist's office.

33. On June 10, 2008, P-3 saw Respondent for a medication check and he refilled her medications. The physical examination he documented was limited and normal. He did not identify the medications he refilled but the "active medication" list did not include Kadian or Norco but, instead, listed OxyContin with two different strengths and use schedules. Seven days later, P-3 reported that her OxyContin was stolen at a party. She reported that she was taking OxyContin 80 mg, two tablets every 8 hours (480 mg or 720 MME). On July 31, 2008, P-3 told Respondent that she was doing poorly and needed rescue medications. She asked to stop OxyContin and, without documenting a physical examination (other than to say that she was in no apparent distress and was well nourished and well developed), Respondent replaced the OxyContin with "extra" Kadian. He did not document quantity, dosage, or instructions. He continued prescribing Kadian and Norco for the rest of 2008.

34. Respondent prescribed Kadian, Norco, Ambien, and diazepam through November 2009 without documenting specific reasons for the prescriptions, treatment plans, medical history, more than scant physical examinations, or progress toward achieving therapeutic goals. On November 10, 2009 Respondent switched P-3 from Kadian to OxyContin 80 mg two tablets bid

[13] Kadian is a trade name for morphine, an opioid analgesic and a dangerous drug as defined in section 4022 and a schedule II controlled substance. It is used for relief from moderate to severe pain.

because she said that she felt better on oxycodone samples she had tried. Again, he did not document a specific reason for the medication, a treatment plan, medical history, physical examination, or progress toward a goal.

35. In April 2010, P-3 was again taking Kadian with no explanation for the change and was attempting to taper the amount. On June 30, 2010, Respondent refilled Kadian 100 mg tid and documented that he had had a long discussion with P-3 and that she needed to detox in one to two months. He noted that he described the significant medication increase and the failure of the approach. By July she was taking OxyContin again instead of Kadian, apparently because of insurance issues—80 mg qid (320 mg or 480 MME). On August 9, 2010, Respondent noted "trial decreasing to 60 mg qid" (240 mg or 360 MME). Again without documenting more than a scant physical examination and without a treatment plan. Although Respondent frequently fails to document the names, quantities, strengths, or use instructions of the medications he prescribes, it appears that by the end of 2010, P-3 was taking OxyContin 60 mg two tablets tid (360 mg or 540 MME).

36. On January 13, 2011, without documenting specific reasons for the prescriptions, treatment plans, medical history, more than scant physical examinations, or progress toward achieving therapeutic goals, Respondent prescribed Kadian 100 mg one tablet bid and OxyContin 60 mg two tablets tid (740 MME). On June 13, 2011, P-3 presented to another physician in Respondent's practice in his absence seeking an early refill of OxyContin. She said she was planning to start Suboxone when Respondent returned. The next chart note is by Respondent, dated June 24, 2011, and states that P-3 had started Suboxone five days earlier. There is no documentation of any of the following: a physical examination, a reason for stopping her other medications and using buprenorphine, obtaining informed consent for using buprenorphine, a treatment plan for buprenorphine, or proper induction of buprenorphine. It appears that P-3 continued taking Suboxone throughout 2011 although there is very little documentation to confirm what medications were being prescribed. It does not appear that P-3 was receiving buprenorphine or any other opioid medication from Respondent in 2012 although there is no documentation of her having been weaned off the Suboxone.

37. On February 19, 2013, P-3 presented with chest pain two days after a skiing accident and Respondent diagnosed her with a rib fracture and prescribed a rib belt and oxycodone 30 mg. He did not document use instructions. A month later P-3 presented again with chest pain saying that she had fallen and reinjured her ribs. Respondent documented a tender left rib cage and prescribed OxyContin 40 mg, again without use instructions. On April 4, 2013, Respondent documented that P-3 was having difficulty getting off the pain medications and wished to use the detox protocol she had used before. He noted that P-3 needed Suboxone detox for one to two weeks and gave her 10 tablets of Suboxone 8 mg to take one to two tablets per day. There was no documentation of informed consent, a treatment plan for buprenorphine, or induction of buprenorphine. On May 1, 2013, P-3 saw Respondent for a medication check and refill. Respondent documented that P-3 had been taking OxyContin since she had surgery for appendicitis in early April. She said that she wanted to detox in three weeks when she returned from a vacation to Hawaii. She presented again on May 8, 2013 saying that she was one week short on OxyContin and needed one more week prior to withdrawal using Suboxone. Apparently, Respondent refilled the OxyContin prescription each time although he did not document having done so. Although there are no further chart notes until September 10, 2013, Respondent prescribed Suboxone for P-3 on July 25, 2013. On September 10, 2013, P-3 complained of right neck, shoulder, and arm pain and Respondent ordered MRIs, sent P-3 to a pain specialist for an injection, and "refilled" oxycodone 30 mg, again without documenting quantity or use instructions. Respondent discussed detoxing from opioid medications using Suboxone with P-3 on several visits through the rest of 2013.

38. In January 2014, Respondent was prescribing OxyContin 80 mg six per day (480 mg or 720 MME) for P-3. He prescribed Suboxone for P-3 again in February 2014, but on March 3, 2014, she reported that she had a severe flare of pain in her right arm since conversion to Suboxone and needed further evaluation of her cervical disc disease prior to detox. He resumed prescribing opioid medications. Respondent discussed tapering medications and detoxing with Suboxone throughout 2014. On May 22, 2014, P-3 was taking OxyContin 80 mg four tablets per day and oxycodone 30 mg 1-2 tablets every four hours (up to 680 mg or 1020 MME). On

October 15, 2014, P-3 told Respondent that she needed an early refill on OxyContin. The chart notes do not reflect Respondent's response. Respondent documented tapering of opioid medications through fall and winter of 2014. On December 22, 2014, Respondent documented that P-3 was on high-dose pain medication pending surgery in January. Respondent documented only sparse or normal physical examinations and did not document treatment plans, reviews of risks and benefits of medication, or progress toward treatment goals in 2014. He did not document with any specificity what medications he was prescribing or the reasons for prescribing them.

39. P-3 had cervical fusion surgery on January 20, 2015. Respondent began a taper of P-3's opioid medications again after the cervical fusion surgery. The taper continued in January and February 2015. On April 22, 2015, P-3 reported having a flare during her physical therapy and as a result using more medication and needing an early refill. Respondent discussed tapering medications and detoxing using Suboxone with P-3 throughout 2015, even prescribing Suboxone in September and November, but he continued prescribing oxycodone as well. On November 10, 2015, Respondent documented that detox was to take place in one month. On December 4, 2015, he documented that detox was planned for early January 2016. Respondent documented only sparse or normal physical examinations and did not document treatment plans, reviews of risks and benefits of medication, or progress toward treatment goals in 2015. He did not document with any specificity what medications he was prescribing or the reasons for prescribing them.

40. Respondent continued tapering P-3's medications in January and February 2016. In Respondent's chart notes for February 17, 2016, he documented that P-3 had successfully transferred to Suboxone. There is no chart entry indicating when he prescribed Suboxone for P-3 or even that he had prescribed it or when P-3 began taking it. By March 1, 2016, Respondent noted that P-3 was complaining of significant pain after detoxing from the Suboxone. On March 8, 2016, Respondent noted that P-3 was steadily improving and started a trial of Butrans patch[14] 20 mcg with rare use of oxycodone. On March 18, 2016, Respondent noted that P-3 was having a cervical block in two weeks and prescribed Subutex 2 mg #30 and oxycodone #30 concurrently.

[14] The Butrans patch is a buprenorphine transdermal system.

On March 29, 2016, Respondent's chart notes indicate that P-3 had had a cervical block and, while not pleased with the results, was doing well on Subutex 2 mg daily and taking "some" oxycodone 2-4 tablets daily. The plan was to decrease Subutex to 1 mg in one week. By April 14, 2016, P-3 was complaining of increased neck pain and, while Respondent did not document stopping the Subutex, it appears that he did not prescribe Subutex for P-3 on that date, only oxycodone. He referred P-3 to a pain specialist. He did not for the most part document detailed physical examinations of the area of P-3's complaints and did not document a treatment plan, review of risks and benefits of medication, or progress toward treatment goals in 2016.

41. Throughout his treatment of P-3, Respondent did not document performing thorough histories and physical examinations. As documented, his physical examinations were scant and he did not include detailed findings on the area where P-3 claimed to have pain. Respondent prescribed high doses of opioids to P-3 who had exhibited aberrant behavior without documenting an appropriate medical history, physical examination, and describing the risks and benefits to her of high doses of opioids. He did not document a clear treatment plan or assessment and documentation of pain severity and functional ability, progress toward achieving therapeutic goals, did not document defined expectations for clinic visits for periodic follow up and monitoring, and did not document potential indications for tapering or discontinuing opioid medications. Respondent's medical records did not reveal why he was prescribing such high dosages of opioid medications and did not identify the name and quantities of medication prescribed on regular basis. He filled oxycodone prescriptions early and allowed additional quantities when requested by P-3. In addition, Respondent and other providers prescribed diazepam and alprazolam[15] for P-3 during the period she was being treated with opioid medications.

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[15] Alprazolam (trade name Xanax) is a benzodiazepine. It is a psychotropic drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence and/or Failure to Maintain Adequate Records)

42. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence), and/or 2266 (inadequate records) of the Code in that Respondent has committed gross negligence and/or exhibited incompetence and/or failed to maintain adequate records in the practice of medicine by failing to assess and document Patient P-3's opioid use disorder, failing to document a treatment plan for the use of buprenorphine, failing to obtain informed consent for the use of buprenorphine, failing to refer to appropriate specialists, and failing to maintain adequate medical records by engaging in the conduct described above.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence and/or Failure to Maintain Adequate Records)

43. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence), and/or 2266 (inadequate records) of the Code in that Respondent has committed gross negligence and/or exhibited incompetence and/or failed to maintain adequate records in the practice of medicine in his clinical assessment of Patient P-3, his failure to formulate a treatment plan, his failure to obtain informed consent, his failure to arrange appropriate referrals, and his failure to maintain adequate medical records during ongoing care of P-3 with very high dose opioids as described above, including, but not limited to, the following:

A. Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient P-3 without documenting specific informed consent, thorough histories and physical examinations with detailed findings on the areas where P-3 described having pain, a clear treatment plan, defined expectations for clinic visits for periodic follow up and monitoring, potential indications for tapering or discontinuing opioids, assessment and documentation of pain severity and functional ability, progress toward achieving therapeutic goals, and adequate monitoring of P-3's drug use.

B. Respondent prescribed extremely high doses of controlled substances in dangerous combinations to Patient P-3 without documenting why Respondent was prescribing such high dosages and without documenting the names, quantities, and dosages of medication prescribed and treated P-3 with extremely high morphine milligram equivalents—up to 1020 MME—when opioid dosages over 50 MME should be carefully used and dosages exceeding 80 MME should be very limited.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 66292, issued to Jonathan Benton Cant Humphrey, M.D.;

2. Revoking, suspending or denying approval of Jonathan Benton Cant Humphrey, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jonathan Benton Cant Humphrey, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: January 30, 2018

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

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