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

In the Matter of the Accusation Against:	)	
Mark Scheier, M.D.	)	**Case No. 800-2017-031603**
Physician's and Surgeon's Certificate No. A 36345	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 20, 2020.

IT IS SO ORDERED: February 20, 2020.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **MARK SCHEIER, M.D.** **5451 La Palma Avenue, Ste. 22** **La Palma, CA 920623** **Physician's and Surgeon's Certificate No. A 36345** Respondent.	Case No. 800-2017-031603 OAH No. 2019040227 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Mark Scheier, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA 92620.

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3. On or about February 23, 1981, the Board issued Physician's and Surgeon's Certificate No. A 36345 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-031603, and will expire on May 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-031603 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 31, 2018. Respondent filed a Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031603 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-031603. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in

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Accusation No. 800-2017-031603 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2017-038244 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

ADDITIONAL PROVISIONS

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 36345 issued to Respondent Mark Scheier, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Until such time as Respondent has successfully completed the Clinical Competence Assessment Program described in condition 6, below, Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances listed in Schedules II and III of the California Uniform Controlled Substances Act, except for in a hospice, skilled nursing facility, or inpatient hospital setting.

Until such time as Respondent has successfully completed the Clinical Competence Assessment Program described in condition 6, below, Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical

purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

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

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation

3. 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.

4. 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 (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (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.

5. 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 (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (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

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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.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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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 (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

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

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation 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. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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

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.

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

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circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Other than hospice care, Respondent shall not engage in the practice of medicine in Respondent's or a 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 thirty (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 as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-

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

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

Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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 or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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.

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ACCEPTANCE

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

DATED: 9/6/19

MARK SCHEIER, M.D.
Respondent

I have read and fully discussed with Respondent Mark Scheier, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: September 6, 2019

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 9/9/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

GIOVANNI F. MEJIA
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2017-031603

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO DEC. 31 2018
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **Mark Scheier, M.D.** 5451 La Palma Avenue, Ste. 22 La Palma, CA 90623 **Physician's and Surgeon's Certificate No. A 36345,** Respondent.	Case No. 800-2017-031603 **ACCUSATION**

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 February 23, 1981, the Medical Board issued Physician's and Surgeon's Certificate No. A 36345 to Respondent Mark Scheier, 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, 2020, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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5. Section 2234 of the Code states, in pertinent 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.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"...."

6. Section 2242 of the Code states, in pertinent part:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"...."

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

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

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"...."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 36345 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code in that he committed gross negligence in his care and treatment of one or more patients, as more particularly alleged hereinafter:

Patient A

10. On or about December 11, 2011,[1] a then forty-three-year-old male, "patient A",[2] was admitted to a hospital in or around La Palma, California by Respondent. At the time, Respondent documented complaints of chest pain, shortness of breath and weakness. Respondent also

[1] Any medical care or treatment rendered by Respondent more than seven years prior to the filing of the instant Accusation is described for informational purposes only and not pleaded as a basis for disciplinary action.

[2] Patients' true names are not used in the instant Accusation to maintain patient confidentiality. The patients' identities are known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery and in accordance with Government Code section 11507.6.

documented a long history of chronic neck pain following a fall several years prior, that patient A had a neurostimulator in place and that patient A was on "high-dose pain medications along with [sic] muscle relaxant for relief of his pain." During patient A's December 2011 hospital stay, on or about December 13, 2011, an imaging study of patient A's cervical spine found "[v]ery mild degenerative changes of the cervical spine." Eventually, patient A was diagnosed with pancreatitis, his condition improved and he was discharged home on or about December 14, 2011. In his discharge note, Respondent documented that patient A was to "[f]ollow up with [sic] pain doctor in one week."

11. Subsequent to patient A's December 2011 hospitalization, Respondent had approximately 25 office visits with patient A through as late as April 2013. Throughout this period, Respondent prescribed multiple opioids and multiple benzodiazepines to patient A in unsafe, at times excessive, combinations and dosages.

12. Beginning on or about January 2, 2012, the California Controlled Substance Utilization Review and Evaluation System ("CURES") database lists concurrent prescriptions for multiple opioid analgesics (Demerol[3] and hydromorphone[4]) and a benzodiazepine (clonazepam[5]) as having been issued by Respondent and filled to patient A:

Date Filled	Drug Name	Strength	Qty	Days Supply
01/02/12	Demerol Hydrochloride	100 mg-1 ml	150	30
01/02/12	Clonazepam	2 mg	90	30
01/02/12	Hydromorphone HCL	8 mg	150	25
01/23/12	Hydromorphone HCL	8 mg	150	25
01/30/12	Clonazepam	2 mg	90	30
02/10/12	Demerol Hydrochloride	100 mg-1 ml	150	30

[3] Demerol is a brand name for meperedine, a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Hydromorphone, also known as Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

Date Filled	Drug Name	Strength	Qty	Days Supply
02/13/12	Hydromorphone HCL	8 mg	150	25
02/21/12	Clonazepam	2 mg	90	30
03/07/12	Demerol Hydrochloride	100 mg-1 ml	150	30
03/07/12	Hydromorphone HCL	8 mg	150	30
03/09/12	Clonazepam	2 mg	90	30

13. The use of opioids in combination with benzodiazepines carries increased risk for adverse events including, but not limited to, respiratory suppression and drug overdose intoxication.

14. Prior to concurrently prescribing multiple opioids and one or more benzodiazepines to Respondent in or around January 2012, or thereafter, Respondent failed to adequately conduct or document an evaluation of patient A.

15. Beginning on or about March 30, 2012 and through on or about September 20, 2012, the CURES database lists a recurring prescription for an additional benzodiazepine, lorazepam,[6] in addition to continuing prescriptions for Demerol, hydromorphone and clonazepam, as having been issued by Respondent and filled to patient A:

Date Filled	Drug Name	Strength	Qty	Days Supply
03/30/12	Demerol Hydrochloride	100 mg-1 ml	150	30
03/30/12	Lorazepam	2 mg	60	20
03/30/12	Clonazepam	2 mg	90	30
03/30/12	Hydromorphone HCL	8 mg	150	30
04/24/12	Demerol Hydrochloride	100 mg-1 ml	150	30
04/24/12	Lorazepam	2 mg	60	20
04/24/12	Clonazepam	2 mg	90	30
04/24/12	Hydromorphone HCL	8 mg	150	25
05/18/12	Demerol Hydrochloride	100 mg-1 ml	150	30
05/18/12	Lorazepam	2 mg	90	30

[6] Lorazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

Date Filled	Drug Name	Strength	Qty	Days Supply
05/18/12	Clonazepam	2 mg	90	30
05/18/12	Hydromorphone HCL	8 mg	150	30
06/04/12	Suboxone[7]	8 mg-2 mg	90	30
06/13/12	Demerol Hydrochloride	100 mg-1 ml	150	30
06/13/12	Clonazepam	2 mg	90	30
06/13/12	Hydromorphone HCL	8 mg	150	30
07/10/12	Demerol Hydrochloride	100 mg-1 ml	150	30
07/10/12	Lorazepam	2 mg	90	30
07/10/12	Clonazepam	2 mg	90	30
07/10/12	Hydromorphone HCL	8 mg	150	30
08/03/12	Demerol Hydrochloride	100 mg-1 ml	150	30
08/03/12	Clonazepam	2 mg	90	30
08/03/12	Hydromorphone HCL	8 mg	150	30
08/27/12	Demerol Hydrochloride	100 mg-1 ml	150	30
08/27/12	Lorazepam	2 mg	90	30
08/27/12	Clonazepam	2 mg	90	30
08/27/12	Hydromorphone HCL	8 mg	150	30
09/20/12	Demerol Hydrochloride	100 mg-1 ml	150	30
09/20/12	Lorazepam	2 mg	90	30
09/20/12	Clonazepam	2 mg	90	30
09/20/12	Hydromorphone HCL	8 mg	150	30

16. Respondent failed to adequately establish or document a medical indication or rationale for prescribing lorazepam to patient A, independently or concurrently with other opioid or benzodiazepine medications, in or around March 2012 or thereafter.

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[7] Suboxone is a brand name for buprenorphine and naloxone, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. The CURES database also lists a one-time Suboxone prescription issued by Respondent and filled to patient A on or about June 4, 2012. Respondent failed to adequately establish or document a medical indication or rationale for prescribing Suboxone to patient A.

18. Beginning in or around October 2012, through in or around April 2013, the CURES database lists, at various times, prescriptions for additional opioid analgesics (Opana[8] and fentanyl[9]) and an additional benzodiazepine (alprazolam[10]), as having been issued by Respondent and filled to patient A in addition to continuing prescriptions for Demerol, hydromorphone and clonazepam:

Date Filled	Drug Name	Strength	Qty	Days Supply
10/12/12	Demerol Hydrochloride	100 mg-1 ml	150	30
10/12/12	Clonazepam	2 mg	90	30
10/12/12	Alprazolam	2 mg	90	30
10/12/12	Hydromorphone HCL	8 mg	150	30
10/30/12	Opana ER	40 mg	60	30
11/02/12	Demerol Hydrochloride	100 mg-1 ml	150	30
11/02/12	Hydromorphone HCL	8 mg	150	30
11/03/12	Alprazolam	2 mg	90	30
11/03/12	Clonazepam	2 mg	90	30
11/23/12	Demerol Hydrochloride	100 mg-1 ml	150	30
11/23/12	Clonazepam	2 mg	90	30
11/23/12	Alprazolam	2 mg	90	30
11/23/12	Opana ER	40 mg	60	30
11/23/12	Hydromorphone HCL	8 mg	150	25

[8] Opana is a brand name for oxymorphome hydrochloride, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

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

[10] Alprazolam, also known as Xanax, is in the benzodiazepine family of drugs, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

Date Filled	Drug Name	Strength	Qty	Days Supply
12/14/12	Lorazepam	2 mg	90	30
12/14/12	Hydromorphone HCL	8 mg	150	30
12/17/12	Demerol Hydrochloride	100 mg-1 ml	150	30
12/17/12	Alprazolam	2 mg	90	30
12/17/12	Opana ER	40 mg	60	30
12/31/12	Clonazepam	2 mg	90	30
01/09/13	Alprazolam	2 mg	90	30
01/11/13	Demerol Hydrochloride	100 mg-1 ml	150	30
01/11/13	Clonazepam	1 mg	90	30
01/11/13	Alprazolam	2 mg	90	30
01/11/13	Fentanyl Transdermal System	100 mcg/hr	10	30
01/11/13	Hydromorphone HCL	8 mg	150	30
02/04/13	Demerol Hydrochloride	100 mg-1 ml	150	30
02/04/13	Clonazepam	2 mg	90	30
02/04/13	Fentanyl Transdermal System	100 mcg/hr	10	30
02/04/13	Alprazolam	2 mg	90	30
02/04/13	Hydromorphone HCL	8 mg	150	30
02/22/13	Hydromorphone HCL	8 mg	150	25
02/26/13	Demerol Hydrochloride	100 mg-1 ml	150	30
02/26/13	Fentanyl Transdermal System	100 mcg/hr	10	30
03/01/13	Alprazolam	2 mg	90	30
03/01/13	Clonazepam	2 mg	90	30
03/22/13	Demerol Hydrochloride	100 mg-1 ml	150	30
03/22/13	Alprazolam	2 mg	90	30
03/22/13	Fentanyl Transdermal System	100 mcg/hr	10	30
03/22/13	Hydromorphone HCL	8 mg	150	25
03/25/13	Clonazepam	2 mg	90	30
04/12/13	Demerol Hydrochloride	100 mg-1 ml	150	26

Date Filled	Drug Name	Strength	Qty	Days Supply
04/12/13	Clonazepam	2 mg	90	30
04/12/13	Alprazolam	2 mg	90	30
04/12/13	Hydromorphone HCL	8 mg	150	25

19. Throughout the period in or around October 2012 to April 2013, Respondent failed to adequately establish or document a medical indication or rationale for changes to the opioids or benzodiazepines prescribed to patient A.

20. On or about April 12, 2013, patient A was found dead at his home. Patient A's cause of death was listed as "[a]cute polydrug intoxication" due to "[c]ombined effects of meperidine/normeperidine, alprazolam/hydroxyalprazolam and hydromorphone[.]"

21. Throughout the course of Respondent's care and treatment of patient A, Respondent failed to review the CURES database for controlled substance prescriptions listed for patient A.

22. On multiple occasions throughout the course of Respondent's care and treatment of patient A, Respondent provided a prescription refill to patient A early, based upon the prescription's quantity and intended dosage.

23. Although Respondent's medical record for patient A documents multiple indicia that patient A suffered from psychological or psychiatric problems, Respondent failed to adequately coordinate or attempt to coordinate patient A's care and treatment with any mental health provider, or refer patient A to a psychiatrist.

24. On multiple occasions throughout the course of Respondent's treatment of patient A, a note for an office visit between Respondent and patient A contained content that failed to adequately or accurately describe observations or conduct occurring on the date indicated in the note, but rather was generated by default by the medical-record-keeping system used by Respondent or was copied forward from one or more prior office visit notes.

25. On multiple occasions throughout the course of Respondent's treatment of patient A, an office visit note authored by Respondent for patient A failed to adequately and accurately document one or more medications or medication amounts prescribed by Respondent to patient A.

26. Respondent committed gross negligence in his care and treatment of patient A in that he prescribed controlled substances to patient A without a proper evaluation including, but not limited to, failing to adequately:

(a) establish the nature and extent of patient A's pain;

(b) establish patient A's history of prior pain treatments;

(c) establish how patient A would use the various prescribed controlled substances;

(d) assess the significance of patient A's apparent psychological or psychiatric problems and how they may impact his ability to safely use controlled substances;

(e) order or review diagnostic testing regarding the potential cause for patient A's reported pain;

(f) develop a differential diagnosis for patient A's reported pain;

(g) review the CURES database for controlled substances listed as prescribed to patient A; and

(h) develop a treatment plan for patient A's reported chronic pain ailment.

27. Respondent committed gross negligence in his care and treatment of patient A in that he failed to properly monitor his treatment of patient A with controlled substances including, but not limited to, failing to adequately:

(a) assess how Respondent's treatment of patient A with various controlled substances was impacting patient A and patient A's functioning;

(b) monitor controlled substances prescription refills;

(c) abstain from prescribing multiple controlled substances in unsafe combinations and dosages; and

(d) collaborate or consult with other medical providers regarding the treatment of patient A.

Patient B

28. On or about September 4, 2013, a then forty-year-old female, "patient B", presented to Respondent for the first time. In his office visit note for this appointment, Respondent documented, among other things, "No Medical History", "no Anxiety [sic]", a diagnosis of lupus,

a history of Suboxone use for five years, a history of chronic pain and a back and leg injury, an assessment of opioid dependence in remission, that patient B was going to Narcotics Anonymous meetings and that patient B's family was aware of "old abuse problems." Respondent documented prescribing a thirty-day supply of Suboxone 2 mg-0.5 mg (180 total, to be administered six times daily), with no refills.

29. Although Respondent documented an opioid use disorder in the September 4, 2013 office visit note, Respondent failed to adequately develop or document a medical history, substance use or abuse history, and social history to corroborate such diagnosis. Respondent also failed to adequately develop or document a treatment plan for the prescribing of Suboxone to patient B.

30. Subsequent to September 4, 2013, Respondent documented approximately 52 office visits with patient B through June 27, 2018 (i.e., approximately 53 total visits from September 4, 2013 to June 27, 2018).

31. On multiple occasions throughout the course of Respondent's care and treatment of patient B, a note for an office visit between Respondent and patient B contained content that failed to adequately or accurately describe observations or conduct occurring on the date indicated in the note, but rather was generated by default by the medical-record-keeping system used by Respondent or was copied forward from one or more prior office visit notes.

32. On multiple occasions throughout the course of Respondent's care and treatment of patient B, a note for an office visit between Respondent and patient B contained inconsistent statements relevant to patient B's medical care and treatment including, but not limited to, inconsistent statements regarding controlled substance prescriptions for patient B.

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33. The CURES database lists recurring prescriptions for buprenorphine (Suboxone) as having been issued by Respondent and filled by patient B in or around September 2013 to February 2014, as well as concurrent Lunesta[11] prescriptions starting in or around November 2013:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
09/04/13	Suboxone	2 mg-0.5 mg	180	30	0
10/16/13	Suboxone	2 mg-0.5 mg	120	30	0
11/12/13	Suboxone	2 mg-0.5 mg	120	30	0
11/12/13	Lunesta	3 mg	30	30	0
12/09/13	Suboxone	2 mg-0.5 mg	120	30	0
12/09/13	Lunesta	3 mg	30	30	1
01/07/14	Suboxone	2 mg-0.5 mg	120	30	0
01/16/14	Lunesta	3 mg	30	30	2
02/05/14	Suboxone	2 mg-0.5 mg	120	30	0

34. In or around March 2014 to November 2015, the CURES database lists recurring prescriptions of alprazolam as having been issued by Respondent and filled by patient B, concurrent with continuing prescriptions for Suboxone, at a higher dosage, and Lunesta:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
03/07/14	Alprazolam	0.5 mg	90	30	0
03/13/14	Lunesta	3 mg	30	30	3
03/13/14	Suboxone	8 mg-2 mg	120	30	0
04/08/14	Suboxone	8 mg-2 mg	120	30	0
04/10/14	Alprazolam	0.5 mg	90	30	0
05/12/14	Suboxone	8 mg-2 mg	120	30	0
05/12/14	Lunesta	3 mg	30	30	0
05/12/14	Alprazolam	0.5 mg	90	30	1

[11] Lunesta is a brand name for eszopiclone, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative and is used to treat insomnia.

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
06/10/14	Lunesta	3 mg	30	30	1
06/11/14	Suboxone	8 mg-2 mg	120	30	0
06/13/14	Alprazolam	0.5 mg	30	10	0
07/15/14	Lunesta	3 mg	30	30	0
07/17/14	Alprazolam	0.5 mg	90	30	0
07/17/14	Suboxone	8 mg-2 mg	120	30	0
08/13/14	Lunesta	3 mg	30	30	1
08/27/14	Suboxone	8 mg-2 mg	120	30	0
09/02/14	Alprazolam	0.5 mg	90	30	1
10/03/14	Suboxone	2 mg-0.5 mg	120	30	0
10/03/14	Alprazolam	2 mg	90	30	0
10/03/14	Lunesta	3 mg	30	30	0
10/07/14	Suboxone	8 mg-2 mg	120	30	0
10/30/14	Lunesta	3 mg	30	30	1
11/25/14	Lunesta	3 mg	30	30	2
11/25/14	Alprazolam	2 mg	90	30	1
12/31/14	Lunesta	3 mg	30	30	3
02/06/15	Alprazolam	2 mg	90	30	0
02/13/15	Suboxone	8 mg-2 mg	60	30	0
02/13/15	Lunesta	3 mg	30	30	0
03/01/15	Alprazolam	2 mg	90	30	0
03/08/15	Lunesta	3 mg	30	30	1
03/17/15	Suboxone	8 mg-2 mg	60	30	0
04/11/15	Alprazolam	2 mg	90	30	1
04/11/15	Lunesta	3 mg	30	30	2
04/17/15	Suboxone	8 mg-2 mg	90	30	0
05/12/15	Lunesta	3 mg	30	30	0
05/15/15	Suboxone	8 mg-2 mg	90	30	0
06/09/15	Lunesta	3 mg	30	30	1
06/16/15	Suboxone	8 mg-2 mg	90	30	0

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
07/09/15	Lunesta	3 mg	30	30	2
07/13/15	Alprazolam	2 mg	90	30	0
07/21/15	Suboxone	8 mg-2 mg	90	30	0
08/24/15	Suboxone	8 mg-2 mg	90	30	0
09/21/15	Lunesta	3 mg	30	30	0
09/23/15	Alprazolam	2 mg	90	30	0
10/06/15	Suboxone	8 mg-2 mg	90	30	0
10/17/15	Lunesta	3 mg	30	30	1
11/10/15	Suboxone	8 mg-2 mg	60	30	0
11/20/15	Lunesta	3 mg	30	30	0

35. In or around December 2015 to as late as March 2017, the CURES database lists recurring prescriptions for carisoprodol[12] as having been issued by Respondent and filled by patient B, concurrent with continuing prescriptions for Suboxone, Lunesta and alprazolam:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
12/11/15	Carisoprodol	350 mg	90	30	0
12/11/15	Suboxone	8 mg-2 mg	60	30	0
01/14/16	Lunesta	3 mg	30	30	0
01/14/16	Alprazolam	2 mg	90	30	0
02/02/16	Carisoprodol	350 mg	60	30	0
02/02/16	Suboxone	8 mg-2 mg	60	30	0
02/13/16	Lunesta	3 mg	30	30	1
03/04/16	Carisoprodol	350 mg	90	30	0
03/04/16	Suboxone	8 mg-2 mg	60	30	0
03/12/16	Lunesta	3 mg	30	30	2
03/31/16	Carisoprodol	350 mg	60	30	0
04/11/16	Lunesta	3 mg	30	30	3
04/11/16	Suboxone	8 mg-2 mg	90	30	0

[12] Carisprodol, a generic for Soma, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and is a dangerous drug pursuant to Business and Professions Code section 4022. It is often used to treat muscle spasms.

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
04/26/16	Alprazolam	2 mg	90	30	0
05/06/16	Carisoprodol	350 mg	90	30	0
05/26/16	Suboxone	8 mg-2 mg	60	30	0
06/01/16	Lunesta	3 mg	30	30	0
06/13/16	Carisoprodol	350 mg	90	30	0
06/24/16	Suboxone	8 mg-2 mg	60	30	0
07/18/16	Lunesta	3 mg	30	30	0
07/25/16	Suboxone	8 mg-2 mg	60	30	0
08/10/16	Carisoprodol	350 mg	90	30	0
08/10/16	Lunesta	3 mg	30	30	1
08/26/16	Suboxone	8 mg-2 mg	60	30	0
09/06/16	Carisoprodol	350 mg	90	30	1
09/06/16	Lunesta	3 mg	30	30	2
09/19/16	Alprazolam	2 mg	90	30	0
09/30/16	Suboxone	8 mg-2 mg	60	30	0
10/03/16	Lunesta	3 mg	30	30	3
10/03/16	Carisoprodol	350 mg	90	30	2
11/08/16	Carisoprodol	350 mg	90	30	0
11/08/16	Lunesta	3 mg	30	30	0
11/08/16	Suboxone	8 mg-2 mg	60	30	0
12/05/16	Lunesta	3 mg	30	30	0
12/09/16	Carisoprodol	350 mg	120	30	0
12/11/16	Suboxone	8 mg-2 mg	60	30	0
01/13/17	Lunesta	3 mg	30	30	1
01/23/17	Suboxone	8 mg-2 mg	60	30	0
01/24/17	Carisoprodol	350 mg	120	30	0
02/20/17	Carisoprodol	350 mg	120	30	1
02/27/17	Eszopiclone[13]	3 mg	30	30	0
03/01/17	Alprazolam	2 mg	90	30	0

[13] Eszopiclone is a generic for Lunesta.

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
03/01/17	Suboxone	8 mg-2 mg	60	30	0
03/19/17	Carisoprodol	350 mg	120	30	2

36. Throughout the period during which Respondent prescribed eszopiclone (Lunesta) to patient B, in or around November 2013 to at least March 2017, Respondent failed to adequately establish or document a medical indication or rationale for the prescribing of this drug. In fact, during this period, multiple office visit notes authored by Respondent documented that patient B had "no [i]nsomnia[.]"

37. Further, eszopiclone (Lunesta) is a controlled substance with abuse potential, which can be problematic when prescribed in combination with buprenorphine, as prescribed by Respondent to patient B on multiple occasions from in or around November 2013 to at least March 2017.

38. Throughout the period during which Respondent prescribed alprazolam (Xanax) to patient B, in or around March 2014 to at least March 2017, Respondent failed to adequately establish or document a medical indication for the prescribing of a benzodiazepine, such as alprazolam. In fact, during this period, multiple office visit notes authored by Respondent documented that patient B had "no [a]nxiety[.]"

39. Further, alprazolam (Xanax) is a controlled substance with abuse potential, which is problematic and generally contraindicated when prescribed in combination with buprenorphine (Suboxone), as prescribed by Respondent to patient B on multiple occasions in or around March 2014 to at least March 2017.

40. During the period during which Respondent prescribed carisoprodol (Soma) to patient B, in or around December 2015 to at least March 2017, Respondent failed to adequately establish or document a medical indication for the prescribing of a muscle relaxant, such as carisoprodol.

41. Further, carisoprodol (Soma) is a controlled substance with abuse potential, which is problematic when prescribed in combination with buprenorphine (Suboxone) and alprazolam

(Xanax) due to the potential for adverse interactions between them, as prescribed by Respondent to patient B on one or more occasions from in or around December 2015 to at least March 2017.

42. Throughout the course of Respondent's care and treatment of patient B, he failed to adequately assess or document patient B's progress, if any, toward treatment goals related to Respondent's stated diagnosis of opioid use disorder.

43. In an office visit note dated April 20, 2018, Respondent documented that patient B's "family called and stated that patient having [sic] memory loss and more confusion." The office visit note fails to adequately document an evaluation or examination of patient B in light of the report from her family, or corresponding changes to any treatment plan or medication prescriptions for patient B.

44. Although Respondent first documented an opioid use disorder diagnosis and controlled substance prescription for patient B on or about September 4, 2013, Respondent did not order or review a subsequent toxicology drug screen for patient B until, at the earliest, more than four years later, on or about May 30, 2018.

45. Although Respondent first documented an opioid use disorder diagnosis and controlled substance prescription for patient B on or about September 4, 2013, Respondent's medical records for patient B contain no record of his having reviewed a CURES report for patient B until, at the earliest, May 2018.

46. Respondent committed gross negligence in his care and treatment of patient B in that he failed to properly monitor the prescribing of medication to a patient with an opioid use disorder including, but not limited to:

(a) generating multiple repetitive treatment notes throughout the course of Respondent's prescribing of controlled substances to patient B with large portions of the content of the notes appearing to have been copied forward from a prior note;

(b) failing to adequately and accurately document medications, and mediation amounts, and medication refills prescribed to patient B;

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(c) prescribing a benzodiazepine, such as alprazolam, to patient B in combination with buprenorphine without adequate medical indication for the prescribing of a benzodiazepine;

(d) prescribing a muscle relaxant, such as carisoprodol, to patient B in combination with buprenorphine and alprazolam without adequate medical indication for the prescribing of a muscle relaxant;

(e) prescribing eszopiclone (Lunesta) to patient B in combination with buprenorphine without adequate medical indication for the prescribing of eszopiclone;

(f) failing to adequately follow up on or document the result of one or more laboratory studies or specialist consultations for patient B;

(g) failing to adequately assess or document patient B's progress with regard to any established treatment goals pertinent to her documented diagnosis of an opioid use disorder;

(h) failing to adequately confirm patient B's compliance with treatment, or lack thereof; and

(i) failing to adequately respond to one or more reports of a significant change in patient B's condition.

Patient C

47. On or about August 10, 2015, a then twenty-seven-year-old male, "patient C", presented to Respondent for the first time. In his office visit note for this appointment, Respondent documented, among other things, that patient C had been taking one Suboxone 8 mg-2 mg per day, that patient C previously "was on heroin[,] oxycodone and onrocode [sic][,]" a diagnosis of opioid type dependence, in remission, and issuing a prescription for a thirty-day supply of Suboxone 8 mg-2 mg, to be administered once per day, with two refills.

48. At patient C's initial office visit with Respondent on or about August 10, 2015, Respondent failed to adequately establish or document patient C's substance abuse, mental health and social histories sufficient to properly formulate a diagnosis of an opioid use disorder.

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Further, Respondent failed to adequately establish or document the nature and extent of patient C's prior abuse of certain drugs.

49. At patient C's initial office visit with Respondent on or about August 10, 2015, Respondent failed to adequately establish or document informed consent for buprenorphine therapy including, but not limited to, discussing or documenting discussion of potential harms of buprenorphine therapy or alternative treatment options for an opioid use disorder.

50. At patient C's initial office visit with Respondent on or about August 10, 2015, Respondent failed to adequately establish or document a treatment plan and objectives for patient C.

51. At or before patient C's initial office visit with Respondent on or about August 10, 2015, Respondent failed to review medical records for patient C by any former medical care providers, order or review a urine drug screen or other toxicology drug screening for patient C, or review the CURES database for any controlled substance prescriptions listed for patient C.

52. Subsequent to the August 10, 2015 appointment, Respondent documented approximately 29 office visits with patient C through as late as May 15, 2018 (i.e., thirty total visits documented from August 10, 2015 to May 15, 2018).

53. The CURES database lists recurring prescriptions for Suboxone, seemingly consistent with a prescribing pattern of Suboxone 8 mg-2 mg once per day, as having been issued by Respondent and filled by patient C in or around August 2015 to March 13, 2016:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
8/14/15	Suboxone	8 mg-2 mg	30	30	0
10/7/15	Suboxone	8 mg-2 mg	2	2	0
10/11/15	Suboxone	8 mg-2 mg	1	1	0
10/12/15	Suboxone	8 mg-2 mg	15	15	1
11/9/15	Suboxone	8 mg-2 mg	1	1	2
11/11/15	Suboxone	8 mg-2 mg	11	11	3
11/29/15	Suboxone	8 mg-2 mg	7	7	0
12/9/15	Suboxone	8 mg-2 mg	1	1	1

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
12/10/15	Suboxone	8 mg-2 mg	5	5	2
12/20/15	Suboxone	8 mg-2 mg	4	4	3
12/28/15	Suboxone	8 mg-2 mg	5	5	0
1/10/16	Suboxone	8 mg-2 mg	1	1	1
1/11/16	Suboxone	8 mg-2 mg	7	7	2
1/19/16	Suboxone	8 mg-2 mg	8	8	3
1/25/16	Suboxone	8 mg-2 mg	7	7	4
1/29/16	Suboxone	8 mg-2 mg	7	7	4
2/3/16	Suboxone	8 mg-2 mg	8	8	0
2/8/16	Suboxone	8 mg-2 mg	7	7	1
2/12/16	Suboxone	8 mg-2 mg	7	7	2
2/16/16	Suboxone	8 mg-2 mg	7	7	3
2/20/16	Suboxone	8 mg-2 mg	7	7	0
2/24/16	Suboxone	8 mg-2 mg	7	7	1
2/28/16	Suboxone	8 mg-2 mg	7	7	2
3/3/16	Suboxone	8 mg-2 mg	7	7	3
3/7/16	Suboxone	8 mg-2 mg	6	6	5
3/10/16	Suboxone	8 mg-2 mg	2	2	4
3/11/16	Suboxone	8 mg-2 mg	2	2	5
3/13/16	Suboxone	8 mg-2 mg	1	1	4

54. Notes for office visits between Respondent and patient C in or around August 2015 to April 13, 2016 stated on multiple occasions that patient C was "[u]sing smaller amounts" without providing further explanation or identifying the drug or substance purportedly being used in smaller amounts.

55. Although Respondent first documented an opioid use disorder diagnosis and opioid prescription for patient C on or about August 14, 2015, Respondent did not order or review a toxicology drug screen for patient C until, at the earliest, approximately eight months later, on or about April 13, 2016.

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56. Respondent would not order or review another toxicology drug screen for patient C until, at the earliest, more than two years later, on or about June 15, 2018.

57. The CURES database lists recurring prescriptions for Suboxone, seemingly consistent with a prescribing pattern of Suboxone 8 mg-2 mg twice per day, as having been issued by Respondent and filled to patient C in or around March 14, 2016 to May 31, 2016:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
3/14/16	Suboxone	8 mg-2 mg	10	5	0
3/19/16	Suboxone	8 mg-2 mg	10	5	1
3/24/16	Suboxone	8 mg-2 mg	10	5	2
3/29/16	Suboxone	8 mg-2 mg	7	3	3
4/2/16	Suboxone	8 mg-2 mg	8	4	4
4/8/16	Suboxone	8 mg-2 mg	7	3	0
4/11/16	Suboxone	8 mg-2 mg	8	4	1
4/15/16	Suboxone	8 mg-2 mg	10	5	0
4/20/16	Suboxone	8 mg-2 mg	10	5	1
4/25/16	Suboxone	8 mg-2 mg	10	5	2
4/30/16	Suboxone	8 mg-2 mg	10	5	3
5/6/16	Suboxone	8 mg-2 mg	10	5	4
5/12/16	Suboxone	8 mg-2 mg	10	5	5
5/17/16	Suboxone	8 mg-2 mg	10	5	0
5/22/16	Suboxone	8 mg-2 mg	10	5	1
5/26/16	Suboxone	8 mg-2 mg	10	5	2
5/31/16	Suboxone	8 mg-2 mg	10	5	3

58. Despite documenting office visits with patient C on March 14, 2016 and April 13, 2016, Respondent did not document any increase in the dosage of patient C's Suboxone prescription until, at the earliest, May 13, 2016. In the office visit note dated May 13, 2016, Respondent failed to adequately establish or document a medical indication or rationale for changing patient C's Suboxone dosage.

59. In the note for the subsequent office visit with patient C dated June 13, 2016, Respondent documented that patient C's current mediations included Suboxone 8 mg – 2 mg

once a day, despite documenting in the preceding office visit note, as well as elsewhere in the June 13, 2016 office visit note, that the dosage had been increased to twice a day.

60. Elsewhere in the office visit note dated June 13, 2016, Respondent documented "[d]iscuss change in med [sic]" as a reason for the appointment and the commencement of a prescription for Bunavail[14] 4.2 mg-0.7 mg twice a day.

61. In the note for the subsequent office visit with patient C dated July 13, 2016, Respondent documented that patient C was to stop Bunavail. Further, Respondent again documented inconsistent Suboxone prescription dosages in this office visit note.

62. In or around June and July 2016, Respondent failed to adequately establish or document a medical rationale for starting and stopping patient C on Bunavail.

63. The CURES database lists a prescription for Bunavail as having been issued by Respondent and filled to patient C in or around June 2016, along with prescriptions for Suboxone:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
6/4/16	Suboxone	8 mg-2 mg	10	5	4
6/8/16	Suboxone	8 mg-2 mg	10	5	5
6/14/16	Bunavail	4.2 mg-0.7 mg	10	5	0
6/17/16	Suboxone	8 mg-2 mg	10	5	0
6/20/16	Suboxone	8 mg-2 mg	10	5	1
6/25/16	Suboxone	8 mg-2 mg	10	5	2
6/30/16	Suboxone	8 mg-2 mg	10	5	3

64. In or around July 2016 to at least March 2017, the CURES database lists no more Bunavail prescriptions, but does list continuing prescriptions for Suboxone as having been issued by Respondent and filled to patient C:

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
7/5/16	Suboxone	8 mg-2 mg	10	5	4
7/8/16	Suboxone	8 mg-2 mg	10	5	5

[14] Bunavail is a brand name for a combination of buprenorphine and naloxone, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
7/13/16	Suboxone	8 mg-2 mg	8	4	0
7/16/16	Suboxone	8 mg-2 mg	10	5	1
7/20/16	Suboxone	8 mg-2 mg	10	5	2
7/24/16	Suboxone	8 mg-2 mg	8	4	3
7/27/16	Suboxone	8 mg-2 mg	8	4	4
7/30/16	Suboxone	8 mg-2 mg	8	4	5
8/3/16	Suboxone	8 mg-2 mg	8	4	6
8/8/16	Suboxone	8 mg-2 mg	8	4	0
8/12/16	Suboxone	8 mg-2 mg	8	4	0
8/16/16	Suboxone	8 mg-2 mg	8	4	1
8/21/16	Suboxone	8 mg-2 mg	8	4	2
8/25/16	Suboxone	8 mg-2 mg	8	4	3
8/28/16	Suboxone	8 mg-2 mg	8	4	4
9/2/16	Suboxone	8 mg-2 mg	8	4	5
9/8/16	Suboxone	8 mg-2 mg	8	4	0
9/13/16	Suboxone	8 mg-2 mg	8	4	1
9/17/16	Suboxone	8 mg-2 mg	8	4	2
9/22/16	Suboxone	8 mg-2 mg	8	4	3
9/25/16	Suboxone	8 mg-2 mg	8	4	4
9/28/16	Suboxone	8 mg-2 mg	8	4	5
10/2/16	Suboxone	8 mg-2 mg	8	4	6
10/6/16	Suboxone	8 mg-2 mg	8	4	0
10/10/16	Suboxone	8 mg-2 mg	8	4	1
10/14/16	Suboxone	8 mg-2 mg	8	30	2
10/17/16	Suboxone	8 mg-2 mg	20	10	3
10/27/16	Suboxone	8 mg-2 mg	8	4	4
11/1/16	Suboxone	8 mg-2 mg	8	4	0
11/4/16	Suboxone	8 mg-2 mg	8	4	5
11/9/16	Suboxone	8 mg-2 mg	8	4	0
11/13/16	Suboxone	8 mg-2 mg	8	4	1

Date Filled	Drug Name	Strength	Qty	Days Supply	Refill#
11/17/16	Suboxone	8 mg-2 mg	8	4	2
11/22/16	Suboxone	8 mg-2 mg	1	1	3
11/23/16	Suboxone	8 mg-2 mg	12	6	4
11/30/16	Suboxone	8 mg-2 mg	2	1	5
12/1/16	Suboxone	8 mg-2 mg	15	7	0
12/9/16	Suboxone	8 mg-2 mg	15	5	1
12/18/16	Suboxone	8 mg-2 mg	15	7	2
12/27/16	Suboxone	8 mg-2 mg	8	4	3
1/2/17	Suboxone	8 mg-2 mg	15	7	4
1/9/17	Suboxone	8 mg-2 mg	15	7	5
1/24/17	Suboxone	8 mg-2 mg	8	8	7
1/29/17	Suboxone	8 mg-2 mg	5	2	8
2/1/17	Suboxone	8 mg-2 mg	15	8	0
2/8/17	Suboxone	8 mg-2 mg	15	8	1
2/16/17	Suboxone	8 mg-2 mg	15	8	2
2/25/17	Suboxone	8 mg-2 mg	7	4	3
3/3/17	Suboxone	8 mg-2 mg	29	14	0
3/23/17	Suboxone	8 mg-2 mg	16	8	1

65. Multiple notes for office visits between Respondent and patient C following June 2016, through at least April 2017, continued to inconsistently document the Suboxone dosages prescribed by Respondent to Patient C.

66. On multiple occasions throughout the course of Respondent's care and treatment of patient C, Respondent failed to adequately assess or document patient C's progress toward any established treatment objectives, patient C's adherence to treatment, or whether patient C was having any adverse effects from his use of buprenorphine (contained in both Suboxone and Bunavail).

67. Although Respondent first documented an opioid use disorder diagnosis and controlled substance prescription for patient C on or about August 14, 2015, Respondent's medical records for patient C contain no record that Respondent reviewed the CURES database

for controlled substance prescriptions listed for patient C until, at the earliest, May 2018, almost three years after commencing treatment of the patient.

68. Throughout the course of Respondent's care and treatment of patient C through at least May 15, 2018, Respondent failed to adequately ascertain or document the nature or existence of any comorbid illnesses relevant to a patient with an opioid use disorder including, but not limited to, ordering or reviewing laboratory testing to ascertain whether patient C had any liver disease or infectious disease, such as hepatitis or HIV.

69. Throughout the course of Respondent's care and treatment of patient C through at least May 15, 2018, Respondent failed to adequately establish or document patient C's involvement in drug abuse counseling or rehabilitation programs.

70. Respondent committed gross negligence in his care and treatment of patient C in that he failed to properly evaluate patient C prior to prescribing him medication for treatment of an opioid use disorder including, but not limited to:

(a) failing to establish sufficient detail regarding patient C's substance abuse history, mental health history, and social history in order to properly establish a diagnosis of an opioid use disorder;

(b) failing to order or review laboratory testing to ascertain whether patient C had any infection, liver disease, or infectious disease such as hepatitis or HIV;

(c) failing to adequately establish informed consent at the outset of buprenorphine treatment;

(d) failing to adequately delineate a treatment plan and objectives for patient C;

(e) and failing to order or review a toxicology drug screen and the CURES database at the outset of buprenorphine treatment.

71. Respondent committed gross negligence in his care and treatment of patient C in that he failed to properly monitor patient C's treatment for an opioid use disorder including, but not limited to:

(a) failing to adequately document patient C's progress toward any established treatment objectives;

(b) failing to adequately document patient C's adherence to treatment;

(c) failing to adequately document whether patient C suffered any adverse effects from his use of buprenorphine:

(d) failing to make adequate efforts to use toxicology drug screens to monitor patient C's compliance with treatment;

(e) failing to make adequate efforts to review the CURES database; and

(f) failing to adequately establish patient C's involvement in drug abuse counseling or rehabilitation.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

72. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 36345 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of at least three patients as more particularly alleged hereinafter:

73. Paragraphs 9 to 71, above, are hereby incorporated by reference and realleged as if fully set forth herein.

74. Respondent committed negligence in his care and treatment of patient A in that he failed to maintain adequate and accurate records pertaining to Respondent's prescribing of controlled substances to patient A for pain including, but not limited to:

(a) documenting multiple office visit notes with repetitive and inaccurate content that appears to have been entered by default or copied forward from prior notes;

(b) failing to adequately document the nature and extent of patient A's pain and its impact on his functioning;

(c) failing to adequately document examination findings relevant to patient A's musculoskeletal and neurological condition;

(d) failing to adequately document diagnostic testing relevant to the patient's reported chronic pain;

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(e) failing to adequately document the Respondent's course of treatment for patient A, including patient A's compliance with treatment, progress toward any established treatment goals, and tolerance for prescribed medications; and

(f) failing to adequately and accurately document prescribed medication and medication amounts on multiple occasions.

75. Respondent committed negligence in his care and treatment of patient B in that he failed to properly evaluate patient B prior to prescribing her buprenorphine for treatment of an opioid use disorder including, but not limited to:

(a) failing to adequately and independently corroborate patient B's prior diagnosis of an opioid use disorder;

(b) failing to adequately address a significant discrepancy in patient B's reported Suboxone use at the outset of buprenorphine treatment;

(c) failing to order or review a toxicology drug screen for patient B at the outset of buprenorphine treatment; and

(d) failing to review the CURES database for controlled substances listed for patient B at the outset of buprenorphine treatment.

76. Respondent committed negligence in his care and treatment of patient B in that he failed to maintain adequate and accurate records pertinent to his prescribing of medications to patient B including, but not limited to:

(a) failing to adequately document patient B's medical history and relevant physical examination findings;

(b) failing to adequately document diagnostic testing for patient B;

(c) failing to adequately and accurately document medications and medication amounts prescribed to patient B on multiple occasions;

(d) failing to document a treatment plan, patient B's compliance with any such treatment plan, and whether patient B was benefitting or being harmed from treatment;

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(e) failing to adequately document ancillary treatment rendered to patient B, such as treatment by any consulting specialists; and

(f) documenting multiple office visit notes with repetitive and inaccurate content that appears to have been entered by default or copied forward from prior notes.

77. Respondent committed negligence in his care and treatment of patient C in that he failed to maintain adequate and accurate records pertaining to Respondent's prescribing of medications to patient C to treat an opioid use disorder including, but not limited to:

(a) misidentifying patient C's sex in all or nearly all of Respondent's office visit notes for patient C;

(b) documenting multiple office visit notes containing repetitive and inaccurate content that appears to have been entered by default or copied forward from prior visit notes;

(c) failing to adequately and accurately document the medication or medication amounts prescribed to patient C on multiple occasions;

(d) and failing to adequately document the history of patient C's course of treatment with Respondent including, but not limited to, patient C's compliance with treatment, patient C's progress toward treatment goals, and patient C's tolerance for the prescribed medication.

THIRD CAUSE FOR DISCIPLINE

(Prescribing, Dispensing, or Furnishing of a Dangerous Drug without an Appropriate Prior Examination and a Medical Indication)

78. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 36345 to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code in that he prescribed, dispensed, or furnished a dangerous drug on one or more occasions without an appropriate prior examination and a medical indication as more particularly alleged in paragraphs 9 to 75, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

79. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 36345 to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code in that he committed repeated acts of clearly excessive prescribing, furnishing, dispensing or administering of a drug or treatment as more particularly alleged in paragraphs 9 to 75, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

80. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 36345 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code in that he failed to maintain adequate and accurate records relating to his provision of services to one or more patients as more particularly alleged in paragraphs 9 to 77, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Violation of the Medical Practice Act)

81. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 36345 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code in that he violated or attempted to violate, directly or indirectly, any provision of the Medical Practice Act as more particularly alleged in paragraphs 9 to 80, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

82. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 19, 1998, in a prior action, the Board issued Decision No. 11-96-61601 (the "Decision"), which is hereby incorporated by reference and alleged as if fully set forth herein, wherein the Board found that Respondent committed repeated negligent acts, incompetence, unprofessional conduct, and failed to keep accurate or complete

records in rendering medical care and treatment to two pregnant female patients. The decision revoked Respondent's Physician's and Surgeon's Certificate No. A 36345, revocation stayed, and placed Respondent on four years' probation. Probation conditions imposed on Respondent included, but were not limited to, completion of a physician assessment and clinical education program of at least three days and including appropriate patient chart documentation, practice monitoring, and the completion of an ethics course. By a subsequent Board decision on or about March 1, 2001, a Petition for Penalty Relief filed by Respondent was granted and his probation was terminated effective March 30, 2001.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 36345, issued to Respondent Mark Scheier, M.D.;

2. Revoking, suspending or denying approval of Respondent Mark Scheier, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Mark Scheier, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: December 31, 2018

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